FIRST-TIME MOTHERS AND THEIR HEALTH VISITORS: PERCEPTIONS OF A HOME VISIT

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For my family, friends and supervisors, who kept me sane and cheerful through all the long rewrites, and for the mothers and health visitors who so willingly gave me their time and shared their thoughts.

DECLARATION

I declare that this thesis is entirely my own work.

CONTENTS

ACKNOWLEDGEMENTS ii

ABSTRACT viii

LIST OF TABLES x

LIST OF FIGURES xi

LIST OF APPENDICES xii

1 INTRODUCTION 1

1.1 Background to study 1

1.2 Justification 2

2 LITERATURE 8

2.1 First-time mothers 8

2.2 Health visitors 11

2.3 Health visitors and teaching 18

2.3.1 Medical advice-giving 18

2.3.2 Advice-giving in nursing 20

2.3.3 Advice-giving in health visiting 21

2.4 Home visiting research 23

2.5 Communication 27

2.6 Perception 29

2.7 Mothers and health visitors: client response 31

2.8 Health visitor and client relationship 36

2.9 Conclusion: gaps in the literature 41

3 METHODS 42

3.1 Background literature 42

3.1.1 Past research in nurse-patient communication 42

3.1.2 Ethnomethodology 44

3.1.3 Triangulation 46
3.2 Aims 48
3.3 Research methods and design 48
3.4 Data Collection 50
3.4.1 Recording home visits 50
3.4.2 Health visitor as researcher 52
3.4.3 Interviews 55
3.4.4 Questionnaires 57
3.4.5 Visual analogue scales 58
3.5 Pilot study 60
3.6 Access 63
3.7 Main study 65
3.8 Summary 68
4 QUANTITATIVE ANALYSIS OF THE DATA 69
4.1 Sample 69
4.1.1 Health visitors 69
4.1.2 Clients 73
4.2 Visual analogue scales 78
4.2.1 Description 78
4.2.2 Class differences 83
4.2.3 Chi-square analysis 84
4.2.4 Correlation 85
4.3 Questionnaire data 85
4.3.1 The length of time health visitor has known client 85
4.3.2 The number of contacts between health visitor and client 86

4.3.3 Most important areas discussed 90
4.4 Interviews 95
4.4.1 With clients 95
4.4.2 With health visitors 95
4.4.3 Data from interviews: aims for the visit 95
4.5 Comparison of interview and questionnaire data 100
4.6 Visits 102
4.6.1 Length 102
4.6.2 Proportional verbal input 105
4.6.3 which visit talked about in depth 110
4.7 Summary 110
5 VIEWS ABOUT HOME VISITS 113
5.1 Practicalities of visiting 113
5.1.1 Past contacts 113
5.1.2 Present contacts 114
5.2 Participants' priorities 118
5.3 Home visits versus clinic visits 120
5.4 Home visits - success or failure 124
5.5 Summary 129
6 ADVICE AND ADVICE-GIVING 131
6.1 Introduction 131
6.2 Congruence of views 133
6.2.1 Anything new learned 133
6.2.2 Clients' main concerns 137
6.2.3 Topics discussed 138

6.3 Clients' perspective 139
6.3.1 Positive response 139
6.3.2 Negative response 142
6.4 Health visitors' perspective 145
6.4.1 Positive response 146
6.4.2 Negative response 148
6.5 Advice-giving in practice 150
6.5.1 Acceptability 151
6.5.2 Strategies of advice-giving 151
6.6 Summary 156

7 ROLE OF THE HEALTH VISITOR, AND HEALTH VISITOR / CLIENT RELATIONSHIP 159
7.1 Introduction 159
7.2 The role of the health visitor 163
7.2.1 Health visitors 163
7.2.2 Clients 164
7.3 Health visitor / client relationship 167
7.3.1 Health visitors 167
7.3.2 Clients 172
7.4 Power 177
7.5 Summary 181

8 CONTENT OF HOME VISITS 182
8.1 Introduction - conversational analysis 182
8.2 Comparison with previous research 184
8.3 Findings 187
8.3.1 Openings 187

8.3.2 Topics - stepwise progression, segmented topic flow 189
8.3.3. Talking to the baby 194
8.3.4 Humour 196
8.3.5 Praise 200
8.3.6 Pauses 202
8.3.7 Recognitions 202
8.3.8 Dealing with rejection 203
8.3.9 Pursuing a response 204
8.3.10 Communication skills 206
8.3.11 Closings 208
8.3.12 Client ploys 210
8.4 Ploys - conscious or unconscious? 211
8.5 Discussion 213
8.6 Summary 216
9. CONCLUSION 217
9.1 Partnership with clients 217
9.2 Limitations of the study 228
9.3 Aims of the study 229
9.4 Recommendations 231
9.5 Looking to the future 234
REFERENCES 238
APPENDICES 261

ABSTRACT

This study explores the relationship between mother and health visitor through their perceptions of a home visit. The aims are to describe the interaction on a routine home visit, compare the perceptions of the participants, and explore their contrasting views. Through this exploration the worth of home visits is demonstrated.

The theoretical framework was based in ethnomethodology, and multiple methods of data collection provided complementary data.

Fifteen volunteer health visitors carried out a routine home visit to three primiparous mothers, with babies aged 2 to 6 months. This visit was tape recorded. Both client and health visitor were interviewed by the researcher, and were asked to complete a short questionnaire after the visit.

There was a similarity of views about the visit and their relationship. Both participants judged a successful visit in terms of the client's response and satisfaction. To the health visitors, a good relationship was not necessary to carry out their work. To the clients, however, a good relationship was of prime importance. A non-authoritarian approach was much preferred.

The interaction revealed a number of verbal strategies whereby the participants guided the interaction. Satisfaction does not depend on having similar aims and priorities for the visit. The health visitors, while possessing more power than they think they have, use many strategies to ensure acceptability.

The home visit is demonstrated as an interaction of some complexity, providing boundless possibilities for the exchange of information, with the client very much an equal participant.

The research ends with recommendations for management, education, and practice, one of which is the use of a health visitor / client contract, which might effectively explain the service offered, and assist in forming good relationships.

LIST OF TABLES

1.	Visual analogue scale: length of visit [in Appendix K]	282
2.	Visual analogue scale: most important areas discussed [in Appendix K]	283
3.	Visual analogue scale: usefulness of visit [in Appendix K]	284
4.	Visual analogue scale: relationship good [in Appendix K]	285
5.	The number of contacts between health visitor and client	86
6.	Comparison of views: most important areas discussed	91
7.	Incidence of topics - most important areas	94
8.	Comparison of views: aims for the visit	96
9:	Incidence of topics - aims for the visit	99
10.	Length of tapes of the visits	103
11.	Comparison of lengths of tapes	104
12.	Which visit longest/shortest	104
13.	Proportional verbal input	106
14.	Most important thing health visitor said or did for client	118
15.	Incidence of most important thing in their past relationship	119
16.	Anything new learned by client	134
17.	Clients' main concerns	137
18.	Summary - comparison of table results, in Appendix M.	289

LIST OF FIGURES

1.	Health visitors' age	71
2.	Health visitors' area of work	72
3.	Health visitors' number of qualifications	72
4.	Clients' housing	74
5.	Clients' social class	74
6.	Age of babies	77
7.	Comparison of participants' scores - 50 or over	80
8.	Comparison of participants' scores - 20 or over	80
9.	Comparison of participants' scores - differences	82
10.	Number of clients more critical than their health visitors	82
11.	Number of contacts	89
12.	Anything new learned by client	136
13.	Clients' main concern helped by health visitor	136

LIST OF APPENDICES

1.	Appendix A: Interview schedule - health visitors	261
2.	Appendix B: Interview schedule - clients	263
3.	Appendix C: Questionnaire - health visitors	266
4.	Appendix D: Questionnaire - clients	270
5.	Appendix E: Information sheet for health visitors	271
6.	Appendix F: Data collection sheet for health visitors	274
7.	Appendix G: Information sheet for clients	277
8.	Appendix H: Consent form - health visitors	279
9.	Appendix I: Consent form - clients	280
10.	Appendix J: Letter for G.P.'s	281
11.	Appendix K: Visual analogue scale tables	282
12.	Appendix L: Chi-square tables	286
13.	Appendix M: Table 18, Summary - Comparison of table results.	289
14.	Appendix N. Transcript notation used in conversational analysis.	291
15.	Appendix P: "Clients' Perception of a home visit". *FOCUS* S.H.V.A.magazine, no. 19, summer 1990, pp 22-23.	296
16.	Appendix Q: "Games health visitors play: interaction on home visits". *Health Visitor*, 65, no. 7, 1992, pp 231- 232.	298

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO STUDY

This study was carried out in a time of great change within the National Health Service and the health visiting profession. This statement, while true from a present perspective, could have been made many times throughout the history of health visiting and indeed the National Health Service. What makes the present "challenge for change" so different?

One difference is the emphasis on accountability, which is being closely linked with demonstrating that services are financially worthwhile. Quality of care is being stressed, but that quality has to be demonstrated, whether in financial or customer satisfaction terms.

This study was commenced in 1988, when practitioners in the health service associated accountability with standards of professional practice. The consumerism movement had led to moves to make patients or clients more aware of the services offered [but not yet allow them, for example, to see their own medical records].

Since 1988, all health professionals have been made more aware of realities of rising costs and limited resources, and hence the need to demonstrate the value of their work.

This study investigates home visits made by health visitors. Health visiting has long had a problem explaining its preventive role. Health visitors are expensive,

as they require extensive training. Home visits are a luxury, in that they are time-consuming, and if measured in purely financial terms one health visitor's time spent with only one client in a home setting cannot match one health visitor seeing many clients in a clinic environment.

The question requiring to be answered, therefore, is, "Are routine home visits worthwhile"?

This study set out to examine home visits through the perceptions of the participants, exploring their interaction and hence the health visitor/ client relationship. It demonstrates the complexity and variety of a so-called "routine" home visit, opens the interaction up to scrutiny, so that its value can be assessed.

1.2 JUSTIFICATION

The study evolved from an initial interest in the relationship between health visitor [HV] and client, and the factors affecting this relationship. As a practising health visitor for 7 years, the author was aware that much of the health visitor's work was not documented, and was not therefore open to outside scrutiny and validation.

Why home visits? Home visits have been shown to be popular with clients, but what is it about contact at home that makes it different from contact at clinic? In Finland, health visiting is almost entirely clinic based, whereas in Denmark it is almost entirely home based. Home visiting is an expensive use of health visitors' time - is it worth it?

Home visiting occupies between a quarter and a third of the health visitor's time [Clark 1981]. The traditional pattern of visiting is that the majority of home

visits are paid to mothers with children under 5 [Marris 1971, Clark 1973] and proportionately more visits paid to first-time mothers, and those with small babies [Wiseman 1979, Clark 1981, Dunnell & Dobbs 1982, While 1985]. Mothers, as opposed to parents, were selected as subjects in this study, because the main caregivers are usually women, and the usual recipient of the health visiting service, although it is only in the last few years that this aspect has been highlighted by feminist authors [Oakley 1980, Kristjanson and Chalmers 1991].

With the area of interest identified as home visits to primiparous mothers with young babies, the study developed into an investigation of the relationship between health visitor and client through their perceptions of one specific interaction i.e. a home visit.

Home visits are an area which has only recently been studied from an interactional perspective. Practising health visitors may well have witnessed few other health visitors at work, other than their Fieldwork Teacher, and colleagues in clinic situations. Home visiting has been called the "core" of health visiting [C.E.T.H.V. 1980:43], and the "essential backbone" of the service [Bax et al. 1980]. Home visits are undertaken by all health visitors to a greater or lesser extent, and the client group, mothers and babies, is a shared priority of all generic health visitors.

The questions to be answered are, from the health visitors' perspective, what objectives are achieved through interaction in the home, as opposed to elsewhere, and from clients', what is the difference between seeing the health visitor in the home as opposed to the clinic?

Susan Sefi [1985], June Clark [1985], and Kate Robinson [1987], had all looked at notification [first postnatal] visits, so this study investigates visits to older babies. The data might demonstrate differences in the relationship, and interaction, from notification visits. Primiparous mothers were chosen, because they might be considered a higher priority to receive home visits, and as these women would have been unlikely to have been in contact with health visitors prior to this time.

From the clients' perspective, is the service meeting their needs? This is a question that has taken on increasing importance with the growth of the consumer movement. This is demonstrated by the increasing numbers of self-help groups offering alternatives to professional help, clients' rights guides, and in the growth of pressure groups seeking to put the clients' point of view and to change services. Two American sociologists went so far as to talk about "the revolt of the client" [Haug & Sussman 1969].

A need for greater partnership with clients has been stressed both in the health visiting literature, and in the wider arena of professional/client relationships.

The Court Report [D.H.S.S. 1976] stated that "professionals should see themselves as partners with parents". This view was reiterated by Cumberlege [D.H.S.S. 1986], with the addition of the child to the equation: "all services offered by community nurses should be viewed as a partnership with the parents and child." In 1978, the World Health Organisation, in the Declaration of Alma-Ata, stated that :

"People have the right and the duty to participate individually and collectively in the planning and implementation of their health care" [W.H.O. 1978].

In response to these official exhortations, "Thinking about Health Visiting", produced by the Royal College of Nursing Health Visitors' Advisory Group, stated three implications about the health visitor / client relationship:

[a] "the client is an active participant rather than a passive recipient of care;

[b] goals should be jointly agreed between health visitor and client;

[c] the client has the right to determine his own course of action."

[R.C.N 1983:41]

"Bridging the Gap" [H.V.A. 1988] discussed the need for health visitors to be more responsive to client needs, and to work in partnership with them.

"Neighbourhood nursing - a focus for care" [D.H.S.S. 1986] and the recent White Paper on the review of the N.H.S. [Department of Health, 1989a] have challenged health visitors to justify their traditional patterns of working, and to demonstrate their effectiveness.

The health visiting profession itself had demonstrated its awareness of shortcomings in practice. "Accountability in health visiting" [R.C.N. 1984] had made the criticism that "many health visitors appear not to share their goals with clients, and therefore it is not surprising that clients sometimes misunderstand and misinterpret them."

"Whither health visiting" [Goodwin 1988] stated that health visitors should start "from what users want rather than what we think they need", and placed increasing emphasis on a more equal partnership between health visitor and client, and a need for a more participative and less directive relationship.

Various policy issues have had an impact on the structure and context of the service being offered. The advent of trust status, G.P. fund-holding, skill-mix, and the differing demands on the health visiting service due to demographic changes towards a more elderly population, have all challenged health visitors to demonstrate the value of each aspect of their work, including home visiting. The practice of universal home visits to all mothers is being challenged, in order that health visitors should target the service, either to those who most need the service, or to develop community outreach approaches that involve groups as well as individuals [Goodwin 1988, Iskander 1989]. This transfer of emphasis, whilst economically logical, might have the effect of stigmatisation of families who do receive regular home visits. The loss of routine visiting would also challenge the tradition of a universalist case-finding approach, which was a search for unmet need. The expanded use of community health profiles, annually collected data on mortality, morbidity, and related factors, would also lead to an officially delineated picture of the community, and would exclude other views of need. It would exclude the search by health visitors, which has been described, in effect as a "systematic ethnographic study of a community by an expert in public health" [Dingwall and Robinson 1993 : 171]. The loss of a case-finding approach would create a reactive rather than a pro-active service.

However, any practice, including universal home viisiting, cannot continue unchallenged, and needs to demonstrate its worth. This study aims to present evidence concerning the quality of the interaction involved in routine home visiting.

The advice of Little and Carnevali [1976] is that a nursing philosophy should contain three elements: 1. the nature of the patient/client, 2. the nature of the nurse and 3. the nature of the interaction between them.

Following these precepts, and with this background of interest in health visiting in practice as demonstrated by a home visit, the study developed into an exploration of the relationship between mother and health visitor through their perceptions of a home visit.

The aims were to describe the client's and health visitor's view of the same home visit, and to explore their similarity and dissimilarity of perception.

The objectives were to answer the following questions:

1. What is the interaction on a routine home visit by a health visitor to a primiparous client?

2. What are the participants' perceptions of the visit, and how do they compare?

3. What are the clients' and health visitors' perceptions and expectations about their relationship?

Through answering these questions, a fourth is raised:

4. What is the value of home visits?

The following chapters consist of a literature review [chap. 2], a description of the methods used [chap. 3], numerical data from the study [chap. 4], participants' views about home visits [chap. 5], an examination of advice and advice-giving [chap. 6], the role of the health visitor and the health visitor/client relationship [chap. 7], an analysis of the content of home visits [chap. 8], and a discussion and conclusion [chap 9]. A recurring theme throughout concerns power within the relationship.

CHAPTER TWO

LITERATURE REVIEW

This chapter first discusses primiparous mothers [2.1], proceeds to look at past research into health visiting [2.2], and in particular their teaching role [2.3]. Home visiting research is examined [2.4], and the role of communication [2.5] and perception [2.6]. Client response [2.7] and the health visitor/client relationship [2.8] are considered, before the final section, [2.9], describes some gaps in the literature, leading towards the subject of this thesis, the contents and perceptions of home visits.

2.1 FIRST-TIME MOTHERS

Having a first baby has been seen as a transition time, when many important aspects of a woman's life are likely to change.

For some women it is a time of stability and psychological well-being [Elliott et al. 1983]. For others it is a time of increased levels of anxiety and postnatal depression [Oakley 1980, Graham 1979]. Some fairly consistent predictors of such mood changes have been identified, including worries about the baby, mother's work conditions, marital stress, poor housing and finance, social isolation, and high anxiety during pregnancy [Oakley 1980, Robson 1982, Paykel 1980, Field et al. 1983, Pistrang 1984]. In the study of 37 married primigravid mothers by Pellegrom and Swartz [1980], the stresses identified were less time spent with husband, change in body shape, and loss of sleep. The mothers 25 years and older were more likely to be uncomfortable at the lack of time. Studying the impact of motherhood after thirty, Mercer et al. [1983] found a decrease in self-esteem, lower gratification and less maternal satisfaction in the role for women who are 30 and older.

Homans [1982] considered pregnancy and birth from an anthropological perspective, as a rite of passage. This viewpoint regarded pregnancy, parturition, and the puerperium as a social transition, a ritualised rite of passage involving loss of personal identity and separation from the rest of society, through to reintegration into society as a mother. The women investigated by Homans found the early months of motherhood particularly stressful, experiencing feelings of isolation and loss of personal identity.

In the study by McIntosh [1986] of Scottish working class women, no fewer than 80% of the mothers complained that at least one aspect of the social experience of motherhood had been problematic for them at some stage during the first 9 months. The main categories of complaint were the demands associated with infant care, restriction or loss of freedom, disruption or curtailment of social life, the responsibilities of motherhood, and social isolation or loneliness.

The most common problems experienced by mothers with young babies seem to be those associated with feeding, excessive crying, settling to sleep and night waking [Osofsky and Danzger 1974, Dunn 1977, Mortimer & Kevill 1985]. In Simpson's study [1986], 56 mother/infant dyads were investigated and data collected on a wide variety of characteristics of a group of 2- 3 month old infants and on their mothers' perceptions of these. A significantly higher proportion of primiparous mothers found the night waking of their babies stressful. Ounsted [1980], too, in her study of 209 primiparous mothers, found that feeding and sleeping presented problems, and many mothers were often unaware of the wide range of normal behaviour in young babies.

The feminist movement has highlighted the rights of women to be individuals, rather than in subjugating self in the mothering role, and this tradition has led to research revealing many dilemmas for the caring professions concerning women and childcare [Oakley 1979, Graham & McKee 1980, Webb 1986, Clark 1988]. These dilemmas are worsened by awareness of the needs of children [Pringle 1983] contrasting with the needs of the mother [Dalziel 1990].

A first child not only has an impact on the mother, but on her partner [Miller and Newman 1978, Breen 1975]. Dalgas-Pelish [1993] suggested that a first child could have a negative effect on marital happiness, due to a variety of possible factors, such as fatigue, feelings of inadequacy, physical demands of infant care, and the emotional responsibility for a baby.

Smith and Whitehead [1986] surveyed 46 mothers to discover what they wanted from a postnatal class. Results included not just babycare, but a broader perspective, including social support and women's needs. Support systems for the mother can include the family, friends, groups and the statutory services, one of which is health visiting. [Wood 1985]. Lee [1986] found that access to social support appeared to help the mothers regain their previous health status more rapidly. The mothers reported other women as most helpful to them, particularly those who had children. Consultations with health visitors were regarded as in addition to those they had with other mothers. Queries were kept until they went to the clinic or the health visitor visited them at home.

First-time motherhood, therefore, has been revealed as a time of great change and anxiety.

2.2 HEALTH VISITORS

Past research into health visiting has concentrated on what health visitors say they do, including time spent, subjects covered, and clients visited. Such studies include the Jameson Report [Ministry of Health 1956], Akester and MacPhail [1963], Marris [1971] and Clark [1973]. These surveys depended on the self-reporting of activities by health visitors, with a consequent loss of depth of data and accuracy. Henderson [1977] employed a personal questionnaire and pre-coded diary sheets in her study of the day to day work of health visitors in Hampshire. Walsworth-Bell [1979] compared area health visitors and those attached to general practitioner surgeries [i.e. group attached]. This study also used self-reporting by the health visitors, requesting them to complete a one-page visiting sheet for every visit. Fitton [1981], too, employed self-administered questionnaires to 49 health visitors in order to describe the job they actually do. Dunnell and Dobbs [1982], in their national survey of 4528 community nurses in England and Wales, utilised interviews and diaries to describe the nurses' activities over a 7-day period. All such studies produced a wealth of quantitative data, but depth was inevitably lost due to the methods of data collection.

Clark [1981] reviewed the research in the field of health visiting for the years 1960-1980. While handicapped by the variety of methods, aims, and classification in the studies, she was able to draw some conclusions. Of the 37 studies reviewed, 35 investigated the proportion of time spent by respondents on various activities. Home visits accounted for between a quarter and a third of the health visitors' time, the proportion ranging from 17.4% to 58.1%. In terms of time spent, home visiting is the most important constituent of health visiting activity. This concurs with the professional literature, which states that home visiting is "the most important aspect, the 'core' of health visiting" [C.E.T.H.V. 1980:43].

Fifteen of the 37 studies reviewed by Clark [1981] revealed the percentage of visits to clients of different ages. The most frequently mentioned group was families with children, which represented between 50% to 80% of the clientele visited. Other studies have demonstrated that health visitors spend proportionately more of their time with families with young children [Clark 1973, Wiseman 1979].

None of the studies reported by Clark [1981] reported on the amount of home visiting received by each client. This gap was filled by While [1985] who found, out of a sample of 756 infants, that the vast majority of families received 6 or less home visits during the first 6 months of an infant's life, and over a third received 2 or less. This low level of visiting was deplored, as she had found that home visiting to families improved the uptake of prophylactic care, such as immunisation rates and high child clinic attendance.

Both Orr [1980] and Foxman et al. [1982] found that mothers preferred to see the health visitor in the home. It is also the part of their work that health visitors most enjoy [Clark 1973]. Orr [1980] found that home visits were non-stigmatising, and allowed women to air worries. All the health workers in the study by Mason [1988] felt that home visiting provided the best setting for health education.

The review by Clark [1981] also considered the length of visits, 9 of the studies reporting an average duration of 13 to 25 minutes. Eight of the studies reported on the source of home visits, with most being health visitor initiated. The percentage of health visitor initiated visits ranged from 59.3% to 91.9%, and client initiated visits from 5.4% to 33.9%.

The topics covered were very wide, in spite of the methodological disadvantage in depending on recall. Most common subjects included child management, screening, general health, immunisation, and problems relating to housing and finance.

Greater reliability of data was obtained when researchers moved away from self-reported data collection methods, and adopted observation and recording of visits. Kratz [1974] and McIntosh [1975] used observation in their studies of the home visits of community nurses, although Kratz felt that the presence of a participant observer altered the interaction.

An alternative methodological approach was taken by Watson [1981] who undertook an observation and time study of the health visitor's work. The aim of this study was to provide documentation of the work that health visitors do and the way in which they do it, using time as the basis of measurement. Thirteen topic groups were identified: reproduction, infancy, childhood, ageing and handicap,"health", illness, immunisation, accidents, income/finance/occupation, housing/home situation, emotional and behavioural problems, services and service providers, and "anything else". The audiotapes of the visit were analysed into activity codes: questioning, listening, information, advice, reassurance, comment, service, demonstration, examination, social chat, talking to children, travelling, and exit. Clark [1985] however found this method difficult to replicate, and criticisms could be made concerning reliability and validity. It is difficult, for example, to define "reassurance".

One major criticism of these quantitative methods was that they may have described what health visitors did, or said they did, but not how they did it. Until

fairly recently there had been little done since Hunt [1972:24] wrote, "a good deal is written on what health visitors should do but little on how they should do it." The descriptive information about the service offered by health visiting is inadequate, because, as Clark [1983] has pointed out, there is a great difficulty in identifying specific techniques of an activity which consists of interpersonal social interaction largely in the privacy of the home. Watson [1981] acknowledged that her study had described the structure, rather than the process of health visiting. Warner [1983] used an alternative methodology in her study of health visiting clinics, and, instead of attempting to measure concepts difficult to define, used ethnomethodology and conversational analysis to look much more closely at the details of the encounters and the experience of the participants. She studied 120 naturally occurring conversations in 14 child health clinics. No attempt was made to assess the effectiveness of health visiting as goals lacked sufficient clarification. She identified negotiation within the interaction, and concluded that the client had more power within the relationship than previously thought.

In a longitudinal study of public health nurse/ mother interactions in child health centres in Finland, Vehvilainen-Julkunen [1992] used grounded theory to identify patterns in their relationship. She described the category as "relationship supporting self-confidence", formed from patterns of interaction including "good to see you again", information sharing and advising, negotiating, encouraging, calming, confirming, joking, listening, silence, and nonverbal communication. The first pattern, "good to see you again", is similar to others' findings of a social, entry, or pre-encounter phase [Sefi 1985, Robinson 1987, and Chalmers 1990].

These studies into health visiting practice are described in the section on home visits, however the concept of evaluation is one that needs to be addressed.

In North America, Barkauskas [1983] noted that whether public health nursing is effective remains an unanswered question. Combs-Orme et al. [1985] reviewed the literature on the effectiveness of public health nursing, summarising empirical studies published between 1960 and 1984. They found that under certain circumstances, that the nurses could effectively impart knowledge to high risk mothers, and can effect positive change in maternal attitudes and parenting practices that in turn can be associated with positive changes in infant health and development.

There is a lack of descriptive information about the process of health visiting, and therefore little evaluation. As one authority put it:

"The methods of work used by health visitors have rarely been analysed in detail, and even more rarely tested for their effectiveness....we believe that it should be possible to document at least some of the methods, procedures and techniques used by health visitors in such a way that their relative effectiveness can be examined."
Royal College of Nursing, 1982:44

There had been few evaluative studies in health visiting until Luker [1980] carried out an experimental study into the effects of health visitor intervention on a group of elderly women and suggested that the intervention had a more than transitory effect upon the improvement of health problems. Carpenter and Emery [1974] investigated the incidence of "cot death" in Sheffield, and found benefits arising from focussed home visiting. Carpenter [1988] later expanded on this scheme, describing how using the Sheffield scoring system, high risk infants could be identified, receive extra care, and thus reduce the increased risk of mortality from sudden infant death syndrome. Lauri [1981], in a study of public health nurses in Finland, found that a focussed approach could help parents solve their childrearing problems. The Bristol Child Health Development Programme [Barker 1984] using the same approach, has demonstrated improved developmental and health outcomes,

using the criteria of incidence of child abuse, nutritional status, hospitalisation of infants, immunisation, and quality of home environment. A pilot study by Kelly [1983], although a small sample size, suggested that a study group of breast feeding mothers who received a special programme of structured support would breast feed for a longer period than mothers who receive only the routine number of home visits. The Leeds Infant Health Project [Parker and Ness, 1986] used an antenatal scoring system to detect mothers at high risk, in an area where there was concern about high infant mortality rates. An experimental group of mothers received antenatal and postnatal visits, following a structured programme, and one quantifiable result was a higher rate of immunisation uptake. Powell [1986] describes a similar scheme in Gosport, and reported a decrease in sudden infant deaths and a perceived improvement in care to families. Improved home safety and accident prevention has been demonstrated as a result of health visitors' home visits [Colver and Pearson 1985, Laidman 1987]. The high incidence of postnatal depression [Kumar & Robson 1984, Cox 1986], can be successfully identified by health visitors [Briscoe 1989], and intensive home visiting can promote successful recovery [Holden et al. 1989]. Health visiting intervention has thus been demonstrated capable of making positive changes in maternal and family health matters.

In an attempt to measure the need for, and the value of, routine health visiting, Dobby and Barnes [1987] used two methods, a morbidity survey to identify unmet needs in children under five, and a randomised clinical trial with 65-75 year old adults. However, many problems arose which prevented useful statistical results. These included low health visitor participation, confusion in the use of assessment criteria, sampling procedures, and variation in the length of the health visitors' intervention.

Since Luker [1978], evaluation in health visiting has become even more essential in order to demonstrate effectiveness to management, peers, and consumers [Dobby and Barnes 1987, Hull 1989]. Current initiatives are the use by health visitors of the nursing process [Luker 1979, Kratz 1980] and quality assurance [Dickson 1987].

In a time of increasing financial constraints, the value of routine home visits has been challenged, as there may be a need to target the resources and use positive discrimination in favour of vulnerable groups [Goodwin 1988]. This, however, can lead to stigmatisation, and a lack of opportunity for anticipatory guidance in the prevention of problems [Cowley 1989]. Briscoe and Lindley [1982], for example, describe the range of psychosocial problems identified in 17 families routinely visited by a health visitor in the course of one week. Such descriptive and evaluative work has raised many queries about the way in which the health visitor carries out the service.

A health visitor's time is largely taken up with visiting, clinics, travelling, and paperwork [Clark 1981, Watson 1981]. The health visitors' work in clinics has been studied by Warner [1983] and the value of clinics has been acknowledged [Rossdale et al. 1986, Karmali and Madeley 1986]. Interest is now focussed on the delivery of the service in the client's home.

2.3 HEALTH VISITORS AND TEACHING

The title "health visitor" suggests that the profession should be concerned with the promotion of health. This is confirmed by the professional literature, such as "An Investigation into the Principles of Health Visiting", which isolated four principles upon which health visiting is based:

1. The search for health needs.
2. The stimulation of awareness of health needs.
3. The influence on policies affecting health.
4. The facilitation of health-enhancing activities."

[C.E.T.H.V. 1977:9]

How are these principles translated into practice? The general title of teaching, can also encompass areas such as "advice-giving", "information-giving", health promotion and health education. These terms are not synonymous, but were often used as such by the participants in this study, so this general title has been chosen to include all the wider aspects of the giving and receiving of knowledge about health.

A variety of studies have investigated factors affecting patients' recall, satisfaction, and compliance with advice. The greater volume of work has been carried out in the area of doctor-patient communication. There are of course obvious fallacies in comparing advice-giving in different settings from different health professionals, but general inferences may be drawn.

2.3.1 Medical Advice-Giving

Recall of medical advice was reviewed by, amongst others, Ley and Spelman [1967] and Bradshaw et al. [1975]. They concluded that patients forget much of what

the doctor tells them, the more a patient is told the greater the proportion he will forget, and patients will remember best what they are told first and what they consider most important. Simple language should be used, and instructions made specific rather than given in general terms. Ley et al.[1973] found that general practice patients had forgotten 50% of statements made to them within less than 5 minutes of seeing their doctor. Anderson [1979], in the setting of an outpatient clinic, found that level of participation was not related to recall. Kincey et al.[1975] emphasised that there is a strong relationship between patient satisfaction and resultant comprehension and compliance. Doctors who behave as if they like their patients [Larsen and Smith 1981], who allow them to tell their story in their own words, and who give more objective information about their problems [Stiles et al. 1979], achieve more satisfied patients. Smith et al. [1987] found that satisfaction correlated with concurrent measures of compliance, and also predicted future compliance. The review by Ley [1982] described some of the literature on communication, compliance, and patient satisfaction, and related these findings to theoretical approaches to communication.

The home setting influences patterns of communication, and control over information. Sankar [1986] describes the effects of home visiting on medical students' attitudes to elderly patients, and how the interactive host-guest relationship accounted for the physicians' loss of control over the communication. Byrne and Long [1976], in a study of doctor/patient consultations, describe how doctors take the initiative away from the client, and dictate both the direction and duration of the interview.

The concepts that have emerged are level of recall, satisfaction with the advice, compliance, and participation.

2.3.2. Advice-Giving in Nursing

In the area of advice-giving between nurse and patient, research is more sparse. It is generally agreed that nurses "ought" to carry out health education [Smith 1979, Syred 1981], and a variety of sources describe, for example, principles of teaching, content, methodology, and new ideas or advances. Research literature has been reviewed by Cohen [1981] and Wilson-Barnett and Osborne [1983], who found that in practice nurses failed to take advantage of all opportunities to teach patients.

Tones [1979:256] points out that, "where education has been successful...it has been due to the appropriate methods and relevant resources, including people."

Nurses are the largest group of health workers, and it had been argued [Smith 1979] that they have great potential for influencing health education. When nurses have been trained in health education, they have been shown to be highly successful [Wilson-Barnett and Osborne 1983]. Redman [1980] describes the process of patient teaching, and many have used Becker's Health Belief Model [Becker 1974, Janz and Becker 1984]. While [1985] used this model in her study of home visits. As she had earlier pointed out [While 1983:9], the majority of health teaching undertaken in the community is on a one-to-one basis, and as this allows for individual needs, this method is likely to be the most reliable and valuable.

The value of preventive home visits to the elderly by nurses has been demonstrated [Luker 1980, Vetter et al. 1984]. However, when there are other nursing tasks to be accomplished, health promotion may take a lower priority. In a study of preventive home visits to elderly people by community nurses in the Netherlands [Kerkstra et al. 1991], it was found that nursing auxiliaries spent only 1% of their working hours on preventive home visits to the elderly, and community

nurses even less. This might support the argument for a health worker whose specific remit is health promotion i.e. a health visitor.

2.3.3. Advice-giving in Health Visiting

In the community, the opportunities are clearer, and the majority of health teaching undertaken is on a one-to-one basis in homes and clinics [While 1983]. Orr has defined the health visitor/client relationship in terms of advice-giving. She has described it as "a therapeutic vehicle in the giving of care and advice, as it enables the health visitor and client to move through the orientation, working and termination stages of the problem-solving process" [1985:116].

Strehlow [1982], in discussing the health visitor's role as health educator, summarised preventive care as consisting of knowledge about health, incitement of self-help, and support and appropriate referral and follow-up, and identified health visitors as being ideally placed to carry out these tasks of health education. While [1986] demonstrated that health visitor home visits increased the uptake of prophylactic care, but also suggested [1985] that health visiting resources cannot sustain adequate home visiting practice for meaningful health education. However, face to face communication allows for the transmission of meaning by many devices, such as feedback, recapitulation, and restatement. Kishi [1983], in studying clients in well-baby clinics, found that higher frequency of client questions was not correlated with client recall. [This study did not differentiate between the four paediatricians and three paediatric nurse-practitioners, as all were described as "health-care providers".] On the other hand, it has been suggested that health visitors are vague about the assessment of priorities [Bolton 1980] and the efficiency of health visitor teaching methods have been questioned [MacFarlane 1982]. Hobbs [1973] commented on the lack of evidence regarding the effectiveness of one-to-one

teaching undertaken by the health visitor. In the setting of the well baby clinic, Warner [1983] describes the health visitors "bargaining", modifying advice they would ideally like to give to that which the client will accept. This implies that health visiting practice is interactionally achieved.

McIntosh [1986] found that advice given in a non-directive manner was more likely to be accepted than advice given where the relationship was more formal.

Mason [1988], in a descriptive and exploratory study, contrasted the work of health visitors in Northern Ireland with the work of public health nurses and community health aides in Jamaica. Drawing on the principles of anthropology, ethnomedicine, and medical sociology, she investigated the different ways of health visiting and advice-giving in the client group of mothers with children under five. She compared clinically oriented and relationship centred approaches to health education, and concluded that the health visitor need not adopt either a social work or a nurse identity, as the two approaches need not be mutually exclusive. Criticisms about advice-giving concerned competence [if the health worker was less experienced or not a mother], the content of advice [theoretical or unrealistic], and the way the advice was given. A health visitor was liked as a "friend and mother", balanced by a dislike of formality, insincerity, and tactlessness.

More research is needed to determine the content and processes of the individual teaching carried out by health visitors.

2.4 HOME VISITING RESEARCH

This section includes a review of home visits, both the content, and the different methodological approaches.

Research into the study of home visits made by nurses began in North America. Johnson and Hardin [1962] were the first to study the content and dynamics of home visits of public health nurses. They tape recorded and categorised the verbal behaviour of 287 visits according to the dominance dimension, subject matter focus, teaching or health counselling dimension, the affective [emotional] component, and problem orientation [Johnson, 1969]. The results provided an objective statistical description of role behaviour in public health nurses, and it analysed variations to identify causal forces affecting nurse and patient behaviour.

Abrams [1963] studied the same subject, categorising topics according to sequences. Conant [1965], in a study of antenatal patients, used Bales Interaction Process Analysis, and discovered that the patients had a more accurate perception of how the nurses felt during the visit than public health nurses had of how their patients felt. Korsch et al. [1971] tape recorded nurses and doctors in well baby clinics, and found most conversations fairly stereotyped, covering subjects in a routine manner with little active participation from the mother. Mayers [1975] used observation and interviews in a study of 16 nurses on 37 visits, and stated that each nurse had a basic, generally unchanging style, and decided that nurses and their patients were following a well-established, time-honoured ritual, with little or no active thought into each developing phase of their dialogue. Although methodological criticisms could be made [sample size, and observer-participant method], her conclusion is a challenging one.

In Britain, research into home visits was started by Kratz [1974] and McIntosh [1975] using observation methods, and only recently has audiotape recording been used. Clark [1985], Sefi [1985], Hennessy [1985], Robinson [1987] and Kendall [1989] have investigated different aspects of the home visits of health visitors, and used audiotape recording as a tool. Kristjanson and Chalmers [1987] used videotaping to study nurse-client interactions in a variety of settings, including 5 home visits. One of these authors, later defined three interrelated phases in the work of health visitors: the entry phase, the health promotion phase, and the termination phase [Chalmers 1992].

In the study by Clark [1985], 15 volunteer health visitors tape recorded home visits to 30 families over a period of a year, from the time of the birth of a new baby. A total of 308 home visits were recorded. A variety of content analyses were considered, but eventually rejected in favour of a qualitative analysis, due to lack of time and resources, and due to problems inherent in the quantitative approach to elicit interpretive data. However, a qualitative analysis of 308 visits proved to be too great a task, and 100 transcripts of interaction at home and clinic were studied. This was still too massive an undertaking for indepth analysis, but concepts which emerged were the maintenance of the health visitor/client relationship, helping people to cope, and "just checking" i.e. secondary prevention. The maintenance of the relationship took precedence over the other goals.

Sefi [1985] explored aspects of the verbal exchanges between 5 health visitors on 9 first visits [i.e. first visit after the birth of the child where the health visitor takes over from the midwife] to primiparous mothers. Using conversational analysis, she identified several features in the interaction, including segmented topic progression, the use of questions as the prime method of control by the health

visitors, and that mothers themselves did not initiate topics, or ask many questions. The health visitors appeared to work within a task-based, problem solving medical model, adopting a pedagogic style. Sefi [1988] acknowledged that this was a study of first visits, and pointed out the necessity in the future to explore whether this pattern of interaction changed over time.

Hennessy [1985] observed and tape recorded 17 health visitors carrying out 60 visits to mothers with a 6-month old baby, as part of an 18-month longitudinal study of postnatal depression. Additional methods used were questionnaires and an examination of health visitor records. She found that the greater proportions of the conversations were about the health of the baby. In two thirds of the visits, health visitors enquired about the health of the mothers, but in a third mothers were not asked about their health, and were not listened to when they tried to introduce the subject.

Like Sefi, Robinson [1987] studied primary visits, using tapes of 28 visits made by 15 health visitors. She was asking "how" the interaction was carried on, rather than what the interaction was, looking closely at the encounter and the experience of the participants. Instead of labelling topics like "social chat", she identified phases, like the pre-encounter phase, and a start procedure.

Kristjanson and Chalmers [1987] analysed their transcripts of nurse client interactions using content analysis. They identified 3 categories in the interactions: structure, processes, and the content. Within the structure category, they identified, like Robinson, an introductory social phase, a working phase, and a closing phase of the interaction.

Finally, Kendall [1991] has used observation, interview, and conversational analysis of audiotapes to determine the extent of parental participation in 62 interactions. She compared a group of health visitors who practised using the health visiting process, to another group of health visitors who practised in a more traditional model. She was unable to detect any difference in approach between the two groups, found a low level of parental participation, and discrepancies between health visitors' and clients' perceptions of needs. She found the health visitor to be dominant in conversations, and her analysis yielded four major categories: setting the agenda, gathering and providing information, giving and receiving advice, and closures. The first category of agenda setting had sub categories of : broad questions, specific questions, evaluative questions, statement of health visitor function, use of the child, and client initiated agenda. Gathering and providing information included: questions and answers, questions answers and commentary, and making observations. Giving and receiving advice encompassed both solicited and unsolicited advice and the use of the child. Closures had sub categories of closing topics, controlled openings, and making a date. She therefore found that it was the health visitor who controlled the interaction.

It is within this context that the present study evolved into an investigation of the relationship of health visitor and client through the content and perceptions of a home visit. Clark [1985] looked longitudinally at visits over a year, but perhaps had too much data, as she recorded 100 transactions. Hennessy [1985] was studying the incidence of postnatal depression, and the participants' views. Both Sefi [1985] and Robinson [1987] studied primary visits, and it might be assumed that some of the clients had not had a great deal of contact with the health visitors concerned, and therefore had not built up a relationship. Kendall [1991] was looking at the clients' participation in the visit. Watson and Sim [1989] studied views of the visit, but had

no record of the visit. They also had a high proportion of non-English speaking clients, which presented a number of different communication difficulties.

This study therefore, is unique in studying the interaction of a home visit and comparing the participants' individual perceptions perceptions.

2.5 COMMUNICATION

It is only relatively recently that the central role of communication in nursing practice has been acknowledged. In the 1960's, patient satisfaction studies revealed complaints about communication. In the 1970's, observation studies described and analysed nurse-patient interaction, and intervention and quasi-experimental studies, when subjects were encouraged to spend more time and use varied techniques, demonstrated outcomes of improved communication. More recently, studies have concentrated on the benefits of improved interpersonal skills teaching [Macleod Clark 1985].

Research in the area of hospital nurse-patient interaction has demonstrated communication which is infrequent, stereotyped, short, and usually occurring in conjunction with a specific task [Faulkner 1980, Macleod Clark 1982]. A variety of methods of communication were identified [e.g. open/closed questions, observing and listening, encouraging]. In her study of nurse-patient communication in surgical wards, Macleod Clark [1982] used a combination of audio and video tape recordings, field notes, observation schedules, and interviews to identify nurses' responses to patients' cues. Nurses were found to control conversations by predominantly discouraging behaviour, using closed or leading questions, "blocking" the response to open questions, and rarely adopting tactics such as mirroring or reflecting as a means of encouraging patients to talk. Lancely [1985], too, in discussing the paradox of the

techniques used by nurses during the rehabilitation of the elderly, identified that the language used was essentially controlling, and as such contributed to a sense of helpless dependence rather than a confident independence conducive to patients' successful rehabilitation. Macleod Clark [1984:61] concluded that:

"There is a growing body of evidence which suggests that nurses do not display or use appropriate verbal communication skills when caring for their patients."

In response to the growing interest in communication, many authors produced manuals stressing its importance, and describing social skills and techniques [Wiedenbach and Fall 1978, French 1983, Ellis and Whittington 1983, Hargie 1986].

In health visiting, the literature has always laid much emphasis on interpersonal skills. It was argued that "the possession of highly developed social skills is a prerequisite for effective health visiting practice". [C.E.T.H.V. 1982:10]. One author [Wiseman, 1981] stressed that the manner and method of communication is the key factor upon which the health visitor is dependant for success or failure. Social skills teaching has been shown to improve social competence and to develop health visitors' ability to communicate with clients [Crute et al. 1989].

However, communication is not an isolated event, but, as Davis [1984:75] has stated, each interaction is a two-way process, with each participant being influenced by labelling, appearances and role expectations. Smith and Bass [1982:151] describe dyadic interaction as occurring "when they are mutually sending, receiving, perceiving, and reacting to the behaviours or messages of the other."

As Kelly and May [1982] have pointed out, there is often a moral tone in suggestions for change, implying that if nurses would only try harder, performance would improve. Trying to identify communication skills of one participant ignores all other influences on verbal behaviour.

Interaction analysis attempted to rectify this, by quantitatively analysing the verbal interaction [Diers and Schmidt 1977]. Kasch [1984 and 1986b] discussed this in connection with interpersonal competence. Using this method, Webster-Stratton et al. [1986] studied the verbal behaviour of paediatric nurse practitioners during well-child visits, and concluded that the nurses conducted comprehensive assessments and provided mothers with a wealth of educational information, but the visit was also dominated by the nurses' questions, commands and opinions.

Researchers following the ethnomethodological tradition [Sefi 1985, Smits 1985, Kendall 1989] used this framework in order to provide, among other things, a description and an explanation of the ways in which individuals use and rely on conventions when participating in social action. This goes beyond the analysis of an individual skill to explore verbal behaviour in greater depth. Language is not just a resource employed in order to interpret events or behaviour, but as a mechanism through which the reality of social life is constructed.

2.6 PERCEPTION

Perception has been described as "the selection of some stimuli and the ignoring of others, and then the transformation of those selected into meaningful and useful information" [Strongman 1979:94]. What influences the selection of stimuli? In the perception of people, Bruner and Tagiuri [1954:640] note how perception can be selective, being affected by a number of differing influences. There are two main

theories of social perception [Cook 1979]. Perception can be intuitive or by inference. Intuitive theories regard perception as innate, purporting that people instinctively recognise and interpret the feelings and behaviour of others. The second set of theories contends that judgements of others are based on inferences made as a result of past experiences [Hargie 1986:45]. Shared perceptions make communication possible [Combs and Snygg 1959:31], and these perceptions are influenced by many factors, including beliefs, attitudes, values, goals, and expectations.

Interpersonal perception may be of another person, of oneself in relation to others and situational constraints, or of how one perceives other people perceiving oneself during interaction. These may be distinguished as person perception, self-monitoring, and meta-perception [Furnham 1983:271].

In looking at person perception, Secord and Backman [1964a:51] identified three factors in forming impressions. The first group was stimulus information, including physical appearance, expressive or other motor behaviour, and verbal behaviour. The second factor was perceiver variables, such as previous feelings and cognitions towards stimulus, reward-cost value of stimulus person's actions, implicit personality theory and stereotypes, and self-concept. The third group, the impression of stimulus person, consisted of attribution of personality traits and other cognitions, contemporary feelings towards him, and perceptions of causality, intent, and justifiability.

Goffman [1959] discusses how the setting and personal front influences one's performance, and Berger and Luckmann [1966] continue the analogy by describing social interaction in everyday life in terms of "actors" and roles. All these factors, therefore, influence perception before, during, and after, health visitor/client

interaction. In this thesis, following Kasch [1986b], the assumptions are made that actions are fundamentally structured by cognitive processes, that health professionals and their clients do not simply react to external forces in their environment, but create a personally meaningful world through their perceptions, and these perceptions guide their actions. An comparison of perceptions and actions might highlight different facets of the health visitor / client relationship.

2.7 MOTHERS AND HEALTH VISITORS: CLIENT RESPONSE

With the growth of the consumer movement, there have been an increasing number of studies into the patient's view of the health services. The survey by Raphael [1967] challenged the staff, by querying, "Do we know what the patients think?" Ley [1972] reviewed the complaints made by hospital staff and patients, highlighting, among other things, the unwillingness of patients to complain, and specific complaints about communication. That these complaints are international problems are demonstrated by Nehring and Geach [1973] and Pascoe et al. [1978]. Klein [1979] summarised a high level of overall satisfaction, with dissatisfaction being caused mainly by the organisational routines of hospitals, and the personal attitudes of staff. Ham [1985] defended the National Health Service in the light of criticism from the Griffiths management enquiry, pointing the way ahead was to use surveys, locality planning and a greater investment in staff training in order to maintain customer support. Cartwright [1983] summarised the findings of a large number of surveys concerning the acceptability of the services.

Looking at the response to medical care, Lebow [1974] and Stimpson [1974] presented an alternative viewpoint to the medical model of the quality of medical care and "noncompliance".

Altschul [1983] discussed the implications for nursing, in listening to the consumer's voice, pointing out that patients are less critical of nursing care than the nurses themselves, and the implications involved with becoming patient advocates.

Moving from patient response in general, to the specific area of health visiting, the attitude of women to health visitors is fairly positive [Graham 1979, Blaxter and Paterson 1982]. However, specific complaints are numerous.

In considering the attitude of the users of maternal and child health services, Scott-Samuel [1980] identified two groups of dissatisfied customers. The first were very aware of deficiencies in the service offered, and highly vocal in their suggestions for improvement. The second group were far less vocal and more anonymous, consisting of the youngest and oldest age-groups of fertile women, those of zero and high parity, the unmarried, and those of low social class. McKinlay [1970] studied some aspects of lower working class utilisation behaviour, and found that underutilisers of the preventive health services were more likely to sustain a crisis existence, experiencing a lack of permanent accommodation, overcrowding, marital instability, financial difficulties, and frequent sickness in the family. However, they also had a stronger available network of friends and relatives. Karmali and Madely [1986] found that poor attenders at a child health clinic in Nottingham, did not believe the clinic to be useful, important, or relevant, and preferred to use alternative sources of help and advice, such as their family. Graham and McKee [1980] also found that mothers who did not appreciate their health visitor or attend the clinic, felt that their functions were more easily filled through other sources.

The health visiting profession, with its roots in sanitary health, has been criticised for an authoritarian image. Many studies have documented the clients'

dislike of being told what to do [Graham 1979, Blaxter and Paterson 1982, McIntosh 1986]. A fifth of the mothers in the study by Blaxter and Paterson expressed wholly negative views, while at least two-fifths were enthusiastic, mentioning particularly how much they had appreciated the health visitor's help when their children were babies, especially their first.

Colliety [1989] interviewed 55 parents about general perceptions of the health visitor, and found that as the child becomes older, the level of home visiting decreases, and the level of dissatisfaction increases. However, over 80% were satisfied with the service, and the majority felt that they were receiving the right amount of visiting. The majority saw the health visitor's role in terms of child care. In a study of consumer's views at six weeks postpartum [Foxman et al. 1982], approximately half of the women were very positive, a quarter were lukewarm, and a quarter held mixed or negative views. Satisfaction was not related to the mother's social class, level of education, or psychological state, but there was a positive correlation with the older mothers and with those who breast fed. In a national survey of teenage mothers [Simms and Smith 1984], 90% found the health visitor helpful, but a small minority criticised them as "interfering" and their contact with the health visitor as a "waste of time".

The Court Report [D.H.S.S. 1976] concluded that underutilisation of preventive child health services may be due in part to confusion amongst mothers about the precise role and function of child health clinics and health visitors. There is evidence that there is confusion about the health visitor's role, and a failure to make their goals explicit. "Thinking about health visiting" [R.C.N. 1982:47] has emphasised that "goals should be made explicit, and agreed with and validated by the patient or client". However, Watson [1986] and Mayall and Foster [1987] describe a

discrepancy of goals reported by health visitor and client. Orr [1980] refers to some discrepancy between what the health visitors say they do and what the client is aware of them doing. Watson and Sim [1989] interviewed 100 clients and their health visitors after a visit, and found overall agreement about the purpose of the visit, and overall satisfaction, but the satisfaction did not depend on the closeness of agreement of their views on the reasons for the visit.

This confusion about goals might be allied to a disagreement about the client's needs. Hennessy [1985] has pointed out that the health visiting approach is based on acquiring some understanding of the client's world and needs before planning the relevant health visiting care. Her results show that there was considerable difference in the health visitors' and clients' opinions of who had had postnatal depression. According to psychometric assessment, 47% of the mothers became depressed postnatally. Health visitors identified only 25% of the depressed mothers. This work could be contrasted with the findings of Holden et al.[1989], who utilised a structured postnatal depression scale, which helped health visitors to identify, and mothers articulate, feelings of depression postnatally.

Concerning the health visitor's role, the study by McIntosh [1986] of working class women revealed that, even when the mothers had been in contact with the health visitors for 9 months, over half reported that they had no idea of the health visitor's professional background. A high proportion [44%] saw the health visitor's main function as monitoring abuse or neglect. In the study of 135 families in London, Mayall and Grossmith [1985] found that most described the health visitor as someone to help with problems, but three-fifths also described the role as being to inspect and to make sure that the children were well cared for. [A quarter also thought that at present they did not have a health visitor]. The mothers appeared

accepting of this policing role, especially as they saw it in connection with others, not themselves [Blaxter and Paterson 1982]. Robinson [1982a & 1982b] found that a minority of clients saw the health visitor as a representative of a bureaucratic system rather than as a source of help. In Northern Ireland, Mason [1988] found that the image of health visitors as middle class promoters of household hygiene persisted, and they were suspected of possessing legal rights of access, with the power to take children away.

Many studies stress the importance of the personality of the health visitor [Blaxter and Paterson 1982, Field et al. 1982, Foxman et al. 1982, Mayall and Grossmith 1985, and McIntosh 1986]. Qualities of friendliness, approachability, tact, and the ability to listen, were stressed as being very important. Negative characteristics also emphasised personal attributes, such as bossy, authoritarian, patronising, and "all the theory out of books" [Orr 1980, Clark 1984b, Simms and Smith 1984]. Some women also wanted the health visitor to be a mother herself [Field et al. 1982, Clark 1985], although this was less important if she had good social skills [Mason 1988].

Satisfaction with the service is therefore fairly high, but declines as the children grow older, and is dependant on the personal qualities of the health visitor. This aspect does not seem to have changed since 1859, when Florence Nightingale first wrote:

"The needs of home health bringing require....tact and judgement unlimited to prevent the work being regarded as interference and becoming unpopular."

Nightingale 1952:33

2.8 HEALTH VISITOR AND CLIENT RELATIONSHIP

When health visitors are asked about their goals, they consistently mention the importance of a good relationship [Clark 1985]. Some of the health visitors studied by Robinson [1987] described the making of a relationship as a primary aim. The central importance of the relationship, according to Clark [1985], was that it enabled things to happen and goals to be achieved which could not be achieved without it. There was evidence from the health visitors studied by Clark that the maintenance of the relationship was preferred before the achievement of other goals.

The client, too, by emphasising the importance of the personal qualities of the health visitor, is stressing the social aspects of their contact. Although the importance of a good relationship is stressed [C.E.T.H.V. 1977, Robertson 1988], there is less information about how to go about it.

In the evaluation by Robinson [1982a], "success" for the client is dependant on the establishment of a satisfactory relationship. She identified two approaches, a problem-centred approach, based on a medical model, and a relationship-centred approach, based on the social sciences.

Clients, she suggested, saw "good" health visiting in respect of themselves as relationship centred, but used a problem centred model in respect of other people. Clients in Clark's study [1985] varied in whether they wanted a friendly or professional relationship. In this context, "professional" has negative connotations rather than positive associations of knowledge, skill, and appropriate behaviour. Orr [1980] presented the view that the clients valued a warm, friendly relationship as a medium for giving advice. The mothers' accounts of their relationship in the study by McIntosh [1986] suggest strongly that the advice of a health visitor who adopted a

non-directive approach and was regarded as a "friend" was much more likely to be accepted and acted upon than that received from one where the relationship was perceived as more formal. Respondents in the study by Karmali and Madely [1986] were more likely to attend the clinic frequently if they had a good relationship with their own health visitor. A relationship may need time to develop.

Warner and Forryan [1988] describe how it was only over time, that a painstakingly maintained relationship between a health visitor and a mother developed, and the client very slowly gained a sufficiently high self-image to begin developing effective parenting skills. The fact that first visits were studied by Sefi [1985] and Robinson [1987] may have influenced their results on participation. The evidence from Clark [1985], was that the health visitors used the relationship in different ways at different times, with the same families, and transcripts of later contacts showed the health visitor more of a "friend" than a professional.

The study by Pearson [1988], published while data collection for this study was underway, examined clients' perceptions of health visiting over a 10 month period. Using grounded theory, parents were interviewed antenatally, when their babies were 8-10 weeks old, and again at 7-8 months old. The 8 concepts to emerge were: health, health problems and other concerns; the need for help - locating the problem; knowledge and experience; legitimation; advice, support and comparing notes; choosing a helper; relationship or problem centred; and power and control. The value attributed to the health visitor's involvement appeared to reflect how far her views diverge from those of the parent. Antenatally, clients value independence, while at the second interview practical difficulties become more important, causing parents to assume a more dependent role. At the third stage, parents feel more confidence in themselves.

Central in understanding relationships is the concept of dominance, who has the power. Illich [1973] has argued that professionalism ties up knowledge in discrete bundles and sets up rituals for its dissemination by certified practitioners. Knowledge is power. Ranson [1977] discussed professional identity as opposed to personal touch, and saw the health visitor's role as central in the sharing of medical knowledge with the public. Robinson [1982b] discussed power in relation to the health visitor and her clients, and pointed out that although most health visitors would deny that their authoritative position contains an element of social control, yet to have knowledge is to have power. Freidson [1986:172] has pointed out the power professionals have over their clients.

The nurse/patient situation has been defined as one where the patient's dependancy places her in a vulnerable position [McGilloway 1976]. In health visiting however, there is no right of access, and the service is usually unsolicited. The health visitor has to negotiate with the client to define acceptable rules of behaviour, including frequency of contact, place of contact, and style of contact. Each participant brings to the interaction a set of experiences and expectations about roles. Because of the voluntary nature of the service, Dingwall [1977a] has pointed out that much of the health visitor's work involves establishing the relevance of her tasks to the client. He considered that this inevitably led to a structure in the visit which allows clients to introduce a wide range of problems that they have, which may not strictly be "health visiting problems" but the health visitor will talk about them as part of a trade-off with the client, so that the client will allow the health visitor to introduce her own topics. Using this negotiation paradigm, a relationship can be maintained in spite of a lack of shared perspectives or goals.

In the study by Sefi [1985], although the health visitors characterised their visits "chats", thus describing the interaction in casual terms, when analysed in detail, it was in fact the health visitor who effectively controlled the topics that were chosen and the extent to which they could be discussed. These findings are very different from the self-reporting by health visitors by Clark [1973] and the observation of Watson [1981] who felt that the client introduced many topics and there was equality in the relationship. Like the analysis of Sefi, Kendall [1989] too, found that while in theory the health visitors expressed very favourable attitudes towards participation, in fact there was a low incidence of parental involvement. It is possible that the length of the contact may influence dominance. Watson [1981] found that the health visitor was dominant in the shorter visits, while the client was dominant in the longer visits. The setting, too, may have implications, as in Warner's study [1983] of interaction in baby clinics, health visitor initiated topics tended to be briefer than client initiated topics, implying that clients had considerable control in shaping what occurred during the encounter. She did, however, conclude that the balance of power lay with the health visitors. Clark [1985], too, suggested the health visitor was more dominant in the clinic setting, and the length of consultation shorter, whereas in the home the initiative was often taken by the client.

The study by Chalmers [1990], using a grounded theory approach to semi-structured interviews with 45 experienced health visitors, investigated how health visitors conceptualise and evaluate their work. She found that being perceived as helpful by clients was the key factor in developing positive relationships. The presence of a "relationship" indicated a good or successful relationship [Chalmers & Luker 1991]. The health visitors were found to develop relationships with clients, not only to provide services, but to ensure access to clients over time. Gaining access [Luker & Chalmers 1990], is described, but of course very much from the viewpoint

of the health visitors. The goal of early work in establishing a relationship was not just to deal with present needs, but also to ensure that the mother would contact the health visitor if a future need or problem should arise. There was a pattern of routine visiting, intensive visits when necessary, then a return to routine. She concluded both parties control the interactions by regulating what they offer and accept from each other, in a complex process involving many factors relating to the health visitor, client, and the context in which the interaction takes place. She suggested the health visitor's success could be enhanced by careful attention to what is offered, and the processes through which these offers are made.

The health visitors in the study by Cowley [1991a], treated health as a process, practising interventions which are primarily either educational or therapeutic and caring. Using the symbolic interactionist device of an awareness context, she collected data by fieldnotes, non-participant observation, and interviews with a total of 53 health visitors. She identified two dimensions in the process of health visiting, openness and consonance, and within that three conditions: legitimacy, normalcy and activity. Due to the universal nature of the service, health visitors and their clients achieve consonance by bargaining, the clients accepting a service in exchange for something they want. Consonance was achieved when the health visitor conveyed a sense of commitment, caring for and about the individual, overt respect and recognition of the rights of the client, and explicit intent and purpose in the intervention. She concluded explicitly allowing the client to take the lead in the interaction appears more important in equalising the balance of power than insisting on complete disclosure by both interactants.

On considering the health visitor / client relationship, it can be seen that it is one of great complexity, with many inherent capacities for misunderstanding and dissonance, but also ability to change over time and within individual interactions.

2.9 CONCLUSION: GAPS IN THE LITERATURE

The preceding review has touched briefly on concepts that will be expanded later using data from the study. Such concepts include negotiation and power within the relationship, and role expectations.

This review has discussed some common problems of primiparous mothers, consumer perceptions of health visiting, past research in health visiting, and the reported value of home visits.

The literature has described what health visitors do, or have said they do, but revealed gaps in knowledge about how they do it, including methods of health teaching. Interaction has been studied during notification visits, but not subsequent visits. It is postulated that later visits may show greater variety of interaction, as the participants have known each other longer, and therefore may reveal more concerning the nature and quality of the health visitor/ client relationship.

The next chapter discusses the aims and methods of the study.

CHAPTER 3

METHODS AND RESEARCH DESIGN

This chapter discusses background literature [3.1], the aims of the study [3.2], the research methods and design [3.3], the data collection [3.4], the pilot study [3.5], arranging access [3.6], the main study [3.7] and concludes with a summary [3.8].

3.1 BACKGROUND LITERATURE

This section discusses past research in nurse-patient comunication [3.1.1], ethnomethodology [3.1.2], and triangulation [3.1.3].

3.1.1. Past Research into nurse-patient communication

This section could have been subtitled, "The search for a theoretical framework." The brief review in the previous chapter of the literature on communication between nurse and patient, revealed the history of a search to identify discrete areas of activity, such as the topic under discussion, or the communication technique used. This tradition, dating back to Johnson and Hardin [1962], has been followed with increasing sophistication of data collecting instruments and categorisation, until the time study by Watson [1981]. Watson herself acknowledged that she had described the structure, rather than the process, of the interaction. Until Watson, there had been discussion of the reliability of the strategy, but its validity was largely assumed. Melia [1979] has criticised nursing research for reducing nursing to mere lists of activities which fail to convey the profession's complex, dynamic, uniquely human characteristics. The study of social interaction is unlikely to be fully encompassed by such quantitative procedures, even by the application of increasingly complex measuring and categorising techniques.

Another disadvantage of this strategy is that, by producing categories of communication skills and techniques, this list can evolve into a moral imperative, whereby a "good" nurse will use the techniques on an "A" list [e.g. open questions, reflection], and a less skilled practitioner will use a "B" list [closed questions, leading questions], taking no account of situation or context. The assumption is, that if each nurse tried harder, received more social skills training, there would be as a final product a perfect, skilled communicator.

Communication between nurse and patient also does not exist unilaterally, but is an interaction, between two or more participants, with each having unique attitudes, goals, and perspectives. Researchers' concentration on one contributor, the nurse, inevitably produces one-dimensional data. During the 1970's, theoretical criticisms were made concerning the relevance of social psychological investigations [discussed by, among others, Banister and Kagan 1985]. Writers such as Harre and Secord [1972] spoke out against research practices that dictated the control and isolation of variables about people or social behaviour. Instead, they suggested more humanistic approaches, encouraging the "reports of feelings, plans, intentions, beliefs, reasons and so on, {whereby} the meanings of social behaviour, and the rules underlying social acts can be discovered" [Harre and Secord 1972:7]. Harre [1979] has advocated qualitative research which works with the accounts themselves, as opposed to a numerically transformed version of them.

More recently, May [1990], has identified the two contrasting perspectives of research into nurse / patient interaction as "technocratic" and "contextual". The first has its basis in theories and models of nursing, and employs extensive research methods. The second derives from sociological or social psychological theory and employs intensive research methods.

To explore aspects of communication between health visitor and client, and in particular the rules underlying their relationship, an alternative theoretical framework was sought, moving away from the "technocratic" perspectives to a more contextual approach. Potter and Wetherell [1987:136], using a discourse-oriented perspective, have pointed out the flaws in traditional social psychological work on categories, where it was thought that categories are preformed and enduring, and have a fixed structure. This would inevitably lead to biased perception. Discourse theorists, on the other hand, see categories as varied and actively reconstructed, and study the detail of how categories are actually used. The terms "client" and "health visitor" would not connote a cluster of categorybound attributes, but change with the differing actions and perceptions of the participants.

In this research, the design was essentially a study of one interaction, a "snapshot" in a relationship. A way of making sense of the social interaction was found in the ethnomethodological tradition.

3.1.2 Ethnomethodology

This approach, based on the work of Harold Garfinkel and Harvey Sacks [Garfinkel 1967, Heritage 1984a, Atkinson and Heritage 1984], is the study of the methods which are employed by the members of any social group to produce order in their everyday social life.

Ethnomethodology has been described, "simply as a label to capture a range of phenomena associated with the use of mundane knowledge and reasoning procedures by ordinary members of society" [Heritage 1984a:4].

Within this theoretical framework, the technique of conversation analysis has been used to discover the competences which underlie ordinary social activities. This technique has been applied in a courtroom setting [Atkinson and Drew 1979], in the classroom [McHoul 1978, Mehan 1979], and in news interviews [Heritage 1984b]. In a nursing situation, Smits [1985] adopted this approach in a variety of nurse-patient conversations, and Mallett [1987] in studying nurses and post-anaesthetic patients. Bowers [1992a] has cogently argued the use of ethnomethodology in nursing research, and used this method in his study of the home visits made by community psychiatric nurses [1992b].

In health visiting, Warner [1983] looked at communication in baby clinics, and both Sefi [1985] and Robinson [1987] studied notification visits. Robinson [1987], indeed, made a powerful argument for the use of ethnomethodology as a framework, without much reference to its previous use, by, for example, Warner [1983].

Following the example of Kendall [1989], this study has dispensed with some of the aspects of conversational analysis, such as the complex transcript notation [Schegloff and Sacks 1973, Sacks et al. 1974], while retaining concepts such as sequencing and participants' competence in the organisation of conversation. The notation is described in Appendix N. The quoted extracts reproduce what was said, but not the timing, or manner [the silences, intonation, or emphasis]. The number at the conclusion of an extract identifies the visit, and page number of transcript, e.g. V 14:30, is from the visit paid to client 14, on page 30 of the transcript.

The audiocassette tapes of the home visits were transcribed by the author. This had the advantage of gaining intimate knowledge of the conversations, so

analysis was carried out directly from the tapes, rather than the transcripts. As Heritage and Atkinson [1984:12] state, *"Like all transcription systems, the one used in this book is necessarily selective.....It is therefore important to stress that, although the transcripts serve as an extremely convenient research tool, they are produced and designed for use* ***in close conjunction with*** *the tape-recorded materials that constitute the data base."* The emphasis is the authors'.

The detailed notation is omitted from the extracts reproduced in this study, as the level of information required could be obtained from the study of the tapes. This aspect is further explored in Chapter 8.

3.1.3 Triangulation

The approach taken in this study was eclectic, in that it drew on both qualitative and quantitative methods. In describing interaction, as well as both participants' perspectives, no one method "fitted" the study, so multiple methods were used, the qualitative methods being employed to describe the affective aspects, and the quantitative methods being used to measure other variables.

Triangulation involves "combining different strategies and techniques in different ways", in an attempt to strengthen the validity of empirical evidence by relying on more than one approach [Bulmer 1984:32].

The origin of the triangulation metaphor is from military strategy and navigation, where multiple reference points are used to locate accurately an object's position [Smith 1975:273]. In the social sciences, Campbell and Fiske [1959] used the term "multiple operationism" to argue that more than one method should be used in the validation process to ensure that the variance reflected that of the trait and not

of the method. Jick [1979] described how triangulation can be used, not just for cross validation, but to capture "a more complete, *holistic*, and contextual portrayal of the unit(s) under study". The weakness of each single method is intended to be compensated by the strengths of another. Mitchell [1986] has pointed out that the use of methodological triangulation requires that:

a] the research question must be clearly focussed;
b] the strengths and weaknesses of each chosen method must complement each other;
c] the methods should be selected according to their relevance to the nature of the phenomenon being studied; and
d] continual evaluation to monitor whether or not the first three principles are being followed.

Triangulation until recently has not been used widely in nursing research, but Sohier [1988] has recommended its wider application, and Hennessy [1985], Pearson [1988], and Kendall [1989] have carried out studies which triangulate data in health visiting.

Interpreting the word in another way, the term triangulation seems highly appropriate in this study, as the home visit could be pictorially represented as the apex of the triangle, with the viewpoints of the two participants in the visit representing the other two angles. The technique of conversational analysis of the home visit is complemented by the descriptive interviews and the questionnaires' numerical data.

The strategy adopted in this study was therefore based on multiple methods, in order to explore the many aspects of both participants' perceptions of one interaction, and through these perceptions, their wider views of their relationship.

3.2 AIMS

This study explored the relationship between mother and health visitor through their perceptions of a home visit. The aims were to describe the client's and health visitor's view of the same home visit, and to explore their similarity and dissimilarity of perception.

The objectives were to answer the following questions:

1. What is the interaction on a routine home visit by a health visitor to a primiparous client?

2. What are the participants' perceptions of the visit, and how do they compare?

3. What are the clients' and health visitors' perceptions and expectations about their relationship?

Through answering these questions, a fourth is raised:

4. What is the value of home visits?

3.3 RESEARCH METHODS AND DESIGN

The research design was a descriptive study of health visitors' home visits, combining survey methods, conversational analysis of the interaction, and in-depth interviews concerning the participants' views.

Health visitors were asked to carry out a routine home visit to three primiparous mothers, with babies aged 2 to 6 months. This visit was tape recorded. The client was interviewed by the researcher the day after the visit, and the health visitor was interviewed after completion of the third visit. These interviews were also recorded. Both client and health visitor were asked to complete a short questionnaire immediately after the visit.

Participants in the study were free to withdraw at any time. The health visitors were therefore volunteers, as the mechanics of the study required willing participation. To enlist volunteers, the researcher attended three group meetings of health visitors, explained the purpose of the research, distributed copies of "Information for health visitors" [Appendix E], and made arrangements to meet the volunteer health visitors on an individual basis. At this meeting, individual queries could be discussed, and, if the health visitor decided to participate, the "Data Collection" sheet [Appendix F] and tape recorder delivered.

The health visitors would then request the participation of 3 primiparous mothers, with babies aged approximately 2 to 6 months. To avoid "choosing" the clients, the health visitors were asked to request the participation of primiparous mothers whose babies were born consecutively in their caseloads.

The clients would be supplied with an information sheet [Appendix G], and if permission was given, consent forms were signed by both health visitor and client [Appendices H and I], sent to the researcher, and a letter of information sent as a courtesy to the client's G.P. [Appendix J].

The study was restricted to primiparous mothers, as they would generally only have been in contact with one health visitor, and because it might be expected that they would receive more home visits than multiparous clients. By restricting the age range of the babies, it was anticipated that the health visitor would have less opportunity to request the participation of specially selected clients, [i.e. only ones with whom they had a good relationship]. However, within that age range, the health visitors would have built up a relationship with those clients, and would still be in fairly close contact.

Routine arranged home visits were chosen for ethical reasons, so that the client had received full information about the study, had signed a consent form, and knew when the health visitor would be coming with a tape recorder.

The health visitor was requested to carry out three home visits, as it was felt that one visit might emerge as atypical from the health visitor's usual practice. It has also been observed that the professional is more aware than the client of the tape recorder [Clark 1984a], and so three visits would give the health visitor more opportunity to carry out a "normal" visit.

The interviewer would visit the client the day following the visit, tape the interview, and collect the questionnaire.

3.4 DATA COLLECTION

Data were collected by audiotape recording of home visits, and questionnaires and interviews with both health visitor and client.

Recording home visits is discussed in the first section [3.4.1], followed by the concept of the health visitor as researcher [3.4.2], the interviews [3.4.3], questionnaires [3.4.4], and visual analogue scales [3.4.5].

3.4.1 Recording the home visits

To capture the interaction of a home visit, some accurate record must be made. Earlier researchers studying nurse-patient interaction in the client's home, had moved from participant observation [Kratz 1974], to nonparticipant observation [McIntosh 1975, Watson 1981], and through to recording the interaction using a tape recorder [Clark 1984a] and even a videotape recorder [Kristjanson and Chalmers

1991]. The use of videotape was considered and rejected in this study as being too disruptive, and also presenting several technical difficulties. Procedural problems could have arisen if, for example, a visit had been arranged at short notice, or, as happened twice in the study, a visit cancelled at short notice. Of the 19 sessions recorded by Kristjanson and Chalmers, only 5 were home visits.

Kendall [1989] used audio recording and nonparticipant observation in her study of parental participation in the visit. Direct observation was considered and rejected in this study as the main data were the perceptions of the participants. Also, although nonparticipant or participant observation would have the advantage of increased insight, this was outweighed by possible disadvantages. As all participants knew the nursing background of the researcher, there was an awareness of the possible confusion of role, with either the client or health visitor assigning the investigator not the role of researcher, but of health visitor. The dilemmas inherent in this situation have been well documented [Klein and Johnston 1979, Clark 1985, Pearson 1988]. Clark [1985] also observed that the tape recorder alone was less obtrusive than the presence of an observer, which might alter the dyadic interaction. She found in her pilot work that whatever instructions she gave to health visitors, they tended to involve her in discussion, and that a number identified alterations in their approach due to her presence.

The use of the audiotape recording method has been used by researchers looking at communication between doctor and patient [Byrne and Long 1976], between social worker and client [Baldock and Prior 1981], between hospital nurse and patient [Faulkner 1980, Macleod Clark 1982] and finally in health visiting [Clark 1985, Sefi 1985, Robinson 1987]. Although she was concerned about a possible

"conscious improvement of performance" due to the tape recorder, Clark [1984a] concluded that the use of a tape recorder was feasible, valid, and ethically acceptable.

The use of tape recorders, as Clark [1985] has noted, may not be suitable for a random sample of research subjects, and should only be used with volunteers. The design in this study was for volunteer participants, for ethical and practical reasons. Ethically, the research subjects had a right to confidentiality, and so had to be volunteers giving fully informed consent, and pragmatically, the health visitors had to agree to discuss the research with their clients, and arrange access, and so had to be in agreement with the data collection method. Tape recording was thus the method chosen for recording home visits in this study. It has the disadvantage of recording verbal interaction only, but the advantages of being relatively unobtrusive to the participants [it was a frequent comment from the participants in this study that they had forgotten the presence of the tape recorder during the visit], and, as 5 tape recorders were available, being readily accessible to all health visitors and thus less disruptive to their visiting patterns.

3.4.2 Health visitor as researcher

The researcher at the time of the data collection had been a health visitor for 7 years. This occupational experience was separated in time from the research by a year of fulltime study, but the professional knowledge must have influenced the interpretation and analysis of the data. Berger and Luckmann [1966] considered that all of us are unable to articulate knowledge that has become deeply sedimented, either through our primary socialisation as members of a society, or tertiary socialisation as members of an occupational culture. To attempt to analyse our assumptions is likened to "trying to push the bus in which we are riding". Ethnomethodology tries to do just that, with the proviso that past experience must be

acknowledged, both as members of a society and as individuals. Becker [1967] suggests that it is impossible to do research which is uncontaminated by personal and political sympathies.

Meerabeau [1992] discusses the "problem" of tacit nursing knowledge, pointing out that many research methods had a large component of tacit knowledge, and this could be used as a hitherto largely untapped resource for cooperative enquiry.

The advantage of the researcher's professional background were in arranging access, understanding of the processes involved, and interviewing experience. The disadvantages were possible confusion of role, and influencing the responses of the participants.

In arranging access, the researcher had to demonstrate honestly and in great detail the uses and worth of the proposed research. As Byrne and Long noted in their study of doctor/patient communication, the acceptability of the tape recording method depends on "the confidence which exists between the researchers and the researched" [1976:10]. The health visitors were given detailed information, and were visited individually by the researcher, before making a firm commitment to participate.

The participants may experience "evaluation apprehension", an anxious concern that the subject gains a positive evaluation from the researcher, and hence alter their responses. In this study, there were great benefits in a professional background when interviewing the health visitors, while the researcher's absence at the home visit introduced an element of distance, so that the health visitor could

verbalise feelings and intentions that might have been expected to be obvious to an observer on the visit. The same ignorance of the visit was of benefit when interviewing the clients, and although her professional background may not have been a help, it did not appear to be a hindrance. On two occasions there was evidence that clients recognised the researcher as a health visitor, when they asked the researcher's opinion of health visiting advice. This dilemma would have been answered by Oakley [1981] with a full, naturally occurring conversation. Her three reasons for doing so were to avoid adopting a purely exploitative attitude to interviewees as sources of data, secondly that she looked on the interview as a tool for women to articulate and record their views, rather than as a tool for the researcher, and thirdly, she found that the usual response such as not answering or evading questions was not helpful in promoting "rapport". Oakley had a long, and intimate, relationship with the women in her study, in some cases being present during labour and delivery. In this study, the researcher met the client only once, and was to some extent constrained by ethical considerations not to interfere between the client and her health visitor. The approach had to be non-judgemental to both client and health visitor. In response the the two clients' queries, therefore, the researcher suggested discussing it with their usual health visitor, and with an explanation of her different role. As one woman went on to explain her dissatisfaction with the advice she had been given, the conversation opened into an area concerning dissatisfaction with advice-giving, and as the discussion was about her worries, did not seem to destroy rapport.

Yarrow et al. [1970] have questioned the accuracy of interview information from parents about interactions in which they themselves have been involved, arguing that they are likely to distort reality by responding in a socially desirable way. Newson and Newson [1968] have demonstrated that information given to

health visitors, who represented authority, differed from that given to interviewers. Currell [1985], however, in her study of maternity care, felt that the fact that the interviewer was a midwife did not influence the respondents at all. Cornwell [1984] suggests that encouraging people to tell the stories of their experiences, and establishing a cooperative relationship with them, reduces the tendency to give "public" accounts.

In this study, all participants were guaranteed confidentiality, and all appeared candid, but as in all social research, there is no guarantee that a complete picture has been obtained using solely interview data.

3.4.3 Interviews

The researcher's interviews with the 45 clients were either arranged by telephone, or, if they had no phone, through the intermediary of the health visitor. The interviews were recorded, and followed a semi-structured schedule [see Appendix B]. On all but 3 occasions, the interview was carried out the day after the recorded visit. To suit those 3 clients, one interview was carried out on the same day, one two days later, and one four days later.

The timing of the interviews with the 15 health visitors was arranged to fit into their working practice. With the permission of nursing management, they were carried out during their working hours, and at their place of work. The interviews were tape recorded and owing to a technical fault, one had to be repeated. For 8 health visitors, the interview was carried out the day after their third visit. For one health visitor, it was the same day as the last visit, for four health visitors, it was 2 days later, and for the last two interviews, it was 4 and 6 days later. There was a brief discussion of all three visits, then the health visitors chose one of the visits to discuss

in depth. To elicit the views, attitudes, and feelings of the participants, two interview schedules were designed for health visitor and client [Appendices A and B]. This schedule followed a semi-structured design. The structured content included aims, goals, health education, the relationship between health visitor and client, and quantitative information about the participants. The more open aspects of the interview allowed exploration of feelings, and other areas introduced by the respondents. Probes encouraged greater elucidation, and more information [Field and Morse 1985].

Oakley [1981] has described some of the difficulties inherent in the social situation of interviewing women, and the impossibility of being totally impersonal. Benney and Hughes [1984] contend that in an interview, both parties behave as though they are of equal status for the duration, whether or not this is actually so. The majority [92%] of the respondents of Oakley [1981] usually offered some form of hospitality, such as tea or coffee, making it a closer, more socially oriented relationship, and she felt that women responded positively to being interviewed by a woman, in a deliberately non-hierarchical way. In this study, the researcher introduced herself by her Christian name, arranged the interview at a time and place convenient to the participants, and answered all queries before starting on the interview "proper", signalled by starting the tape recorder. The schedule was shared with the respondents, and due to the interviewer's familiarity with the questions, was used more as an aide memoire than as a fixed agenda. A final question on the schedule, asking about further comment or query, did not open up new areas of enquiry with the clients, which might indicate that their concerns had been fully covered.

The interviews were all carried out either in the health visitor's place of work or the client's home. All were at a time chosen by the respondents, and the approximate length of the interview known. However, there were the inevitable interruptions by phone or knocks on the door, which did not however appear to be too disruptive. In three clients' interviews, the respondents were uncomfortable and gave short replies. On two of these occasions a third party was present, and the mothers appeared uneasy about discussing details about the visit, and the third woman it emerged would much rather have been watching the television at the time of the interview. Most of the respondents appeared very happy to air their views openly, the health visitors looking on it as an opportunity to discuss many taken-for-granted issues about their work, and the clients being pleased to express their views about a service with which they were so intimately concerned. Some of the mothers also said that they were glad of the opportunity to return something in exchange for the service they had received, and this must be borne in mind when considering some of the later difficulties in eliciting critical comment.

3.4.4 Questionnaires

As there was a time gap between the home visit and the interview with the researcher, two short questionnaires [Appendices C and D] were introduced, to record the participants' immediate perceptions of the visit. Views were requested on the length of the visit, the areas covered, the usefulness of the visit, and the client/health visitor relationship. The data from the interview could expand and elaborate on these opinions.

The quantitative aspect of the study consists of questionnaire data to obtain demographic information about the participants, and the use of visual analogue scales to elicit the participants' immediate impressions of the visit. A questionnaire was

chosen to elicit this data, and was intended to allow the respondents time and privacy to consider their replies, especially about such areas as "the most important areas discussed in the visit." In practice, however, while the majority were completed before the interview with the researcher, a minority were only completed at the time of the interview.

3.4.5. Visual analogue scales

Respondents are asked to indicate their agreement or disagreement with a statement by marking a cross on a 100 mm line. The use of visual analogue scales allows the respondents to create their own scale and range of values.

The use of visual analogue scales in rating subjective feelings has been well validated [Bond and Lader 1974, Gift 1989], and it is simple to use, making it appropriate for a variety of subjects. However, as Oswald [1980] found, occasionally individuals will jump from one extreme of the scale to the other. There is also a tendency to place a cross on the same point in the line without necessarily absorbing the meaning of the statement. To lessen this possibility, the four scales used were constructed so that in two, positive feelings would indicate a cross placed on the right of the scale, and in the remaining two, the same feeling would produce a cross placed on the left.

In this study, the benefits of multiple methods were demonstrated, because when the respondents' answers to the scales were discussed at the interview, further questioning allowed elaboration of their feelings. In two cases, respondents had placed a cross on the line indicating the complete opposite of their intentions. [They altered the position of their response. These two occasions were of course the only

ones when the respondents were given the opportunity to change the trend of their immediate reply.]

Duffy [1987] points to this validation as one of the benefits of triangulation, that "additional probing can be done to determine whether the mismatch was because of a weakness in the instrument or to misinterpretation by the individuals taking the test."

Another advantage of visual analogue scales is in demonstrating changes of mood or feelings over time [Zealley and Aitken 1969]. In this study, the health visitors had an opportunity to do this, as they completed the scales on three different occasions, about three different visits. The clients, on the other hand, only had one opportunity to depict her thoughts using the scales. This may have had the consequence of polarising the clients' views, while the health visitors could apply the scales with a finer adjustment.

The research tools were the tape recordings, the interview schedules, and the questionnaires.

The study was designed, therefore, to study the interaction of home visits by recording and examining the tapes of home visits by conversational analysis. The participants' views were collected by semi-structured interviews, and some numerical data and immediate impressions gathered from short questionnaires.

3.5 PILOT STUDY

A pilot study was carried out to test the data collection instruments, test the comprehensiveness and comprehensibility of the information given to health visitor and client, and to check the validity of the method.

Four volunteer health visitors made 10 routine arranged home visits to primiparous mothers with young babies. Three health visitors made three visits, one only one visit.

A dilemma was presented, whether to interview the health visitor three times, once after each visit, or only once, after she had completed all her visits. If interviewed three times, the advantages would be that the health visitor would have time to think, different issues could be raised and developed, and there would be a greater depth of data. The disadvantage would be that knowledge of the interview questions might alter the health visitor's actions on the next two visits [i.e. contamination]. If interviewed only once, the advantages would be that there would be less time commitment for the health visitor, and no bias from the interview with the researcher, and the disadvantage would be loss of data on two out of the three visits. The pilot study, therefore, was used to test both options. One health visitor was interviewed only after her last visit, one after her only visit, and two after each visit. Of the two health visitors interviewed three times, both felt that they had been influenced by the interview with the researcher, albeit in a minor way [one went into detail about her role, while the other was self-conscious about carrying out health education]. Although more data was obtained, much of it was repetitious. Therefore it was decided to interview the health visitors only once, using the questionnaires to gather immediate data about all visits.

The pilot study was used as a testing ground of some of the techniques arising from past research into communication. For example, in addition to the three objectives of the study listed at the beginning of the chapter, a fourth question had been postulated:

4. Are the participants' perceptions influenced by the interpersonal skills demonstrated on the visit?

This question, displaying its origin in the tradition of isolating discrete communication techniques, was omitted from the main study, not least because of possible questions concerning reliability of identification of categories. Another question took its place, arising from the data generated from studying the interaction, namely, are home visits worthwhile?

This shift in theoretical thinking also decided the researcher against attempting to generate suggested coding categories for the content of the home visits, but towards the use of conversational analysis techniques.

However, some aspects of measuring were retained, such as proportional verbal input, and the scores obtained through the use of visual analogue scales.

The data collection instruments proved generally satisfactory. The tape recorders were acceptable, but it was found advisable that each health visitor should carry spare batteries, as one health visitor, although supplied with new batteries, found the recorder stopped midway through the visit, and had to borrow batteries from her client's radio! The rechargeable batteries proved invaluable. The questionnaire required no amendments, but the schedules were altered slightly to

encourage more critical comments from the mothers. For example, when it was found that few of the mothers wished to express dissatisfaction with their own health visitor, a question was introduced [qu. 30, Appendix B], asking "Does anybody you know not have a good relationship with their health visitor?"

The information sheets proved satisfactory, in that no-one expressed mystification or misunderstanding with the content.

A superficial analysis of the tapes of the home visits was made according to proportional input, topic, and "style" of health visiting. This third category provided the greatest depth of analysis, whilst also raising most questions about reliability and validity, particularly in the area of topic introduction. This aspect was later studied then discarded from the main study as raising too many questions about validity.

Subjects of interest included questions about role expectation, negotiation, manner and method of health visiting, relationship between professional and client, and the client response.

The pilot study also revealed a relative homogeneity in the client group, and so it was resolved to carry out the main study in three different areas, in order to obtain a more heterogeneous sample of clients, and to exclude factors that might possibly arise from local health visiting practice.

3.6 ACCESS

The research proposal was submitted and approved by the General Practice / Community Medicine Ethics of Medical Research Sub-Committee. Three Directors of Nursing Services [Community] of one Health Board were approached, and gave permission and encouragement for the study to be carried out. After contacting nursing officers in the 3 areas, the researcher attended health visitors' meetings to explain the purpose of the study, and to request volunteers. The researcher had not worked as a health visitor in these areas.

Topics raised at these meetings included questions about ethics and confidentiality, the validity of the research, and practical problems concerning the tape recorder.

Concerning confidentiality, the health visitors wanted to know how the tapes would be used, and how the clients' anonymity would be protected. They were also understandably concerned about issues concerning assessment of individual performance, especially in view of the "Big Brother" connotations of the tape recorder. They were assured that only the researcher and her academic supervisors would have access to the tapes, and the identities of all participants would be concealed.

Concerning the validity of the research, the health visitors queried how representative of their work one visit to a selected client would be. In responding to this, it was pointed out that this study could not hope to represent all the health visitor's work, even with one client group, but could describe a snapshot, or cross-section, of their work, on that particular day and time. Their point about selection was valid, but mitigated by the relatively narrow range of criteria for participation in

the study [see Appendix E]. To avoid selection bias, the health visitors were asked to request the participation of clients whose babies were born in chronological order in their "birth book", a record of all babies in their caseload.

Questions about the tape recorder concerned positioning and operation, and as a result of similar questions arising during the pilot study, these and possible difficulties were discussed in the information sheet for health visitors [Appendix F].

As a result of the meetings, several health visitors agreed to a subsequent individual discussion, and eventually 15 made a firm commitment to participate. It is interesting to note that the largest number of health visitors [7] volunteered in the area where the researcher faced the most challenging and searching questions. An additional four health visitors had volunteered, but later withdrew. One reported commitments to crisis visiting, two had insufficient primiparous mothers within the selected age range, and one had a client unhappy to be tape recorded. [This was a rare occurrence and was only reported to the researcher on one other occasion]. However, the experience of Cowley [1991a] was that health visitors initially expressed willingness to tape record home visits, but eventually only 3 [out of 53] did so, for both practical and emotional reasons. There was a sense of intrusion into a private and intimate situation. In this study, the researcher addressed approximately 60 health visitors, 21 asked for further information, 19 made a commitment to participate, and finally 15 completed the full requirements of data collection.

3.7 MAIN STUDY

The design of the study followed the outline presented earlier, in section 3.3., consisting of a conversational analysis of the audiotapes of home visits, and interviews and questionnaires with the participants concerning their views about the visit and their relationship.

The data consist of 45 taped interviews with clients, 15 taped interviews with health visitors, 45 completed client questionnaires and 15 from the health visitors. There are 39 audiocassette tapes of home visits. [Six further tapes of visits proved to be blank, due to mechanical fault or operator error.]

Data collection was carried out in the three areas in three two-month blocks, starting in November 1988, and concluding in May 1989.

Analysis of the data consisted of direct comparison of the health visitor and client replies from the questionnaires and interviews, and conversational analysis of transcripts of the audiocassette tapes of home visits.

The participants are numbered, for anonymity. HV 1 visited clients C 1, C 2, and C 3, HV 2 visited C 4, C 5, and C 6, and so on. Dialogue from the visit to C 1 is identified by V 1, and the visit to C 2 by V 2, &etc. Names included in the transcripts of the visits are pseudonyms, and geographical details changed to ensure anonymity.

Criticisms have been made in the past by health visitors that they have been used as information-gatherers for researchers without receiving information and feedback. In this study, feedback to the participants consisted of a 20 page summary report sent to each health visitor, and a profile of each visit, concerning the

proportional verbal input. The clients knew this report was to be provided, and when, so that they too could have access. The greatest response, however, was when the researcher addressed two meetings, one at the local professional society meeting, and the second to two groups of fieldwork teachers. Many of the health visitors who had participated were present, and shared some of their feelings at using the tape recorder, and repeated their previously stated views that the visits were indeed "typical" and the clients not "chosen" in any way. Two published articles [Appendices P and Q, reproduced here with the permission of the publishers], in journals with a wide circulation among health visitors, triggered further comment and discussion.

Findings are discussed in the next chapter, but two practical aspects proved to be vital in the successful completion of the study.

The first is the availability of the researcher. Although the health visitors were given a stamped addressed envelope to send containing the consent forms and details of when the visits were to be carried out, in practice, these were not used, as visits were frequently arranged at short notice. It was therefore extremely important that the health visitors could contact the researcher by phone, and so both a work and home phone number were given. [An ansaphone or secretary would have been extremely useful!] Also, as approximately a fifth of the clients did not possess phones, the health visitor kindly made arrangements when it would be suitable for the interviewer to visit.

The second point is the time-consuming aspect of transcribing audiotapes of varying quality. Working on a ratio of 1:8 to calculate the length of time necessary to transcribe taped interviews, proved wildly over-optimistic about the researcher's

typing skills. The researcher had no control over the positioning of the tape recorder during the home visits, and some tapes were an exercise in ear strain. The final ratio of time involved was probably 1:12, or longer.

Fortunately, the budgeting had allowed for the employment of an audiotypist, who made an initial transcript of 10 of the home visits. These transcripts were then expanded by the researcher, who was able to fill in some gaps because of of greater knowledge of subject matter and idiom, and due to more insight caused by repeated playing of the tapes. The act of transcribing was useful as part of the analysis, gaining intimate knowledge of the data, which is why it was valuable for the researcher to transcribe all interview tapes, but it was also of immense practical help, in terms of time, to have assistance in an initial skeleton transcription of the visit.

3.9 SUMMARY

Fifteen health visitors volunteered to carry out a routine home visit to three primiparous clients. The visits were tape recorded, and the clients interviewed usually the day after the visit. The health visitor was interviewed after the completion of the third visit. Both participants were asked to complete a short questionnaire soon after the visit about their immediate impressions.

The data consist of 45 taped interviews with clients, 15 taped interviews with health visitors, 45 completed client questionnaires and 15 from the health visitors. There are 39 audiocassette tapes of home visits.

The approach taken to this study was based on methodological triangulation, in order to describe the composition and interaction on a home visit, the many aspects of both participants' perceptions of the interaction, and through these perceptions, explore their wider views of their relationship.

The next chapter describes numerical aspects of the data, followed by three chapters of analysis of the questionnaire and interview data, before the final chapter of analysis, Chapter 8, studies the interaction of the home visits.

CHAPTER FOUR

QUANTITATIVE ANALYSIS OF THE DATA

The data consist of 45 taped interviews with clients, and 15 taped interviews with health visitors. There are 45 completed client questionnaires and 15 from the health visitors. There are 39 audiocassette tapes of home visits.

This chapter considers six areas: characteristics of the sample of participants [4.1], the visual analogue scale results [4.2], questionnaire data including most important areas discussed [4.3], interview data including aims for the visits [4.4], a comparison of the questionnaire and interview data [4.5], numerical aspects of the interviews and visits [4.6] and concludes with a summary [4.7].

4.1 SAMPLE

4.1.1 Health Visitors

Fifteen health visitors participated, 3 from one area, 5 from another, and 7 from a third. Twelve worked full-time, 3 part-time. Concerning their title, one was male, 11 were married women, and 3 were either Miss or Ms.
[Note: As can be seen from the above details, one of the health visitors was male, but to maintain confidentiality in the transcripts and throughout this thesis, health visitors are described as though all were female.]

The health visitors' ages, in three age-bands of under 35, between 35 and 50, and over 50, are depicted in Figure 1. As can be seen, the majority were under the age of 50.

The areas where the health visitors work, whether mainly urban, mainly rural, or a mixture of the two, are described in Figure 2. The majority of health visitors [11] worked either in urban or mixed urban settings.

Caseload numbers of children under 5 are as follows:

Health visitors who worked part-time: from 120 to 188, with a mean of 146.

Health visitors who worked full-time: from 145 to 384, with a mean of 242.

Years practised as a health visitor varied from 6 months to 23 years, with a mean of just over 8 years.

The number of qualifications possessed by the participating health visitors are described in Figure 3, demonstrating that the majority [9] had 4 or 5.

In addition to the expected H.V. and R.G.N. or S.R.N., qualifications included S.C.M., F.W.T., D.N., N.N.E.B., N.D.N.D., D.M.S., Dip. Nursing, R.S.C.N., R.M.N., and Q.N.S.

To ascertain whether this group of 15 health visitors could be said to be representative, a random sample of 45 was abstracted from the health visiting register held by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. [There is no separate register for Scotland.]

The information consisted of 45 entries, identified by their P.I.N. *[personal identification number]*, listing date of birth, number of qualifications, and date of registration. The first two measures could be directly compared with the research group. The third item, the date of registration, is not of course the same as years practised as a health visitor, and so is not directly comparable.

Age of Health Visitors

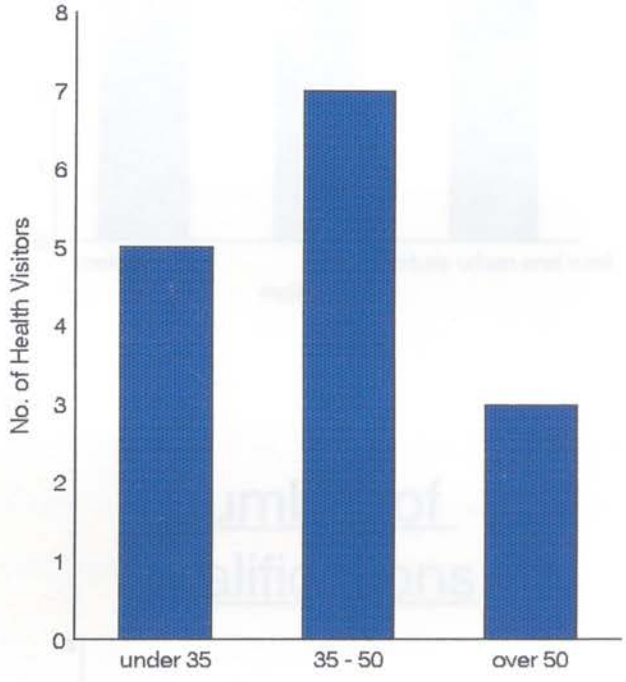

Fig 1

Area of Work

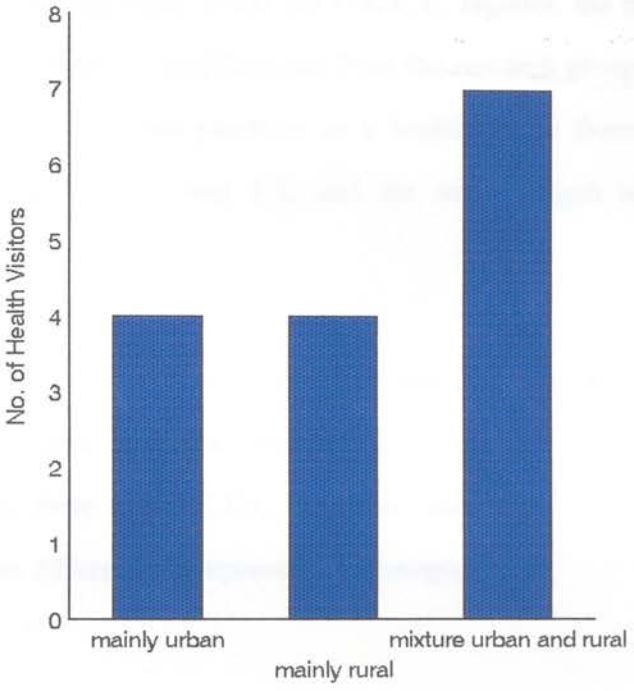

Fig 2

Number of Qualifications

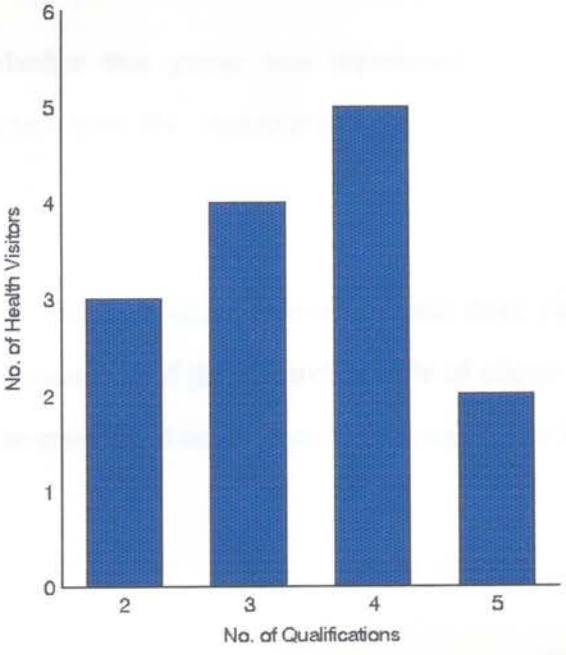

Fig 3

On comparing the research group with the random sample from the Register, both age and number of qualifications are similar. The largest group in the research sample was in the 35-50 age band. From the U.K.C.C. register, the mean age was 46.6 years. The mean number of qualifications from the research group was 3.6, and from the Register, 3.0. The years practised as a health visitor from the research group, in full-time equivalents, was 8.5, and the mean length of time since registration was 15.9.

It could therefore be inferred, that the research group, although perhaps slightly younger and better qualified, was similar in age and qualifications to a random sample taken from the U.K.C.C. Register, and so there is no reason to suppose the group was different to a representative sample.

4.1.2 Clients

Forty-five clients participated, three for each of the 15 health visitors.
Of the 45 women, 35 were married, and 10 were not. Of the 10 unmarried women, only 3 lived alone with their babies, and thus could be termed single mothers. Their ages ranged from 16 to 36, with a mean age of 25.

To ascertain whether this group was representative, the mean age of primiparity was abstracted from the computerised records of the research area's Health Board.

In 1988, the mean was 24.7, and rose over the next three years to 25.1, 25.4 and then 25.6 years. The mean age of the research sample of clients was therefore as expected, and so might be considered no different from a representative sample.

Clients' Housing

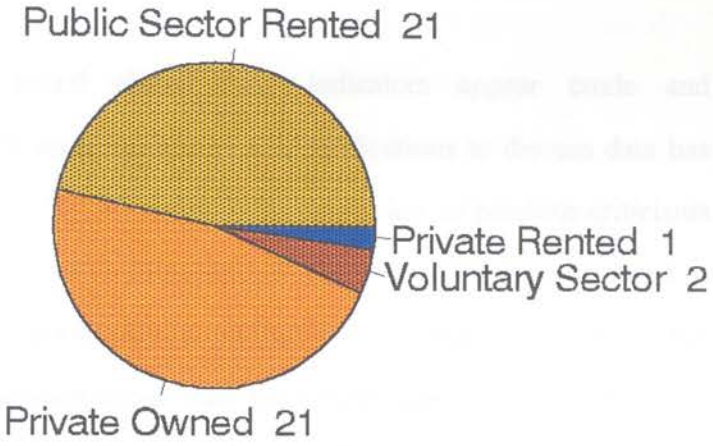

Fig 4

Clients' Social Class

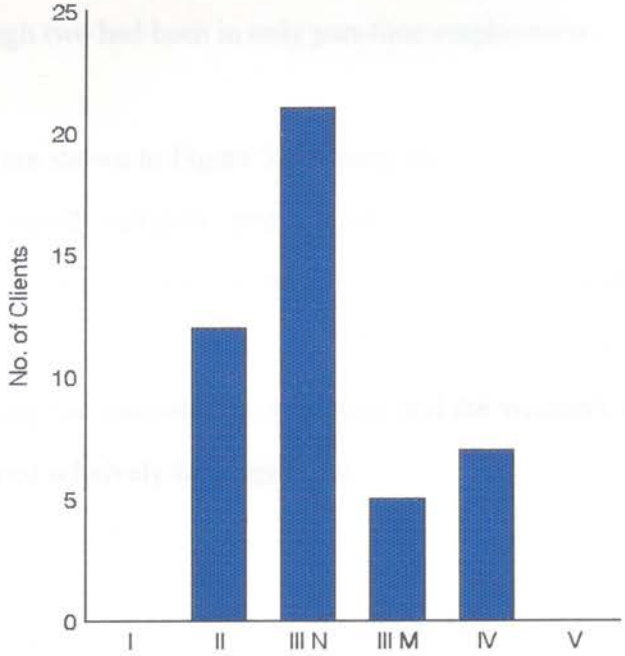

Fig 5

The clients were asked whether their housing was privately owned, privately rented, rented through the public sector, or rented through the voluntary sector. The results are described in Figure 4, which demonstrates that the proportion of women who lived in privately owned and public sector rented housing, was the same.

When considering social class, many indicators appear crude and inappropriate. The validity of using occupational classifications to discuss data has been questioned [Murgatroyd 1984, Morgan 1983], but in view of previous criticisms of health visiting by working class women, some assessment had to be considered. It was decided to use the Registrar General's classification according to occupation, but to ask the question of the women rather than their male partners. The practice of classifying women by their husband's occupation, or, if unmarried, by their father's, started early in the twentieth century, when most women were not economically active. Now, however, most women work at least part-time in paid employment. In this study all the respondents were female and in some cases there were no male partners. As it might be expected that many of the clients would state childcarer as their present occupation, the question was asked, what had been their occupation in the previous year. All the women in the study had been employed at some time in the previous year, although two had been in only part-time employment.

Their replies are shown in Figure 5, showing the largest individual group [21] was in the 3, non-manual, category, and the remaining clients evenly distributed above and below this group, with no-one from the extremes of the social spectrum.

Therefore, using the two criteria of housing and the woman's occupation, the sample could be termed relatively heterogeneous.

At the time of the interview, the mothers were asked the age of their babies, to the nearest month. The results appear in Figure 6. As can be seen, the majority of babies were aged between 2 and 4 months.

The babies were evenly split by gender, 22 boys and 23 girls. Of the 39 of whom greater details are known, 10 were breast fed, and 29 bottle fed. [This ratio of breast to bottle fed infants is in accordance with national statistics for this older age group of babies.]

On comparing the health visitors with their clients, therefore, the health visitors are likely to be older, and, by definition of their profession, belong to a higher social classification than the majority of the mothers.

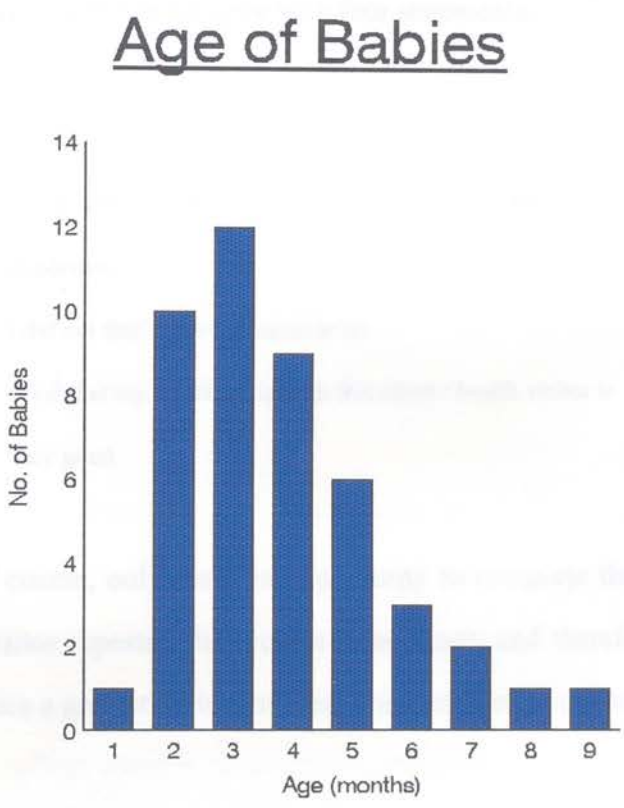
Age of Babies
No. of Babies
14
12
10
8
6
4
2
0
1
2
3
4
5
6
7
8
9
Age (months)

Fig 6

4.2 VISUAL ANALOGUE SCALES

The visual analogue scales are described in section 4.2.1, class differences discussed in 4.2.2, chi-square analysis in 4.2.3, and correlations in 4.2.4.

4.2.1 Description

In the questionnaires completed after the visit [Appendices C and D], the participants were asked to agree or disagree with four statements.

These statements were:

1. I felt that this visit lasted too long.
2. During the visit we talked about all areas I thought were important.
3. I did not find this visit useful at all.
4. I feel that my relationship with this client / health visitor is very good.

The client, of course, only had one opportunity to complete the four scales, whereas the health visitor repeated the process three times, and therefore had more opportunity to introduce a greater variety of gradations into her responses.

A positive scale was alternated with a negative scale i.e. a respondent, if she had felt that the visit was a completely enjoyable and worthwhile experience, could not just place crosses all down the left side of the scale, but had to read the questions carefully and place the crosses at different ends of the scale. This arrangement of questions was validated in the pilot study and found to be comprehensible.

However, in the following analysis, the scores are standardised, so that a high score indicates dissatisfaction with the visit, and a low score, satisfaction. The results of the four questions appear in Tables 1, 2, 3, and 4, listed in Appendix K.

Overall, the scoring was highly positive on all the areas. When looking at those who had a completely negative view, [i.e. scores over 50], the picture is as presented in Figure 7.

This demonstrates that the health visitors felt that a third of the visits lasted too long, whereas only 2 of the 45 clients [i.e. 4.4%] felt the same way. Four of the clients [8.8%] did not find the visit useful, and the health visitors felt this about 2 [4.4%] of the visits. None of these negative scores were about the same visit, i.e. the other participant in these 6 visits did find the visit useful.

Therefore, in 13% of the visits, one participant did not find the visit useful. However, one of the clients [C 25], who had not found the visit useful, also felt that the visit had lasted too long, and their relationship was not good.

In a scoring system ranging from zero to 100, with 100 being the most negative view, very few of the clients placed their crosses higher than 20. These results appear in Figure 8.

The health visitors were far more critical, especially in the questions about the length of the visit, and their relationship with the client.

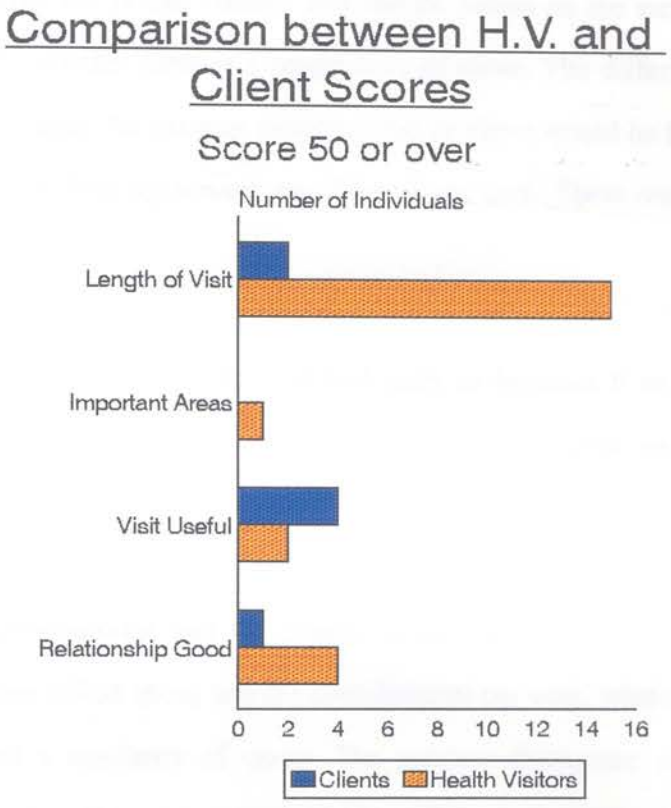
Comparison between H.V. and Client Scores
Score 50 or over
Number of Individuals
Length of Visit
Important Areas
Visit Useful
Relationship Good
0 2 4 6 8 10 12 14 16
Clients
Health Visitors

Fig 7

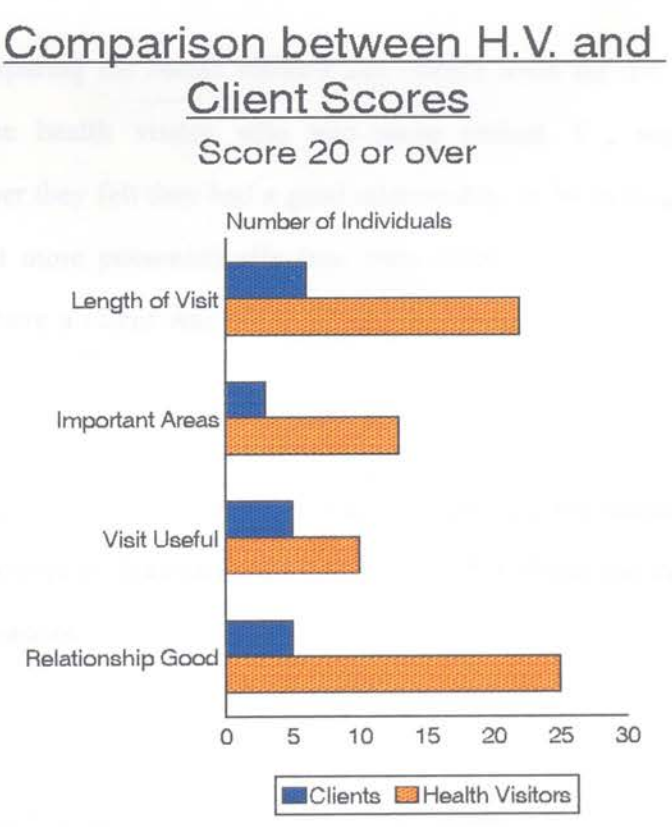
Comparison between H.V. and Client Scores
Score 20 or over
Number of Individuals
Length of Visit
Important Areas
Visit Useful
Relationship Good
0 5 10 15 20 25 30
Clients
Health Visitors

Fig 8

By comparing the health visitors' and clients' scores on the same topic, it is possible to identify whether there is a congruence of views. The difference between the two scores was taken. An extreme disagreement of views would be indicated by a figure close to 100. A close agreement would be near to zero. These results appear in Figure 9.

A difference in scores of the matched pairs of between 0 to 20 might be termed a congruence of views. Between 21 to 50, is more divergent, and a difference of over 50 shows disagreement.

Figure 9 demonstrates that the closest congruence of views was about the most important areas talked about and the usefulness of the visit, where 32 out of 45 pairings [71%] had a similarity of views. The greatest divergence was about the length of the visit, where 14 pairings [31%] had a difference in score of over 50.
figures 9 & 10

When comparing the health visitor's and client's score for the same item, it was generally the health visitor who was more critical. For example, when considering whether they felt they had a good relationship, in 39 pairings [87%], the health visitors felt more pessimistically than their clients. The results on the four question areas, where a client was more critical than their health visitor, appear in Figure 10.

Concerning questions 1, 2, and 4, it was very strongly the health visitors who held a more negative view. Sixteen of the 45 clients [36%] found the visit less useful than their health visitors.

Comparison between H.V. and Clients

Differences between Scores

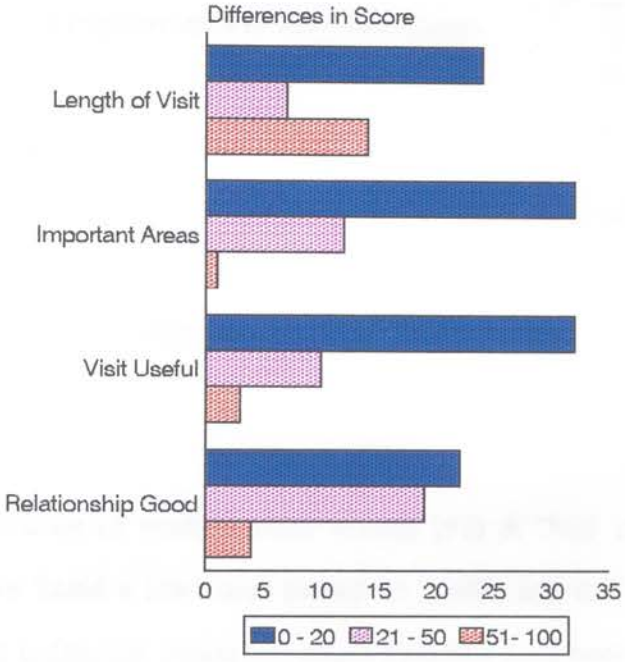

Fig 9

Number of Clients more Critical Than Their Health Visitor

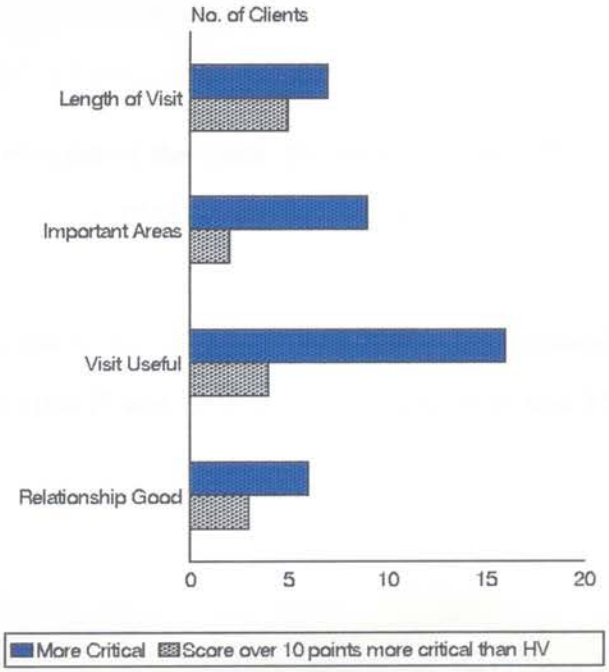

Fig. 10

When some close differences between the scores are excluded, by omitting differences in scores of 10 or under, re-examining the data shows the contrasting results in Figure 10. Only a small number of clients [between 2 and 5] took a more negative view than their health visitor. Overall, therefore, it was generally the health visitor who gave a more negative answer than their clients.

4.2.2 Class differences

Concerning the social class of the client, it has been suggested that women of a lower social classification, may make less use of the preventive services [McKinlay 1970, Black Report D.H.S.S 1980a], and have more critical views of health visitors [McIntosh 1986].

Two other studies of working class women [Pill & Stott 1986, Blaxter & Paterson 1982] have found a low value placed on health, and that positive health maintenance was an unfamiliar concept. It might therefore have been postulated that women from the lower socio-economic groups might have had higher scores on the visual analogue scale results. Using the two measures of usefulness of the visit, and strength of relationship [columns 7 and 8 in Appendix M], a mean was taken of each woman's reply, grouped by social classes according to the Registrar General's classification.

Concerning the usefulness of the visits, the mean response of social class II [n=12] was 9.9, IIIN [n=21] was 5, IIIM [n=5] was 13.4, and IV [n=7] was 10.3.

Concerning the replies to the statement "I feel that our relationship is very good", the mean of social class II was 10.7, IIIN was 12.5, IIIM was 10.8, and IV was 13.4.

These narrow differences do not indicate a wide range of opinion according to social classification.

Using the alternate socio-economic indicator of housing, the two groups contrasted were those women living in privately owned accommodation [n=21], and those living in public sector rented housing [n=21]. Again, a mean was taken of their scores on the replies concerning usefulness of the visit, and whether they felt they had a good relationship.

The totals for both groups were very close. The means of the first group were, respectively, 10.3 and 4.3, and for the second group, 5.9 and 8.1.

In view of the small numbers of respondents, these results may need to be interpreted with caution, but they do not seem to indicate that socio-economic factors influenced the clients' responses to the visual analogue scale questions.

4.2.3. Chi - square

A chi-square test was performed on the scores on the four analogue scales. First, a two-by-two table was constructed on the number of health visitors and clients who had scored over 50, or 50 and under. The calculations are listed in Appendix L. The results were significant only on the first scale, the length of the visits [Yates corrected = 10.44, $p < 0.01$].

As there is a tendency to avoid extremes of scoring on these scales, the figures were re-examined, looking at the number of health visitors and clients who had scored over 20, or 20 and under, on the four scales. Using this different benchmark figure, showed significant results on the first [$p < 0.001$], second

[$p < 0.02$] and fourth scale [$p < 0.001$]. The Yates corrected figures were, respectively, 11.25, 6.16, and 19.14.

4.2.4 Correlation

The health visitors' and clients' scores on the four visual analogue scales were tested for correlation, using the Spearman rank correlation coefficient. The scores were ranked, and the resulting correlations were highly significant, at a level of probability of less than 0.01.

First scale: rho = 0.974

Second scale: rho = 0.974

Third scale: rho = 0.958

Fourth scale: rho = 0.985

Therefore, the strongest correlation between the health visitors' views and the clients', was about their relationship.

4.3 QUESTIONNAIRE DATA

The questionnaires [Appendices C and D] supplied information on how long the health visitor had known the client, how many times they had been in contact, and what each participant considered the most important areas discussed on the visit.

4.3.1 The length of time the H.V. had known the client:

The health visitor was asked how long she had known the client. As the youngest baby in the study was 6 weeks, 5 weeks was the shortest probable time of contact. When rounded to the nearest month, the usual length of time they had been in contact varied from 2 to 9 months. [There was one atypical instance of the health visitor knowing the client for 36 months.] The mean length was 5.4 months. [Details of each pairing are listed in the summary Table 18, Appendix M.]

4.3.2 The number of contacts between health visitor and client:

The health visitors were asked to list the number of contacts at the client's home, or clinic, or other occasions [which included phone calls, meetings in the street, shops, or friends' houses]. Table 5 lists the number of contacts for each client, listed under home, clinic, other, and totalled:

Table 5 : The number of contacts between health visitor and client

CLIENT	HOME	CLINIC	ELSEWHERE	TOTAL
1	5	3	0	8
2	6	8	0	14
3	6	10	0	16
4	4	7	0	11
5	7	2	0	9
6	4	7	0	11
7	5	7	1	13
8	6	8	0	14
9	11	7	0	18
10	4	3	0	7
11	6	1	0	7
12	2	3	0	5
13	4	6	0	10
14	3	4	0	7
15	3	5	0	8
16	5	3	0	8
17	3	0	1	4
18	3	3	1	7

19	4	4	0	8
20	4	15	0	19
21	2	3	0	5
22	5	8	0	13
23	6	8	0	14
24	4	6	0	10
25	6	10	0	16
26	4	8	0	12
27	3	6	0	9
28	6	11	3	20
29	3	6	1	10
30	7	8	11	26
31	6	5	2	13
32	4	3	3	10
33	3	3	0	6
34	6	11	0	17
35	3	4	0	7
36	4	2	0	6
37	9	7	0	16
38	7	5	3	15
39	8	15	0	23
40	3	4	2	9
41	2	7	0	9
42	4	7	0	11
43	6	27	0	33
44	5	3	2	10
45	4	8	2	14

The relative weighting of home to clinic varied considerably. The smallest number of contacts was 5, the largest 33, with a mean of 12 contacts. The smallest number of home visits paid was 3, and the largest 11, with a mean of nearly 5.

When the total number of contacts was banded into three groups, 1 - 8, 9 - 15, and over 16, the results are displayed in Figure 11, which demonstrates that just under half the pairings of health visitor and client had between 9 and 15 contacts before the recorded visit.

The study by While [1985] was the first to examine the number of home visits an individual client may receive. She found that the vast majority of families received six or less home visits in the first six months of an infant's life, and over a third [between 35% and 47%] received two or less visits in this period. The group in this study, therefore, some of whom had babies considerably younger than 6 months, had received more home visits than the group studied by While. Another of her findings, that babies who were breast fed received more home visits than those who were bottle fed, was not confirmed in this small sample. Of the 39 for whom the method of feeding is known, those breast feeding [n = 10] received a mean of 4.3 home visits, and attended the clinic 6.1 times. The 29 mothers feeding by bottle, received a mean of 4.8 visits, and attended the clinic 6.1 times.

There has been much evidence in the past that socioeconomic variables can influence the views of clients, and their response the the child health services. Wedge and Prosser [1973], for example, found that one in three disadvantaged children in their cohort study never attended a child health clinic compared with one in five other children. The mean number of home visits, and total number of contacts were crosstabulated with the socio-economic groupings described in section 4.2.2.

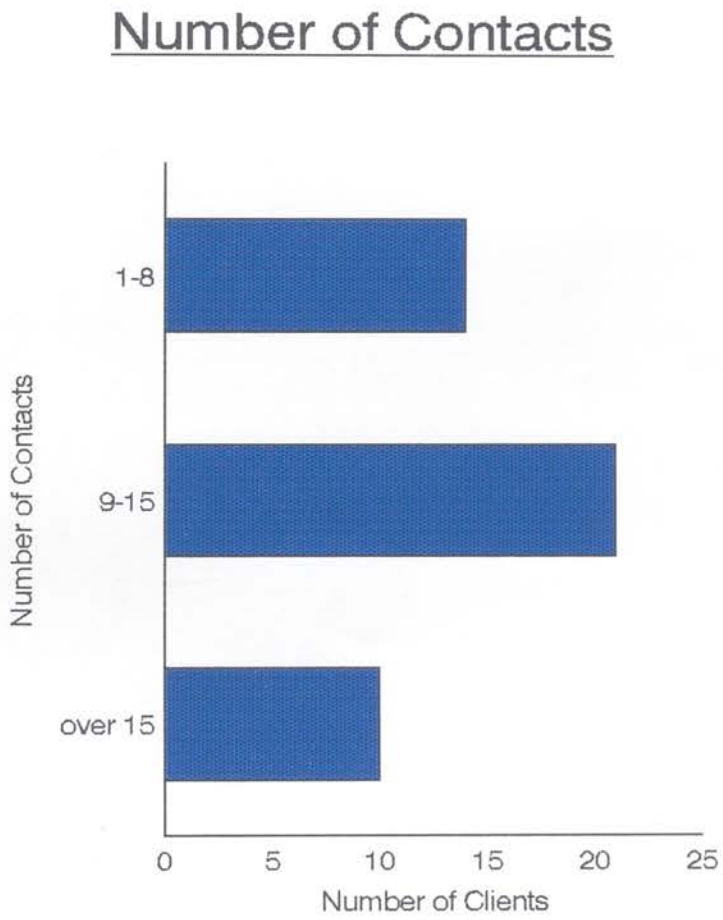
Number of Contacts
1-8
9-15
over 15
Number of Contacts
0
5
10
15
20
25
Number of Clients

Fig 11

Class II mothers had 4.3 home visits, and 10.6 contacts. Class IIIN women had 5 home visits, and 12.5 contacts. Class IIIN women had 4.6 home visits, and 10.8 contacts. Class IV women had 5 home visits, and 13.4 contacts.

When the alternative variable of housing is examined, women living in privately owned accommodation received a mean of 4.8 visits, and had a total of 11.8 contacts. Mothers in public sector accommodation received 4.8 visits, and had a total of 12.3 contacts.

It might therefore be inferred, from these very close results [from an admittedly small sample], that the number of home visits a woman receives does not seem to be decided by socio-economic factors.

4.3.3. Most important areas discussed

Both client and health visitor were asked in the questionnaire to note down what they considered the most important areas discussed in the visit.

The range of topics listed was very wide. These ranged from the very general, e.g. the health visitor listing "the mother's worries" and "baby's general health", and the client saying, " what is going on in my area", to the very particular, such as "taking the baby swimming"," going abroad on holidays" and "cot death syndrome". The most common item listed, by both health visitor and client, concerned the baby's diet. The individual comparisons for each pairing are listed in Table 6.

Table 6: Comparison of views - most important areas discussed

VISIT	HEALTH VISITOR	CLIENT
1	weaning, nutrition	weaning, nutrition
2	nutrition, immunisation, safety in the home	weaning
3	safety in the home	general baby care
4	feeding, mother's problems	everything
5	feeding, immunisation, family planning	baby's health, weaning, immunisation
6	weaning	-
7	diet and weaning, mother's worries, mother's general health	all, immunisation, baby food
8	mother's health, mother's diet, mother's expectations	all
9	mother's feelings, responsibilities of parenting	own personal feelings about baby, my relationship with husband
10	relationship with family, child development, mother's confidence	baby's development, how I am coping with baby
11	safety, baby's skin, immunisation	feeding, health, development
12	mother's feelings, weaning, oral thrush, immunisation, baby's development	weaning, whooping cough immunisation
13	immunisation, weaning	weaning, immunisation
14	how sexuality affects roles, importance of good parenting	diet, other children, going abroad on holiday
15	weaning	weaning
16	feeding	feeding, social contact
17	weaning, safety	what to do with a baby with a temperature
18	weaning	weaning, teething

19	returning to work and breast feeding, weaning, welfare rights advice	weaning, baby's health
20	practical problems moving, weaning	feeding, general health
21	weaning, use of laxatives	immunisation and side effects
22	feeding, home safety	feeding, immunisation
23	mother's self-confidence	feeding, sleeping
24	baby's leg, feeding, immunisation	feeding, baby's contentedness and interest in surroundings, immunisation, my attitudes
25	immunisation, feeding	immunisation
26	immunisation, mother's health	feeding, baby's progress
27	mother's feelings	about the baby
28	sleep, return to work	sleep
29	development, mother's attitude to work	constipation, weaning
30	feeding, development	immunisation, cot death syndrome, baby walkers and mobility
31	all development, breast feeding, immunisation, sore bottom, postnatal appointment	lying baby on side
32	solids, stimulating the baby, immunisation, mother's health	feeding, development, immunisation
33	solids, mother's emotional needs, immunisation, cradle cap	weaning, what is going on in my area
34	feeding	development, solids
35	mother's feelings	development, feeding
36	wind, constipation	feeding, windy
37	diet, holiday care, safety	development, teething, holidays, diet
38	feeding, sleeping, postnatal exercises, how to bath baby	baby's well-being, my well-being
39	mother's future diet, safety, baby's health	baby's health

40	colicky baby, mother's anxieties	unsettled tummies
41	mother's feelings, hydrocoele, weaning, immunisation	baby's development, immunisation
42	immunisation, breast feeding	immunisation, postnatal exercises
43	development, parents' feelings about baby	development
44	feelings about motherhood	immunisation, taking baby swimming, my health, cot bumpers
45	feeding	feeding

On comparing the health visitors' and clients' thoughts on the most important areas discussed, there was a relatively close congruence of views.

Broad definitions were adopted, such as equating "nutrition", "feeding", and "weaning", and taking some general answers such as "health" or "general baby care" to include more specific replies. Using such broad criteria, in 13 out of the 45 visits, there was no concurrence [visits 6, 11, 14, 17, 21, 23, 26, 27, 29, 30, 31, 35, and 44.] This is just over a quarter of all the visits [29%]. On 21 visits, there was one area of agreement, on 10 visits there was 2 areas of agreement, and on one visit there were 3 areas in common. Thus the participants had at least one shared priority of topic in 71% of the visits. [These results are tabulated in Appendix M, summarising Tables 1 - 4, 5, 6, 8, 13, 14, 16 and 17.]

When individual topics are considered, each mention of a topic was counted, the most usual subjects being diet, immunisation, baby's development, sleep, safety, mother's health and baby's health. The incidence of each are itemised in Table 7.

Table 7: Incidence of topics - most important areas

TOPIC	HEALTH VISITOR	CLIENT
Diet	30	26
Immunisation	13	13
Development	6	8
Sleep	2	2
Safety	7	0
Mother's Health	28	8
Baby's Health	7	14

This table demonstrates the priority of both health visitor and client to be the baby's diet, followed by for the health visitor the client's health and well-being and immunisation, and for the client the baby's health and immunisation.

The health visitors' stated priority of interest in the mother's well-being is in contrast to the finding of Hennessy [1985], that in a third of the visits the mothers were not asked about their health. The clients' concentration on subjects concerning babycare might support the finding of Dalziel [1990] who reported views from women's health groups that health visitors were only interested in the baby.

4.4 INTERVIEWS

4.4.1 Interviews with clients

The interviews with the 45 clients were recorded, and followed a semi-structured schedule [see Appendix B]. The lengths of the interviews varied from 20 minutes to 75 minutes, with a mean length of 41 minutes.

4.4.2 Interviews with health visitors

The interviews with the 15 health visitors followed a semistructured schedule [Appendix A], and were again tape recorded. The lengths of the interviews varied from 35 to 90 minutes, with a mean length of 70 minutes.

4.4.3 Data from Interviews: aims for the visit

Both participants were asked what their aims were for the visit [repeating the question asked in the questionnaire], and also what they thought the other's aims were.

The number of aims of the health visitors ranged from 1 - 7, and of the client, from 1 - 4. Similar to the findings of section 4.3.3, on "the most important areas discussed", topics could range from the very general, such as a health visitor saying, " to allow space for the mother to introduce any topic", "helping the mother to cope", or a client's wishes "just reassurance about everything", to the very specific, e.g. a health visitor "discuss mother's feelings about going back to work", or a client saying " to talk about the baby's rash." Table 8 compares the participants' aims for the same visit:

Table 8: Comparison of views - aims for the visit

VISIT	HEALTH VISITOR	CLIENT
1	immunisation, weaning, safety in the home, teething	weaning
2	nutrition	weaning
3	nutrition, teething, immunisation uptake, safety in the home	nothing
4	immunisation follow-up, weaning	immunisation, weaning
5	feeding, immunisation, family planning	weaning
6	immunisation, feeding	swimming, rough skin, immunisation
7	immunisation, weaning	general, immunisation, baby food
8	mother's general health, developmental progress	feeding
9	assess development, mother's general health	general
10	weaning, immunisation, development, mother's well-being	development
11	weaning, immunisation, baby's development, mother's health especially emotional	feeding, my worries, development
12	feeding, mother's emotional well-being	weaning, immunisation, sleep
13	immunisation, weaning, parent's expectations	immunisation, weaning, clicky hips
14	weaning	feeding
15	weaning	going abroad for holidays
16	introducing solids, safety, assess development	solids
17	weaning, safety, immunisation	development, help for me

18	weaning, safety, immunisation, development	solids
19	weaning, immunisation, teething, sleep, mother's return to work, cervical smear, father's job security	solids
20	recent bereavement, weaning, dental health, sleep, immunisation	feeding
21	allow space for any topic, weaning, child development, immunisation	immunisation, teething
22	feeding, immunisation, home safety	feeding
23	immunisation, developmental progress, weaning-savouries	feeding, sleeping
24	general, mother's worries	reassurance, general, weight
25	mother's reactions, feeding, development, follow-up talipes	nothing
26	weaning, immunisation, mother's emotional state, plans to return to work	feeding, sleeping
27	feeding, immunisation, mother's confidence in handling child	how baby was, how I was
28	sleep, immunisation, mother's return to work	sleep, immunisation
29	development, immunisation, mother's attitude to work, care of baby	constipation, teething, immunisation
30	feeding, immunisation, development, home safety	immunisation, safety
31	developmental assessment, postnatal appointment, breast feeding, sore bottom, immunisation	baby lying on side, developmental assessment
32	how mother is coping with baby, feeding, development, immunisation	feeding
33	immunisation, solids, cradle cap	everything, rash, solids
34	developmental assessment, feeding, immunisation, stimulation and play, mother's general well-being, any problems that arise	reassurance, general things

35	feeding, development, any of mother's questions, general family support	feeding, development
36	giva a chance to talk, support	wind
37	developmental screening, diet, sleep, teeth, immunisation, safety, support parents	development, reassurance
38	developmental assessment, feeding, sleeping, immunisation, fluoride, safety, family planning	colic, sleep, baby's health, mother's feelings
39	development, diet, sleeping, teeth, immunisation, safety, support mother	development
40	immunisation, baby's colic, 6 week medical check, general assessment of mother and baby	colic, reassurance
41	immunisation, mother's well-being, baby's well-being	reassurance, hydrocoele
42	immunisation, breast feeding, mother's well-being, baby's well-being	baby's head, immunisation, postnatal exercises
43	developmental assessment, hearing test, baby's sleeping pattern	nothing
44	immunisation, feeding, fluoride, mother's feelings about baby and coping	somebody to talk to, how I'm coping
45	weaning, any of mother's anxieties	cot bumpers

When comparing the client's and health visitor's aims for the same visit, on 8 visits they had no aim in common [visits 2, 3, 8, 15, 17, 25, 36, and 43]. This represents 18% of the visits. On 22 visits they had one aim in common, on 13 visits 2 aims in common, and on 2 visits 3 common aims. Therefore, in 82% of the visits, the participants had at least one shared aim for the visit. [These results are tabulated in Appendix M, summarising Tables 1 - 4, 5, 6, 8, 13, 14, 16 and 17.]

When individual topics are considered, each mention of a topic was counted, in a similar way to Table 7.

The most usual subjects were found to be diet, immunisation, baby's development, sleep, safety, mother's health [physical and emotional] and baby's health. The incidence of each are itemised in Table 9.

Table 9: Incidence of topics - aims for the visit

TOPIC	HEALTH VISITOR	CLIENT
Diet	36	20
Immunisation	33	10
Development	19	7
Sleep	7	4
Safety	10	1
Mother's Health	21	10
Baby's Health	4	1

This table demonstrates that both health visitor and client had aims for the visit concerning the baby's diet, immunisation, and mother's health.

When asked what they thought the other's aims were for the visit [comparison data available only on 15 visits], the health visitors identified none of the mother's aims on 4 visits, 1 on 9 visits, and 2 on 2 visits. Thus on 73% of these visits, the health visitors correctly identified at least one client aim.

When the client was asked why she thought the health visitor had wanted to come [data available for 45 visits], 8 identified none of the health visitor's stated aims, 20 identified 1 aim, 14 2 aims, and 3 3 aims. At least one health visitor aim was identified by the client on 82% of the visits.

4.5 COMPARISON OF INTERVIEW AND QUESTIONNAIRE DATA

Until now in the analysis, results have been explored by looking at the health visitors' or clients' replies about the same topic. When instead the results are considered alternatively, by following the answers given by the same pairing of health visitor and client, some interesting points emerge.[Table 18 in Appendix M lists individuals' scores from various tables.]

On visits 2 and 3, where the clients did not find the visit useful, and the health visitor did not feel that their relationship was good, the participants had no common aim for the visit, but had one area of agreement about the most important area discussed.

In visit 6, the participants had a difference of over 50 in 3 areas on the analogue scales, the client did not find the visit useful, and there was no agreement about the most important areas discussed.

The health visitor on visit 15 did not find the visit useful, and had no common aim with the client. In contrast, in visit 17, the participants had no common aim for the visit or agreement about most important topics, yet still scored positive on other areas, with the exception that the health visitor had felt the visit lasted too long.

It is interesting to note that client 25, who from the visual analogue scale results, had found the visit too long, not useful, and felt their relationship not good, also had no shared aim with her health visitor for the visit. Looking at visits 27 and 35, the health visitor felt that their relationship was not good, and the participants did not coincide on what they considered to be the most important topics discussed. The participants in visit 43 had no aim in common, and the health visitor felt the visit lasted too long and she did not have the opportunity to talk about all she wanted. However, in visit 45, where the participants did have one shared aim and one area of agreement about topics, the health visitor still did not find the visit useful.

Using these comparisons, it is possible to see that participants can have differing aims and differing views on the most important areas discussed in the visit, and still feel that a visit was useful, did not last too long, that they had an opportunity to talk about what they wanted, and feel their relationship was good. In other words, agreement or disagreement in these areas does not signify a better visit or a stronger relationship. This supports the findings of Watson and Sim [1989], that satisfaction with the visit, did not depend on a similarity of views about the reasons for the visit, but contrast with the findings of Sheppard [1993], who investigated clients' perspectives of mental health work, and found that overall, satisfied clients were more frequently aware of practitioners' definitions of their problems and of the work they undertook.

4.6 VISITS

This section includes the length of the visits, proportional verbal input, topics discussed, and a short discussion of the visits chosen by the health visitors to discuss in depth.

4.6.1 Length of the visits

Forty-five visits were carried out, of which there are tapes of 39. The health visitors were asked to record when they started the visit and when they completed it. Although the tape was not switched on at the door, generally the health visitors felt that there was little lost at the beginning, at the most 5 minutes, and perhaps the same at the end. On two occasions the tape was switched off after the majority of the visit, as confidential matters were being discussed. On one occasion, due to mechanical problems, a visit was interrupted and repeated.

The shortest length of recorded visit was 7 minutes, and the longest 53 minutes. The mean length of tape was 27.6 minutes. The lengths of the tapes of the visits are listed in Table 10.

Table 10: Length of tapes of the visits: (in minutes)

	FIRST VISIT	SECOND VISIT	THIRD VISIT
1	7	20	9
2	16	19	24
3	27	33	29
4	41	53	46
5	38	44	29
6	49	25	25
7	27	11	30
8	22	18	23
9	21	30	22
10	27	25	52
12	44	30	23
13	25	-	-
14	30	21	23
15	11	-	28

The mean length of all the tapes was 27.6 minutes. The mean length of all first visits was 27.5 minutes. The mean length of all second visits was 27.4 minutes. The mean length of all third visits was 27.9 minutes.

The tapes were studied to see if the order of the visit had an effect on the length of the visit. Tapes of three visits are available for only 12 health visitors. The results appear in Table 11.

Table 11: Comparison of length of tapes:
(longest =1, shortest =3)

	FIRST VISIT	SECOND VISIT	THIRD VISIT
1	3	1	2
2	3	2	1
3	3	1	2
4	3	1	2
5	2	1	3
6	1	3	3
7	2	3	1
8	2	3	1
9	3	1	2
10	2	3	1
12	1	2	3
14	1	3	2

When these results were examined to see if there was a discernible pattern, the results were as follows in Table 12:

Table 12: Which visit was the longest/shortest?
Incidence (1 = longest tape, 3 = shortest tape)

	FIRST VISIT	SECOND VISIT	THIRD VISIT
1	3	5	4
2	4	2	5
3	5	5	3

Thus the second or third visit is most likely to be the longest, and the first or second visit, the shortest. This tallies with the mean lengths of the tapes.

The lack of a discernible pattern might indicate the naturalness of each visit, and support the views of the participants that the recorded visits were representative of their other contacts in the client's home.

The length of tapes in this study is in accordance with other researchers' findings. In the review by Clark [1981], 9 of the studies reported an average visit duration of 13 to 25 minutes, and a mean of 33 minutes was reported by Sefi [1985].

4.6.2 Proportional Verbal Input

Examining each participant's verbal contribution to the encounter may give an indication whether this home visit could be described as an "orchestrated encounter" [Dingwall 1977c], or a more relaxed, mundane conversation. For example, in the teaching situation, it has been demonstrated that in antenatal classes, the teacher talks for 77% of the time [Murphy-Black 1986], and has noticeably longer turns than the pupils [Atkinson 1981]. In Bain's study of group practice consultations [1976], the doctors contributed 58.5% of the verbal input, to the patients' 41.5%. In the study of health visitors' home visits by Robinson [1986], the health visitor in all cases had the larger share of the utterances. Baldock and Prior [1981] found that social workers talking to clients were better listeners, and more likely to ask open-ended questions, and hence the client had a greater verbal input [80% in one conversation]. How would these home visits compare?

In order to ascertain each participant's verbal contribution to the visit, an analysis was conducted using the BBC Micro Event Recorder Programme. This is a

simple method of recording events, by pressing a function key at the start of an event, and releasing the key on its completion. The duration of the event is computed and added to the running total of the cumulative duration of that event. Up to 10 distinct events or categories can be computed. In this analysis, 5 events were recorded: the health visitor's input, the client's input, silence, the baby, and "others". The baby's input was included only when verbalisations produced a response from the adults i.e. when the baby was an active contributor to the verbal interaction. [The introduction of the category of the baby's input, thus moving from a dyad to a tryad, is discussed by Vehvilainen-Julkunen, 1992.] The "other" category included contributions from, on different occasions, the client's partner, mother, sister, friends, and dog!

The Event Recorder Programme was particularly appropriate for this crude analysis of input, because as well as measuring sequential events, it can also record events that occur at the same time. As in normal conversation voices frequently overlap, all verbal contributions could be recorded. The following table, Table 13, records the scoring for all 39 visits, to the nearest second.

Table 13: Proportional verbal input (in seconds)

	HV	CLIENT	SILENCE	OTHER	BABY
1	246	235	1	.	3
2	808	531	9	.	4
3	400	242	20	.	2
4	635	331	12	.	23
5	546	672	23	10	4
6	690	810	17	.	5
7	1171	576	5	.	.

8	1179	938	1	.	12
9	1097	900	3	.	16
10	835	906	21	715	9
11	1408	1713	61	.	45
12	1356	1633	64	29	4
13	827	1311	1	162	.
14	1801	1270	36	.	.
15	672	989	62	.	36
16	964	2223	21	.	28
17	693	967	20	.	.
18	906	763	27	.	.
19	1192	446	17	.	9
20	220	476	2	.	4
21	974	888	17	.	3
22	789	536	4	.	30
23	501	564	2	31	2
24	647	666	10	.	9
25	494	751	20	.	11
26	710	1068	29	.	10
27	571	770	12	.	.
28	1072	666	.	.	.
29	959	552	.	.	.
30	2010	1169	.	.	.
34	1365	978	154	.	146
35	884	828	8	88	10
36	756	618	15	.	.
37	599	838	3	.	17

40	868	924	6	.	33
41	627	642	23	.	6
42	784	639	3	.	.
43	217	227	27	210	22
45	556	1122	3	.	3

As can be seen from this table, the health visitor had the larger gross verbal input in 19 of the visits, and the client, in 20 visits. The baby was rarely an active participant, and silence was rare, except in visit 10, when the mother left the room to carry out a task elsewhere.

Silence had been noted in other studies of nurse patient interaction, when nurses were carrying out nursing tasks. For example, in the first major study to look at the content and dynamics of home visits in the U.S.A., Johnson and Hardin [1962] found substantial periods of silence. Indeed, Ashworth [1976], investigating communication between nurses and patients in 5 intensive care units, found that verbal interaction occupied only 14% of total nursing time. The absence of substantial periods in this study points to these interactions having the characteristics of mundane conversation.

The role that fathers play in health visitors' home visits was not a subject of enquiry of this study, as the research criteria specifically addressed mothers, but it is interesting to note that in the three recorded visits where the father was present [13, 35, 43], in only one [visit 43], did he make a significant verbal contribution. This agrees with other researchers [Robinson 1986, Sefi 1985] who suggest that fathers are not encouraged to participate in the interaction.

When examined for patterns, it can be seen that two health visitors [visiting clients 10-12, and 25-27] talked consistently less than the mothers, and four health visitors [on visits 1-3, 7-9, 28-30, and 34-36] had the greater verbal input. This did not seem to affect these participants' views from the visual analogue scales on whether the visit had lasted too long, but two of the clients who had talked less [on visits 2 and 3] had not found the visit useful.

When these visits were discussed at the interviews, the participants were asked who they thought had done more of the talking during the visit. Comparisons are available for 13 pairings.

In 8 out of the 13 visits, the health visitor had the greater input, and in 5, the client. In answer to the question, who they thought had done more of the talking, the health visitor was right on only 8 of the 13 visits, and the client right on 7 of the visits. No significant association could be found using the chi-square test on this data [see Appendix L].

These scorings on verbal input were compared to those who had expressed dissatisfaction on the visual analogue scales. There was no association except in one area, that of feeling that the visit lasted too long. Of the 14 visits which the health visitors felt were too long, the clients had had the larger verbal input in 8. However, in the 2 visits which the clients felt were too long, the clients had talked more.

This brief analysis of proportional verbal input has showed no discernible pattern of either client or health visitor having a dominant contribution to the talk. In other words, equality, more representative of the elements of mundane conversation.

4.6.3 Which visit talked about in depth?

The health visitors were asked which visit they wished to talk about in greater detail. Of the 15 visits, 4 were first visits, 4 were second visits, and 7 were third visits. In answering the question why they had picked that particular visit, the most common reason was because they remembered it best. A record is available for 13 of these visits. In 8 of these visits, the health visitor had the greater proportion of verbal input. The visits did not appear atypical from the other two visits paid by the health visitor.

4.7 SUMMARY

This chapter considered six areas: characteristics of the sample of participants, the visual analogue scale results, questionnaire data, interview data, a comparison of these, and numerical aspects of the interviews and visits.

The characteristics of the sample of clients were shown to be heterogeneous, and the age of the mothers shown to be the mean expected for this Health Board area. The sample of health visitors were of the age expected when compared with the U.K.C.C. register, and slightly better qualified. There is therefore no reason to suppose that the groups were different to a representative sample.

The visual analogue scale results revealed that the health visitors were far more critical, especially in the questions about the length of the visit, and their relationship with the client. A third of the health visitors felt that the visits had lasted too long. Few clients gave negative scores. Socio-economic factors did not seem to affect the clients' responses concerning the usefulness of the visit or the strength of the relationship. A strong correlation existed between the clients' and health visitors' scores on the four scales. It was demonstrated that the closest congruence of views

was about the most important areas talked about and the usefulness of the visit, where 71% of the health visitor / client pairs had a similarity of views.

A chi-square test performed on the health visitor and client scores on the four analogue scales showed that the results concerning the length of the visit, and the strength of their relationship were significantly associated at $p < 0.001$.

The questionnaire data revealed a wide range in the number and types of contact between health visitor and client. On comparing the health visitors' and clients' thoughts on the most important areas discussed, there was a relatively close congruence of views, in that the participants had at least one shared priority of topic in 71% of the visits.

Both prioritised the baby's diet as the most important area, then the health visitor highlighted topics concerning the mother, and the client topics concerning her baby. From the interviews, in 82% of the visits, the participants had at least one shared aim for the visit. Both participants prioritised as an aim for the visit the baby's diet, followed by immunisation, the mother's health, and baby's development.

On comparing interview and questionnaire data, it can be seen a successful visit or relationship does not seem to be dependant on aims in common or agreement about most important topics discussed.

The mean length of tape was 27.6 minutes. Using the Event Recorder Programme revealed that the health visitor had the larger gross verbal input in 19 of the visits, and the client, in 20 visits. The absence of silence, and equality of verbal input, might suggest that interaction in the home has more of the quality of a

mundane conversation than an orchestrated encounter such as a teaching situation. These indicators imply fairly congruent views about the visit.

The following chapters will explore how the participants can have differing priorities and perspectives, and still negotiate and manage the interaction so that a social relationship is maintained, and individual objectives achieved. Chapters 5, 6, and 7 describe the differing perspectives, and Chapter 8 examines the verbal interaction during the home visit.

CHAPTER FIVE

VIEWS ABOUT HOME VISITS

This chapter discusses the participants' views on the practicalities of visits [5.1], their priorities for visits [5.2], compares home visits and clinic attendance [5.3], and describes their definitions of a home visit's success or failure [5.4] and concludes with a summary [5.5].

5.1 PRACTICALITIES, PAST AND PRESENT

This section discusses some of the issues raised by the participants about both the recorded home visits and details about the past history of their relationship.

5.1.1 Past Contacts

Some clients expressed a desire to meet the health visitor antenatally:

"It was nice at the beginning when you went to the antenatal classes, because you actually were introduced to your health visitor before they actually came chapping on your door, so you knew who was going to come, I felt that was good anyway, it wasn't a complete stranger coming to your door, saying, I'm your health visitor, you know, they knew you before you had the baby, and I felt that was good as well."

[C 1]

Those health visitors who brought up the subject stressed the benefits of meeting prospective mothers in terms of greater knowledge and depth to their relationship. One health visitor felt that she had a greater rapport with those clients she had met antenatally, and felt she had a different relationship with the mothers she encountered only after their babies were born.

Confirming the data of Chalmers [1990] and Cowley [1991a], it was found that the first contact can be critical in setting the tone for the rest of their relationship.

One client recalled vividly being offended by being contacted by the health visitor to arrange a visit antenatally, feeling that she had done something wrong, and then being reassured by the actual visit. That client's health visitor said that:

"I tend to think that your first contact with someone is a critical time whereby you either bury yourself for evermore and they don't wish to dig you up again because they don't like you, or else you really promote health visiting and that's where the credibility of the profession and yourself starts."

[HV 7]

5.1.2. Present Contacts

On the subject of planning visits, in agreement with the views expressed by the women in McIntosh's study [1986], arranged visits were preferred. When invited to choose between the health visitor just "popping in" or making an appointment to visit, the majority of clients said that they would prefer to know when they she was coming. Reasons given included positive ones, such as being prepared with questions to ask, or negative ones, such as they would not want the house to be in a mess. When asked if they thought that the health visitor was looking at the state of the house, the majority said no, but they still expressed some reservations, for example that they would still like the house to be tidy for any visitor.

"Before I got to know her very well, I thought, oh, I'm not going to like this very much, having someone coming round, it means I'm going to have to keep the house tidy, but now I've got to know her I know she doesn't expect the house to be wonderful and whatever, and I just see her every week now so I can just ask her anything I want".

[C 4]

This issue, of the health visitor looking at the house, is an interesting one, as it demonstrates the ambivalence in the health visitor's role, between being a supportive friend, who might be expected to ignore the state of the house, and a more

authoritarian figure, who had the right to make judgements concerning cleanliness and hygiene. One health visitor, who reported that antenatally she stresses that she is not coming to look at the house, and in fact who says she would be worried if the house is too tidy, has a client who felt that:

"If your house is clean, they'll no' bother, but I have heard if the house is dirty, they'll look into it, for the sake of the baby."

[C 21]

Another client felt that the health visitor might look at the house as an indication if the mother was coping with motherhood, or suffering from depression. A health visitor who had earlier described her role solely in terms of support, described one of the advantages of home visits as being the best place for information-gathering about the mother's circumstances and well-being. During one visit, [V41], the health visitor reported that a query had been raised in her mind about the mother's well-being because of the immaculate state of the house. Both health visitor and client later reported that they had been pleased to discuss the mother's boredom with motherhood, and felt they had gained a greater understanding of each other, because of this visit. It had been neither of their aims to discuss the mother's daily routine, but because of following this cue, a discussion had been triggered that both felt had deepened their relationship. With this underlying capacity for misunderstanding, it is therefore understandable if some clients prefer visits by appointment so that they can prepare themselves and their houses.

When considering closeness, and perhaps equality, in the health visitor / client relationship, it is interesting that in the majority of cases, the participants called each other by their Christian names. In 6 out of 45 cases, the health visitor addressed or discussed the client by her surname, and in 11 out of 45 cases, the client addressed or discussed the health visitor by her surname.

Concerning the frequency of visits, although as demonstrated in chapter 4.3.2, there was a wide range in the number of contacts, most clients were satisfied. There did not appear to be overt negotiation about arranging contact, but generally the clients felt that they decided how often they went to the clinic, and the health visitors decided about the number of home visits. There was some uncertainty:

"When she came round the first day, and she never said I'm your health visitor or anything, she just introduced herself, she never actually said I'm your health visitor and we're there if you need us, we come to see you every week, so I didn't actually know that first visit whether this was a regular thing and she would come round and see me or what. All she said was we have the clinic on a Thursday, and if you feel up to it, come and see us on Thursday, and that's how it, it's just come from there, and I've just assumed that she's there if I do need her. She's never actually said that, that was one thing, because I had to ask my sister, does the health visitor come round every week, but they don't, they're just on call if they need them."

[C 4]

The clients valued the phone as a means of contacting the health visitor if a problem arose, and there appeared to be no hesitation or difficulty in doing so.

"She told me never hesitate to call your health visitor, which is a really good point as well, you don't have to feel you know, just pick up the phone if you've got a problem, its no, we'll pop up and see you or we'll tell you over the phone, whatever you feel, you're worried about or whatever, so it was made very clear that don't worry about contacting them, that's their job, and they're there to help you."

[C 1]

Many women expressed a desire for frequent visits in the early days after discharge from the hospital, and saw less of a need for visits later on. Just "knowing that someone was going to come in" [V 1] was helpful, as the mother could save up problems and worries. Later visits were seen as welcome from a social point of view, rather than for practical reasons.

"I liked the health visitor coming round to the house just after he was born, but it was just a nice time for them to stop doing it once I was under control, once you're organised and you think you know what you're doing, it's nice to know that they're down the road of you do need them."

[C 11]

When the health visitors were asked about how they decided the frequency of contact, they either replied describing a fixed schedule of home visits, e.g. weekly for the first six weeks, or, more usually, gave reasons tailored to the individual client's needs. These reasons included family circumstances, for example how much support the mother had, the baby's health and method of feeding, and cues from the client. These cues included response at the home visit, whether they looked surprised or relieved to receive a visit, whether new subjects were being raised, whether there was a positive response to the offer of a visit, following up cues demonstrated at a clinic visit, or if they took the lead when requested to phone if they wanted a visit.

There did not appear to be overt negotiation about the frequency of contact, but it might be said that both participants were responding to covert cues, the health visitor in arranging home visits, and the client in attending the clinic. It might be expected that such negotiation had been completed by the time the home visits were recorded for this research, as the participants had known each other for a minimum of six weeks, and such was the case.The only negotiation about contact identified was the client requesting, or the health visitor offering, information about the baby's next developmental check or immunisation, or an automatic cliched farewell at the conclusion of a visit:

HV: *"So nice seeing you. Be in touch anytime. Remember I'm at the clinic on a Wednesday morning."*
C: *"I will remember that."*

[V 14]

5.2. PARTICIPANTS' PRIORITIES

To compare the participants' views about the past history of their contact, and to get some idea of their respective priorities, both were asked what single most important thing the health visitor had said or done for the client. The replies are listed in Table 14.

Table 14: The most important thing the health visitor said or did for the client.

	HEALTH VISITOR		CLIENT
HV1	early visits	C1	early visits
HV2	baby's snuffles	C5	immunisation, feeding
HV3	breast feeding her confidence	C9	myself
HV4	someone to talk to	C12	baby's colic
HV5	mother's feelings	C14	early visits
HV6	antenatally	C18	antenatally
HV7	first meeting	C19	first meeting antenatally
HV8	baby's health	C23	baby's cold
HV9	don't know	C27	don't know
HV10	soya milk	C30	baby clinic
HV11	notification visit	C31	first visit after baby born
HV12	antenatally	C36	baby's sleep
HV13	early visits	C39	early visits
HV14	yesterday's visit	C41	when the baby was one month old
HV15	baby's colic	C43	baby's colic

Table 14 shows a considerable degree of congruence, considering the very general nature of the question. Of the 15 linked pairs, 9 gave similar replies [on visits paid by health visitors 1, 3, 6-9, 11, 13, and 15].

Of all 45 clients, the replies about the most important thing in the history of their relationship were separated into categories as described in Table 15.

Table 15: Incidence of most important thing in their past relationship.

MOST IMPORTANT THING	INCIDENCE
something about the baby	21
early visits	9
something about myself	8
antenatally	4
not one thing, or don't know	4

[The incidence totals 46 because one client was unable to decide between an event in connection with herself and one concerning her baby.]

The replies demonstrate that a third of the women stressed early contact with the health visitor, approximately half cited an instance concerning baby care, and 8 women prioritised an incident concerning themselves.

5.3. HOME VISITS VERSUS CLINIC VISITS

Clinic attendance was not the subject of this enquiry, but the question was asked, what was the difference between seeing the health visitor at home, and at the clinic. As demonstrated by this and other studies, contacts in the clinic outnumber home visits. Reasons for attending the clinic, have been shown to be for reassurance, health visiting advice, a general check, getting the baby weighed, advice from the clinic doctor, a developmental check, and meeting other mothers [Sefi and Macfarlane 1985, Sefi and Grice 1994]. Warner [1983 & 1984b] demonstrated how an apparently simple phrase like "How are you" could be used to achieve several different goals. Each turn in conversation in baby clinics has been shown to be shorter, and the length of consultation shorter than home visits [Clark 1985]. Clark also felt that the health visitor initiated and changed the subject matter, whereas in the home the client often took the initative. In the clinic, Clark felt that a topic was introduced, dealt with, then closed. In the home, in comparison, the subject was extensively explored, and could be dropped for a while and then reintroduced. This aspect is explored in Chapter 8, but described here are the participants' views on the differences between the two environments.

When asked where they would prefer to talk to the health visitor, the majority of clients expressed a preference for their own home. Reasons were either expressed positively, "the home has a more relaxed atmosphere", " there's more time", or negatively, "lack of privacy at the clinic", " there, there's too many people and distractions". The better and more private the clinic facilities were reported to be, the less the women felt strongly the preference for a home visit.

"I think at home you've got more time, you can really ask the questions you want, and have a general chat anyway. The clinics themselves are O.K. but they can be rushed, if there's loads of people there. You always feel pretty bad if there's people waiting, and you're trying to ask umpteen questions, so yes, home visits are good, I like them."

[C 8]

The advantages of clinics were seen as an opportunity to get out of the house and meet other mothers, as well as the more obvious one of getting their babies weighed.

The health visitors, too, listed the benefits of visiting at home in terms of privacy, and a more relaxed atmosphere, both for themselves and the client. They identified the home as the client's territory, where the mothers might be more confident, take the lead in conversations, and be more willing to bring up things that were troubling them. In two of the recorded visits, some very personal matters were discussed, concerning family relationships, and when the participants were asked if they would have discussed this at the clinic, the answer was a definite negative. One of the clients, [C 9], felt that she could not even have approached the health visitor about it, she needed the health visitor to approach her. Health visitors viewed the home as an ideal place to discuss subjects that would take a longer time, such as anticipatory guidance about the baby's future or home safety.

From the interview data, the health visitors felt that the clients have greater power on their own home ground:

"They're more forthcoming in their own house. In a clinic, no matter how friendly you are, or how they feel, it's still a false situation, and you've still got people waiting outside the door. They say, "Well, I won't keep you", you know? Whereas in their own home, very few people say, "I won't keep you any longer because I know you're busy", very very rarely do they do that, because once they've got you in their house, they've got you."

[HV 3]

Health visitors viewed clinic attendance as the mother's choice.

"It's up to them how often they come to the clinic, you know, if somebody says do I have to come to the clinic every week I'll say there's no have-to about it at all, the clinic is there, and if you're breast feeding then it's quite nice just to see how the baby's gaining weight, from your viewpoint more than mine, so you may find some of them will come every week, and you think they're going to come every week forever, and then some of them will start coming fortnightly. And if someone hasn't come for a while, you make a point of going to see them."

[HV 2]

However, the above statement also demonstrated another facet, that this health visitor would visit at home if the client had not attended the clinic. The health visitor might interpret this as a danger sign, that the client may be having problems, and therefore might benefit from a visit.

This can be interpreted as authoritarian, the health visitor "checking up" on the mother, by those who do not appreciate the service.

"If it was left to me, I wouldnae go down every week or every fortnight, I mean I just go because I didnae want them coming to my door asking me why I've not been down, so I just make the effort to go, plus I like to know what weight he is and make sure everything's fine, but, em, what did they do years ago, do you know what I mean?"

[C 3]

This mother obviously felt coerced into attending the clinic, and did not feel she could be honest with her health visitor about her unwillingness. She was "going through the motions" to demonstrate to an outside, presumably powerful, authority her fitness as a mother.

Another mother, who did appreciate clinics, also felt a compulsion to attend, so much so that she felt obliged to explain her non-attendance:

"I know it sounds silly, but I just like to let her know I'm going away, because I wanted to let her know I won't be at the clinic, so that she knows I'm not just not bothering, or not interested, or not well"

[C 4]

The clients, in regard to such areas as how often they saw the health visitor or whether at home or clinic, seemed puzzled at the thought of discussing this openly with the health visitor. The mother in the above quotation [C 4] obviously felt an obligation in regard to attending clinic. The impression is that she is conforming to her own and health visitor's expectations, and fulfilling her side of an [apparently] unspoken bargain.

The quotation from this client's health visitor, HV 2, on the previous page, shows the other side of the coin, where the health visitor expects mothers to follow the hidden agenda and reduce overly frequent attendance at the clinic, when the health visitor no longer regards it as necessary. In comparison with the previous data, the following section uses examples from both the past and present. Clients and health visitors were asked about home visits, and when they felt they were a success or failure. To define this concept, the respondents used concrete examples, usually the recorded visit.

5.4. HOME VISITS - SUCCESS OR FAILURE

In defining success Rappaport [1984] has pointed out that it cannot be defined in a single way. It needs to be defined by the people concerned. A client's view of a successful visit may be radically different from the health visitor's. Both were asked in the interviews whether they felt the visit had been a success, and how they judged a visit successful.

The clients judged a visit a success when they had had an opportunity to discuss all they had wanted to, or had learned something.

"Because we talked about the things I wanted to talk about, put my mind at rest."

[C 4]

Unsuccessful visits were where the client had not talked about the areas she wished to, or where she felt the question had not been adequately answered.

" I need somebody to approach me, rather than me ask them to come down and talk to me because I've got worries, I'd rather they sort of come down and talk to me anyway, without having to ask, that's all. When Alice visits, she does visit, she doesn't come into you and say hallo, cheerio, and out the door, she makes you feel as if she's there and she's there for you to talk to your heart's content sort of thing. She doesn't overstay her welcome but she doesn't understay her welcome, she seems to know just the right time to leave the house."

[C 9]

The health visitors judged success or failure in terms of client response, emphasising openness and freedom to talk, and also in terms of demonstrating professional competence, for example in carrying out her aims.

"I hope it was a successful visit in that the information that was given and exchanged was useful."

[HV 2]

"I think feedback, rapport, a lot of it is how they use you as well. I think my main criteria is, if I think I've done well with somebody is, if they find me approachable. If they find me approachable, and I know that they will just come and ask me something whatever or ring me, or leave a message for me, then I think I've made some headway, because at least then they think, oh I'll ask Alice, or I'll ask her to call, then at least they must think of you as a useful source of something, whether information, guidance, whatever they interpret, but they must find it of use, find it acceptable."
[HV 3]

The health visitors therefore judged visits by positive cues from the clients, such as the client being pleased the health visitor had come, and wanting to arrange another visit. Willingness to follow advice or appreciation of information, were also positive signs. An example of a successful visit was given by HV 14, as the recorded visit to C 41, where the client had opened up for the first time, and discussed herself, and not just the baby. It was successful because it was seen as a turning point in their relationship.

The common factor in these definitions by the health visitors is the response of their clients. An extreme example of an unsuccessful visit is being refused entry to the house, but this is an extremely rare occurrence. A more frequent incident is the "doorstep visit", where the discussion is held on the doorstep of the house, as the visit is at an inconvenient time or unwelcome. These are obvious extreme cases, but, more usually, the health visitors described unsuccessful visits as ones where the health visitor was not wanted, or felt that her professional advice was not valued. Cues could be verbal or non-verbal:

"Well if they sit sort of very quiet, although they may be very shy and not awfully vocal, but if you can see them sitting strained, and there's not many smiles, and there's not much eye contact, you can tell by the way they're reacting to what you're saying whether they approve or disapprove, whether in fact they feel comfortable with you or whether they feel that you're there as an authoritarian to check on them."
[HV 1]

The health visitor could feel that the client does not care for the advice or the person giving it. Two health visitors volunteered that they would feel the visit was a failure if the client preferred the advice of the doctor or their family. Another health visitor felt that it was failure if the client did not take responsibility for her own health. These two contrasting viewpoints, with only the latter allowing the client autonomy, have a common theme in the client's view of the health visitor's worth.

The health visitors' feeling of insecurity or inadequacy could be caused therefore, not just by negative feedback, but by very little feedback, as the professionals judge their own performance by the clients' reaction.

Another aspect of failure could arise due to an inadequate performance by the professional, either by commission or omission. One visit described by a health visitor as a failure was due to awareness that she was failing this family by not allowing sufficient time or space to express their feelings. If success was allowing the client freedom to talk, its converse was not encouraging it, and in this instance the health visitor was aware of not picking up on the cues that were offered.

An unsuccessful visit from the health visitors' viewpoint was therefore due to feelings of professional inadequacy, or more commonly, due to negative client response.

The influence of other people in the visits could contribute to both the success and failure of visits. Strangely enough, the baby was reported by no-one as contributing to the success of visits, but occasionally contributing to a swifter conclusion than desired. Normally on a home visit, the health visitor and client form a dyad, or a tryad to include the baby, but of course others also present could include

the client's partner, family, friends, pets, &etc. The presence of other contributors was sometimes reported as welcome by both participants, but also could be detrimental to the interaction. Where the presence of others was welcomed, it was in the context of joining in the subject under discussion as a partnership. One client was pleased her friend was there to remind her about a past incident in connection with the baby, and a health visitor welcomed the presence of the baby's father to discuss worries about immunisation. Other participants were reported as hindering the interaction when they interfered with the participants' aims for the visit. One mother preferred to see her health visitor at the clinic because of the lack of privacy at home due to her extended family. HV13 described her frustration in attempting to build up a relationship with a young client when the client's mother was always present, and who wanted to discuss problems with another relative. HV14 described her dread of visiting a certain family where she always had an attentive and critical audience of never less than four adults.

The informal nature of the home visit is demonstrated in that neither the mother or health visitor treated it as a formal interview, where outsiders could be made unwelcome. Health visitors more than clients reported discomfort at other participants in the interaction, and their presence is one example of the greater power of the client in the home situation as opposed to attendance at the clinic, where, being the health visitor's home ground, she would have more control over the environment.

The health visitors had a variety of strategies to cope with visits that were difficult or uncomfortable. Some volunteered that they offered the minimum service, and left it to the client to set the pace. Others tried varying the approach.

"I find it very difficult sometimes when I get nothing back, when you get nil response. It's terribly difficult to make yourself go back in, when you're getting nothing back,

but I think I've learned rather than taking face value, if I persist, being around, offering and being a credible source of information, in a situation like that I tend to let them know what my role is, why I'm there, and they can approach me at any time, this is what I'm here for. I probably tend to lay down my job description, if you like, a lot more precisely than I would for somebody else. I've never had the door slammed in my face yet!"

[HV 3]

Varying the approach might include trying to establish credibility by, for example, carrying out specific tasks such as a developmental check, and thus demonstrating her skills in a concrete form. The technique of "scouting round the edges" implied using exaggerated caution. "Ingratiation" was used by another health visitor, expressing gratitude when a client attended the clinic, offering repeated appointments, or providing extra services, such as a taxi service.

None suggested confrontation as a strategy, perhaps because of the importance, as mentioned by three of the health visitors, of maintaining their contact, no matter how minimal, in order to gain access to the child.

An initial guarded response could improve into a better relationship using these techniques, but the health visitors felt that visits to some clients were never going to improve past satisfactory.

These examples have described the extremes of the spectrum of success or failure, to aid definition. Partially successful visits, or disasters narrowly averted, are of course possible, and must have occurred in the course of the relationship, and the numbers of home visits involved, but both participants have repair mechanisms to avoid or retrieve difficult situations, and these are described in Chapter 8.

5.5 SUMMARY

The results from this chapter demonstrate the popularity of the health visiting service, and in particular the preference of home visits in comparison with clinic attendance. Clients prefer arranged visits, and more frequent visits soon after discharge from hospital. Clients judged a visit a success when they had the opportunity to discuss all they had wanted. Health visitors made their judgements on the basis of client response, and in terms of demonstrating professional competence. The home setting gives more power to the client, allowing her to relax and discuss worries. The health visitors recognise this greater sharing of power in home visits, by acknowledging that this is the client's own territory, and welcomed the change from clinic contacts.

In many of the areas discussed in this chapter, there was uncertainty expressed by both mothers and health visitors. Four health visitors expressed regret that due to the confidentiality of the research, they could not be given more information on how exactly their service was perceived by their clients. Some of the uncertainty attached to these unspoken rules might be mitigated by the use of a health visitor / client contract, to verbalise the service offered by the health visitor and overtly come to a joint decision about such fairly basic aspects as the frequency and type of service offered. This suggestion is discussed in greater detail in Chapter 9.

Another point arising from the health visitors' uncertainty about acceptability is the need for greater support for novice practitioners, so that dilemmas and difficulties of practice can be discussed honestly and openly with peers. Group support may be of equal value to experienced health visitors who, while sharing insights, can have their expertise as advanced practitioners acknowledged, and receive in return renewed energy and enthusiasm, possibly preventing the onset of

"burn-out", an accusation levelled at many professionals who have practised in the same role for many years.

The next chapter discusses one aspect of the health visitor's role that provides examples of possible conflict or disagreement of perception: the area of advice and advice-giving.

CHAPTER 6

ADVICE AND ADVICE-GIVING

6.1 INTRODUCTION

This chapter discusses the role of health visitor in advice and advice-giving, as demonstrated by the data from the study. The interviews with the participants provided specific examples of contrasting views about health teaching during the visits, by the respondents' answers to the questions, "Did the client learn anything new during the visit?", and "What have been the client's main concerns?" [6.2]. Perspectives on advice-giving are explored from the point of view of the clients [6.3], and the health visitors [6.4]. Advice-giving in practice, and in particular some of the strategies used, are described [6.5].

First, in this introductory section, these findings are set into the perspective of the professional literature. "An Investigation into the Principles of Health Visiting" [C.E.T.H.V. 1977:9] listed the principles upon which health visiting is based. These are: " 1. The search for health needs.

2. The stimulation of awareness of health needs.

3. The influence on policies affecting health.

4. The facilitation of health-enhancing activities."

All are based on the belief in the value of health, and all demonstrate an awareness of the health visitor's role as a health educator, promoting health and preventing ill-health. These principles have been re-examined and still found to be valid for health visiting practice today [Twinn & Cowley 1992, H.V.A. 1992], and identified in practice [Chalmers 1993].

The Court [D.H.S.S. 1976], Black [D.H.S.S. 1980a], and Short [D.H.S.S. 1980b] Reports have all highlighted the potential value of health education in the community. The community nurse's role, in particular, has been emphasised by "Neighbourhood Nursing" [D.H.S.S. 1986] and, to a lesser extent, "Promoting Better Health" [D.H.S.S. 1987]. Fatchett [1990] argues this latter document, by giving the key role in health promotion to family doctors instead of health visitors, threatens the role of health visitors, and suggests they should strengthen it by examination of the content of their work.

Acknowledging the importance of this aspect of the health visitor's role, this chapter describes the area of advice and advice-giving, as discussed by those proffering the advice and its recipients, and advice-giving in practice, as demonstrated by the content of the home visits.

The general title of "advice-giving" encompasses areas such as information-giving and health education. These terms are not synonymous, but were often used as such by the participants, and discussion of one led into discussion of others, so this general title has been chosen to include all these wider aspects. This description also acknowledges the power differential between health visitor and client, in that it is the professional who offers advice, rather than vice versa, and so starts from a more powerful position.

In the literature review in Chapter 2, [section 2.3], the concepts that emerged were level of recall, satisfaction with the advice, compliance, and participation.

In this study, it was hoped that recall would not be a major problem, as the questions asked were not about specific statements, but general areas. Although it had been shown that even a short time after an interview, instructions could be forgotten [Ley et al. 1973], recall of the home visit did not appear to be difficult. The questionnaire was completed immediately following the visit, and the interview held the following day.

Compliance also was not a specific issue, but the client was asked to state whether she intended to use the advice, and whether past advice had been useful. Satisfaction with the advice was, however, an important point, as it seemed to be inextricably intertwined with the client's satisfaction with the service in general, and the health visitor in particular. Level of participation in the visits, as described in Chapter 4 [section 4.6.2], has been demonstrated to show great contrasts, but this factor appears to have far less implications than the area of satisfaction.

6.2 CONGRUENCE OF VIEWS

Two areas in the interview schedule elicited responses about advice and advice-giving. The first question was whether the client had learnt anything new about her own or her baby's health. The associated probes were if the client had been given any advice, and whether she would use the advice. The second area was what the client's main concerns had been in the previous month, either with herself or the baby, and if the health visitor had been any help.

6.2.1 Learned anything new?

The clients were asked, "Did you learn anything new from the health visitor yesterday about your own or your baby's health?" The health visitors were asked, "Do you think the client learned anything new about her own or her baby's health?

Table 16 summarises the replies, for the 15 linked pairs:

Table 16: Anything new learned by client

	HEALTH VISITOR		CLIENT
HV1	weaning, nutrition	C1	weaning, immunisation
HV2	weaning, immunisation, taking baby swimming	C5	weaning, immunisation
HV3	giving mother support and confidence	C9	myself
HV4	weaning	C12	weaning
HV5	baby's diet and development	C14	feeding
HV6	weaning, sugar intake	C18	weaning, teething
HV7	breast feeding, use of cup	C19	off breast onto solids, teething, baby's bowel motions
HV8	don't know	C23	feeding, immunisation, sleeping
HV9	client's confidence, immunisation	C27	immunisation
HV10	cot death	C30	immunisation, baby walker
HV11	immunisation, juice	C31	feeding, teething
HV12	baby's constipation, fennel drink	C36	baby's wind, fennel drink
HV13	development, diet, teeth, safety	C39	my hay fever, baby's sunburn
HV14	home safety, development	C41	calpol after immunisation
HV15	baby's sleep	C43	baby's diet

Table 16 thus demonstrates a fair degree of congruence about advice given on the visit. Nine of the 15 pairs listed a common item [on the visits paid by health visitors 1 - 7, 9, and 12].

All of the 45 clients were asked if they had learned anything new on the visit. Only if the answer was negative was the associated probe used about any advice given on the visit. The answers were as depicted in Figure 12, in that 32 clients had learned something new. Of the remaining clients who answered that question in the negative, only one could not think of any advice given in the visit. Thus only one client could not recall any advice or did not learn anything new. Of the 44 who had learnt something, all said they would use the advice, which, if their stated intention is translated into practice, says something very positive about the appropriateness of the information, and the value of the home visits.

All the health visitors thought the clients would use the advice. When considering the role of the health visitor, it is interesting to note that only two of the clients mentioned items specifically relating to themselves, as opposed to their babies, and in the above table only two health visitors [HV 3 and HV 9] listed items about the client, and both were in connection with her role as mother. The most common topics mentioned were feeding, which was listed by 25 clients, and immunisation, listed by 12 clients.

Has the Client Learned Anything New?

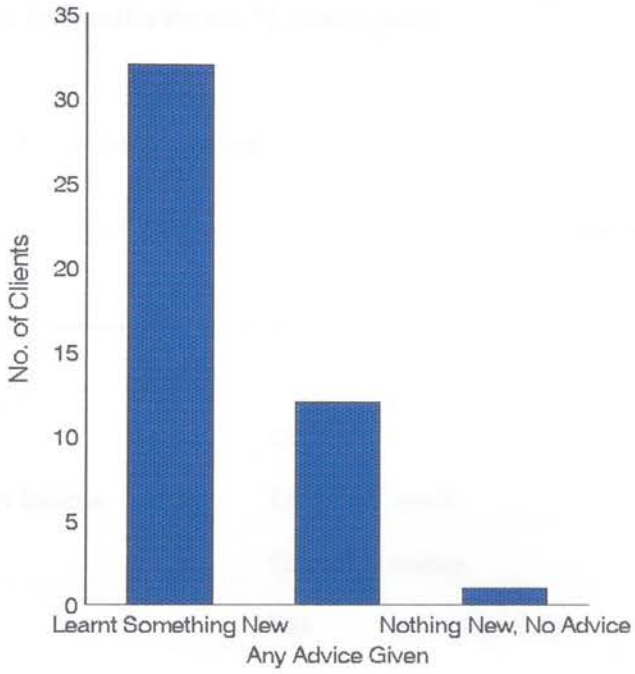

Fig. 12

Has the Health Visitor Helped ?

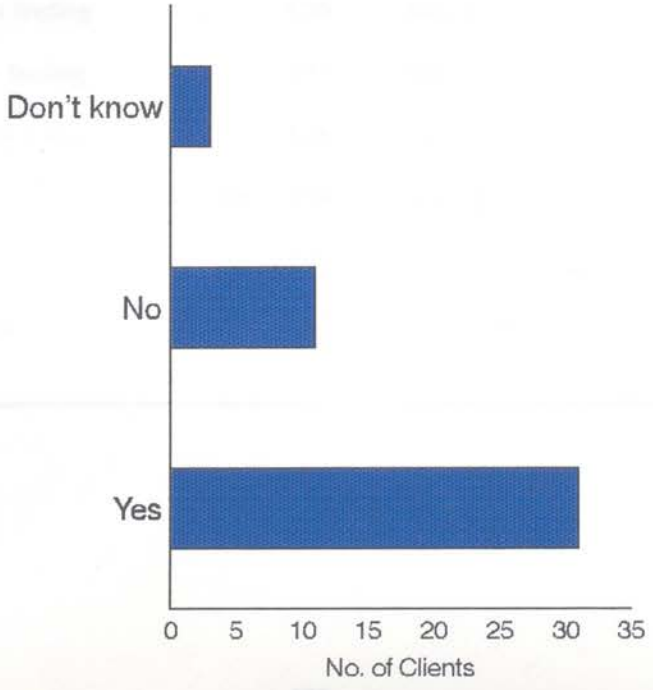

Fig. 13

6.2.2 Clients' main concerns

The clients were asked, "In the last month, what have your main concerns been with yourself or your baby?" The health visitor were asked, "In the last month, what do you think the client's main concerns have been with herself or the baby?" Table 17 summarises the results for the 15 linked pairs.

Table 17 : The client's main concerns

	HEALTH VISITOR		CLIENT
HV1	none	C1	sleep
HV2	feeding	C5	my health, baby's weight
HV3	mother's feelings	C9	myself
HV4	feeding	C12	feeding
HV5	none	C14	not enough sleep
HV6	feeding	C18	bathing baby
HV7	mother returning to work	C19	baby and asthma
HV8	baby's diet	C23	feeding
HV9	handling the baby	C27	baby's health
HV10	baby's feeding	C30	baby's feeding
HV11	breast feeding	C31	baby's nappy rash, feeding
HV12	moving house	C36	baby's health
HV13	breast feeding, client's health	C39	nothing
HV14	baby's weight	C41	feeding
HV15	housing	C43	baby's diet

In Table 17, five of the above pairs had common items [visits 3, 4, 8, 10, and 11.] Concerning topics, the health visitors listed personal concerns of the mother 6 times [out of a possible 15], and 6 of the 45 clients mentioned personal items. The most common topics listed by the 45 clients were feeding [19 mentions] and their baby's health [10 mentions]. Following the question about what their main concerns had been in the previous month, the 45 clients were asked if the health visitor had helped them. The responses were as described in Figure 13. Two-thirds of the clients [31] felt that the health visitor had helped.

6.2.3. Topics Discussed

As demonstrated in both tables 16 and 17, topics frequently mentioned included feeding [breast, bottle, and introduction of solid food], immunisation, minor ailments, sleeping, safety, and personal concerns of the mother. The frequency of these topics might be expected, given the relatively small age range of the sample of babies, and the shared anxieties of first-time mothers. However, in general the clients placed more emphasis on problems of child-rearing than did the health visitors, who mentioned more personal concerns of the mothers.

To repeat the view of Tones [1979:256], "Where health education has been successful,....it has been due to the selection of appropriate methods and relevant resources, including people. The right people use the right techniques in the right place at the right time." The previous chapter demonstrated that a successful home visit paid by a health visitor to a primiparous mother can consist of the right people, in the right place, at the right time. What are the right techniques?

6.3 CLIENTS' PERSPECTIVE

When asked about the health visitor's visit, clients frequently defined the visit successful or useful because of the advice or information given.

This section discusses how the clients described the way the health visitors gave advice, and what evoked a positive or negative response.

6.3.1 Positive Response

A positive response can be elicited because of what is said or how it's said.

"She doesn't just say, you've got to do this or got to do that, you know she'll sort of say maybe something like, well maybe if you would try, you know, you don't feel you're being forced in to it. Her advice is good and I mean as I say if I want it I just ask for it and she gives it, which I think is quite good, instead of her coming along and sort of saying you're not doing this right or you're not doing that right, you know, do this or do that."

[C 5]

The majority of clients responded to being given the information, and having the freedom to make their own choice. It was a minority, usually the younger or less confident mothers, who wanted more definite guidance, to be told "the right thing to do". It was this latter group who also did not want to ask questions at first:

I used to feel dead stupid, I didnae want to ask that, they'll think she's no' a good mother, but as times went on I feel that I can talk about anything."

[C 19]

Some more confident mothers could not remember receiving any advice:

"I don't wait to be given advice, I ask questions, so everything I've been told about I've actually asked for advice on, I don't think I've actually been given advice without asking."

[C 8]

With this range of opinion as demonstrated by these three mothers, it is obvious that there was no one right way that clients wished to be offered advice.

The spectrum perhaps could be described from left to right, as requiring no advice [e.g. C 8], wanting a range of options to choose from [e.g. C 5], and, to the right of the scale, wanting to be told what to do [e.g. C 19]. However, the greatest density of mothers were in the centre of the scale, wanting the information and the independence to choose from a range of suggestions, and for their decision to be accepted.

A positive response was more likely where the client and health visitor had a good relationship, where the client had trust in the advice. Mason [1988] pointed out that the manner of the caregiver was sometimes thought to equate with the advice given, so that a health worker with good social skills was thought to give "good advice", and mothers were less likely to listen to advice at all if it was given in an unacceptable way. In this research, "trust" in the advice was mentioned. This could have been created because previous advice had proved effective, or the health visitor had shown a positive interest by following up a client's query, or, more generally, because the client trusted someone who appeared to have a lot of experience dealing with children. The advice may not necessarily be used, but the client might appreciate that it was there if needed. Some mothers were pleased to receive information in advance of when it was needed [e.g. about home safety], while another said she would prefer to wait until it happens,

"Rather than being thrown a lot of things that you can't remember"

[C 26].

Advice could be welcome because it was what the client wanted to hear. The clients narrated instances when they did not want new advice or information, but simply :

"A sounding board, and a bit of reassurance, someone to say when you come to a decision, that's all right"

[C 16].

The advice also has to be couched in acceptable language. One 21-year old mother found her health visitor very approachable:

"She's aye very friendly, she'll come in and she doesn't sort of talk to you above, she's down at your level, she'll chat away to you. Like some people are maybe, think themselves better than you, but she doesn't, she really listens to you, and what you say."

[C 42]

Clients also like the personal touch, avoiding a formal approach:

" She relates it to herself and her own personal life as well, which she doesn't have to do, but she does, so you don't sort of feel alone when she explains about things that have happened with her, somebody that she might know, she never mentions any names, but she meets a lot of women and learns a lot by listening to them. Her advice is good.
I wouldn't say that I would always act on it, you couldn't act on everybody's advice, but it probably would help me, then again as she says, it's advice only, and it's up to you whether you take it, so it's fair enough. She does explain to you that it's just advice, and certain people have worked it out this way, and certain people another way, I'll just tell you how it might help if you do this, if you do that."

[C 9]

The personal information was also appreciated because it had been shown to be effective, "it's not just from books". Books appeared to be unsatisfactory, because of contradictory information, and the necessary generalisation. The desired advice had to be tailored to the individual. One articulate mother wanted a health visitor that was

"going to take the mother's point of view rather than the book's point of view"

[C 26].

Another mother did, however, express a desire for a leaflet to run through things to do for a crying baby, so that she could use it as a checklist for reference.

The clients knew what they liked, but were not always aware how the final result was achieved.

"Well Isabel doesnae really give you advice, if you've got any problems you just ask her and she tells you, ken what I mean? You could say that was advice, but she doesnae say right you dae this and you dae that....You can ask her what she says, and you can say I'll try it, but she says if you don't really agree with it, don't do it."

[C 44]

Another client of the same health visitor had a great deal of insight into how this health visitor achieved acceptable advice:

"Let me think how she does it, I think she'll ask questions. By doing that you see, she gets you to give you the answers then she'll just confirm them."

[C 45]

The common factor in achieving a positive response appears to be offering the client a choice.

6.3.2 Negative Response

Overwhelmingly, clients do not want to be told what to do. In agreement with the findings of Orr [1980], and McIntosh [1986], a dictatorial or authoritarian approach was found to be counterproductive, and the immediate cause of the few negative comments about health visitors in the study. It was not the personal experience of the participants, but had entered the folklore about "nosy" and "bossy" health visitors. The clients described stories of friends who had poor relationships with their health visitors because of adverse criticism or unwanted advice, and where the health visitor was now unwelcome.

On the other hand, one client found her health visitor too non-judgemental:

"Sometimes you feel as though you're talking to a wall. No, that's not fair, but sometimes there's an awful lot of listening, and sometimes you feel as though you're not necessarily getting a response, but then again, that I think is an awful lot of Sally judging what response you require, so perhaps that's what it is, because sometimes you feel as though you're jabbering like a budgie."

[C 16]

One client traced her distrust of her health visitor's advice back to a specific instance, where she thought the advice she had been given was not only the wrong advice, but positively harmful to her baby. Another client was dissatisfied simply because the advice she had been given was not the advice she wanted to hear. She had wanted to be told to take the baby to the doctor, and instead had been offered a range of other options, leaving her thinking,

"Why did I bother saying anything"

[C 26].

Another mother expressed her disgust, acknowledging that she had never been given bad advice or no response, but the health visitor had agreed completely with what the mother thought, and not provided

"The miracle that would stop this crying baby"

[C 16].

An interesting comparison of these responses is when the health visitor disagrees with the actions or intentions of the client, and offers criticism, or the client disagrees with the advice given by the health visitor.

Clients were more willing to accept criticism, once they had formed a good relationship with their health visitor:

"Dictated? I would just have told them to get out. I would. He is my baby, and I dae know what he is like, and I've got used to his ways and wanting pampered and lifted and cuddles and smiled at and grinned at, and if anybody came in now and started saying, "you do this" I would just tell them to leave, whereas when the health visitor comes in she sort of knows what she's doing, and she's able to tell you in the nicest way, and if you are doing anything wrong, they'll tell you."

[C 12]

The same client continued:

"Well, I would listen, because they've been so nice all the way through, and as I say, they've always put things over in a nice way, advised you, they've no' dictated, whereas now I feel if they said, "right, you're doing that wrong" I would listen".

The clients could accept criticism if couched in an acceptable manner, with adequate explanation, at an appropriate time and place.

If the client disagrees with advice, she has a variety of options. The first, and perhaps the hardest for some, is to say so to her health visitor. The majority of the women thought this was what they would do, or had done on a previous occasion. Others thought they would just do what they wanted without reference to the health visitor, and keep quiet about it. The third option is to try the advice, but this choice was selected by very few of the women, although more said that they would have taken this option in the early days home from hospital, before they had gained in confidence.

The client could like the health visitor, but still disagree with the advice, in which case the client would provide excuses for the health visitor, saying for example she did not know the whole history of the incident, or perhaps the advice would have suited other babies, but not hers. If, however, they had a cool relationship, the client placed less importance on the advice, and was less willing to accept it, and was more unlikely to open up and ask questions.

The same dilemma arose when the women were given conflicting advice. The women had received conflicting advice from different midwives, family, friends, books, doctors, and health visitors:

"I think you get advice from all sorts, and you just sort of collect it all together and decide yourself what you're going to do, because if you listen to everybody you get all confused. The midwife tells you one thing, and the health visitor tells you another, and your mum saying one thing, and you're there in the middle. I just listen to everyone and make up your own mind."

[C 5]

This measured response from a 17-year old contrasts with the anger expressed by an older mother:

"There seems to be an awful lot of conflicting advice, even in those books that you get in the clinic, one seems to contradict the other. I just gave him the books to play with! I just kept listening to other folk, then I thought, to hell with the whole bloody lot of youse! I just take a wee bit from everybody and see if I can arrange it to suit myself."

[C 20]

The above response from a 32-year old mother demonstrates what appears to be the usual reaction to conflicting advice, frustration followed by a decision to follow an individual path. This way of resolving the dilemma was mentioned by several women, but a minority who looked for more guidance, consulted either the health visitor, or a member of their family, like their mother or sister.

6.4. HEALTH VISITORS' PERSPECTIVE

The health visitors, when asked to define how they would like their clients to see their role, often used the acceptability of their advice as a criterion. It was also used as a determinant of the success or failure of a visit.

The health visitors were acutely aware of the complexity of advice-giving, and that their clients were not, despite the similarity of the topics described earlier in this chapter, a homogeneous group with similar needs. The clients may have had a shared interest in topics such as feeding and immunisation, but they had different needs in discussing these topics:

" I don't see that you can have a set approach - it's impossible. I like seeing what they are wanting from you. That's why I think health visiting is so difficult, because so many people want so many things from you, not just someone wanting advice from you, some are not, someone wanting guidance, some are just wanting a listening ear, some are wanting a friend."

[HV 3]

Health visitors therefore said that they did vary their approach, sometimes offering only a listening ear. Several expressed awareness that some clients do not want or need advice.

The health visitors reported a variety of techniques they used in offering advice. The first was information-giving, leaving it to the client to agree or disagree. A health visitor might bring up a topic, and judge its acceptability by the client's response, so the subject was not continued unless the client continued the conversation with questions. A range of suggested alternative solutions could be offered, so the client could choose her own method of solving the problem.

Repetition was used to emphasise a suggested course of action. Acceptability was judged by the clients' response.

6.4.1. Positive Response

The health visitors judged acceptability of their advice by the clients' previous response, and the present response, in terms of verbal and non-verbal behaviour.

The clients' previous response was a good indicator to the health visitors. If the health visitor had established credibility, by providing useful advice in the past, she felt that the present advice would be considered. For example, the client may have returned to the health visitor, and reported success or failure with a suggested course of action, and be requesting further possibilities to try.

The health visitor determined acceptability by words, or by actions, such as compliance with previous advice.

A positive verbal response could be a client expressing interest, asking questions, repeating the advice, or asking for the information to be written down. A verbal assenting response was not assumed automatically to be a positive sign, but was combined with the health visitor's knowledge of the client, previous experience with regard to advice, and non-verbal response.

Effective communication is interactive. As many students of communication have commented [McCron & Budd 1979, Heath 1986], face-to-face communication allows participants to use comments, gestures, and facial expressions to express understanding or meaning. Although the evidence from the visits is verbal behaviour alone, the health visitors were able to describe some of the cues they follow when they know they are "getting the message across" or "getting nowhere."

"I think body image certainly, I mean you can tell by looking at somebody's face whether it's sinking in or not, or you can see by the look on the face if they've started to switch off, then you know this is not what they're wanting. I think just general body stance, and the replies they're giving you, if they're giving positive vibes back, yes this is what I want to hear, whereas the sinking back in the chair and sort of shaking the head or looking blank or they're starting to get that closed look on their face, you'll know this is not working, and then you say, well how do you feel about that, is this not what you would like"

[HV 3]

To summarise, positive cues include eye contact, smiling, and nodding. Negative cues include a glazed or bored expression and avoidance of eye contact. Health visitors generally felt that they had no problem judging the acceptability of their advice:

"I think just her reaction to me, just her voice, the way she responds to you and what she says in reply to what I say. Maybe she tries to draw you away onto something else. They're very skilled the clients, I think, even though they've not got any training!"

[HV 6]

6.4.2. Negative Response

Kelly and May [1982] have examined the literature whereby patients have been labelled "good" or "bad", and pointed out that patients are not passive recipients of nursing labels, but as parties to the interaction retain the power to influence, shape, and ultimately to reject nurses' attempts to impose their definition on the situation. However, the issue may be one of control, of power and authority. Heyman and Shaw [1984] report that nurses in their research described poor nurse-patient relationships in terms of non-compliance. Nurses describe most positively those patients who present no problems of disruption or legitimation. In this research, the setting is in the client's home, and the health visitor has a vested interest in maintaining a long term relationship. How then does the health visitor react to a challenge to her professional knowledge and authority?

If a client was unwilling to accept advice, the health visitors had two stated reactions. The first and most usual was, to acknowledge client autonomy, and accept that the health visitor was not omnipotent.

"You've just got to accept, people are not always going to do what you advise, it's their right, it's their baby"

[HV 1]

The phrase, "it's your baby", was repeated several times by different clients and health visitors, acknowledging that the client was the expert on her own child. This attitude also fits in with self-perception theory [Bem 1972, Collins and Hoyt 1972], that the greater the perceived choice, the greater the sense of personal responsibility. Cowley [1991a], too, described a category of "not imposing", when the health visitors recognised the rights of clients, accepted signals that they did not wish to receive the service, and by this acceptance achieved consonance with their clients.

The second reaction to a client's unwillingness to accept advice, was that they had failed in their professional task as purveyors of a health education message, and so not taking their advice was a sign of failure of their relationship:

"A client who doesn't act on information that she receives, you construe that as, well that person doesn't look to you as...the person that she would go to, so that might be a sign that you're not getting on."

[HV 5]

Therefore, alongside these expressions about the client's ability to choose, was the dichotomy involved in this role of being a professional and also a friend. The health visitor may well see no need to offer advice, but only after she had assessed the situation and detected no risk to the child. To take the topic of immunisation as an example, health visitors have some interest in maintaining their immunisation uptake rates. This is a measure that is of interest to their employers, the Health Boards, and, since the introduction of general practitioner contracts, of financial interest to their medical colleagues in the primary health care team. On this subject, the health visitors were unanimous, that this was the clients' choice, the health visitor was there as an information-giver only, and the ultimate decision belonged with the parent. However, they would go to some lengths to provide more information, repeated appointments, and several home visits, in order to discuss worries or encourage uptake. It would not be surprising if the health visitor experienced a dilemma between the individual and public health interest. [The dilemma between professional and friend will be discussed in the next chapter on the subject of child abuse.]

In her study of behaviour in baby clinics, Warner [1983] noted that clients were given every opportunity to comply with the health visitor before the health visitor would risk action which would be interpreted as criticism. In none of the interviews did the health visitors overtly criticise the clients for failure to respond to

advice. They described other strategies to cope with an apparent failure. First, they could drop the subject completely, perhaps returning to it at a more suitable time, or when the client gave positive feedback that she was ready to discuss the topic. The health visitor might also challenge her own methods, discussing problems of communication with colleagues in order to identify a more acceptable strategy.

In general, the health visitors stated they would prefer clients to say they were not taking their advice, as they valued an open relationship, in preference to forced compliance or covert non-compliance. Their stated reaction would be acceptance of the client's right to choose.

6.5 ADVICE-GIVING IN PRACTICE

In an extensive study of 1,470 tape recorded G.P. consultations, Tuckett et al. [1985: 205] found that the "doctors did little to encourage patients to present their views, quite often actively inhibited them from doing so or evaded what patients did say, very rarely explored what a patient was understanding of what they said, and did not usually tailor advice and instructions to known details of the patient's life."

Availability of time may be an important factor in carrying out health promotion. A survey of community nurses' views in one region [Littlewood & Parker 1992] revealed that the vast majority of health visitors and district nurses felt that they had insufficient time to carry out health promotion.

The tapes of the 45 visits demonstrate that these home visits were ideal fields for eliciting the clients' views and for tailoring instructions to suit individuals. Strategies of advice-giving are identified.

6.5.1 Acceptability

In the study by Warner [1983], only once were health visitors observed to proceed to give advice before obtaining vocal acknowledgement from the mother that she wished to discuss the subject. The tapes from these 45 visits could not provide the same comprehensive information, but perhaps a clue about the acceptability of the information may be found in the interview data about anything new learnt during the visit, where all 44 clients who had been given advice about the new topic, reported their intention to use that advice.

From the visit data, acceptability of advice was judged by positive verbal responses, such as vocal expressions of agreement or interrogation, requests for further elucidation, or repeating the health visitor's advice.

6.5.2 Strategies of Advice-Giving

Having established acceptability, there were a number of ways the health visitor could proceed. In a situation where the client introduced the topic, the scenario was one where the health visitor listened to the problem, occasionally prompting with questions, to establish the problem before offering advice and/or sympathy. In this way, the health visitor also identified what the mother was already doing or what solutions had already been tried to remedy the situation. The health visitor could then make suggestions, "have you tried..." or "how do you feel about..". Using this method, the health visitor could also establish the extent of the client's knowledge or awareness before proceeding to offer more information, and avoid a possible conflict by advising a strategy already found to be useless or disliked by the mother.

The data from this study supports the findings of Warner [1983], in contract to those of Kendall [1991]. Kendall's conversational analysis of home visit interaction revealed a low level of client participation, and concluded that even solicited advice was not participative since the clients' current beliefs, knowledge and experience were not solicited. However, Warner [1983] had found that the health visitors used interactional techniques to arrive at mutually achieved goals. Techniques described included offering the mother objective evidence, diminishing the mother's responsibility for an observed problem, and building on the mother's existing knowledge and practice.

Continuing the theme of acceptability, the health visitors used a number of verbal devices to cloak advice in a less dogmatic style. For example, they used a number of tentative words, such as "maybe", "might", or "perhaps", to avoid didacticism. Giving advice in the form of a question, such as "Have you thought about.." or "Have you tried..", elicits the mother's feelings, so that the client can safely respond to the advice, or refuse it.

An even more tentative approach might be giving advice in question form and preceding it with a negative, for example, "I don't know if you've ever thought about...". Sefi [1985] described two styles of advice giving, one authoritative, which was used by the health visitors in her study, and the other affiliative, more supportive and suggestive. This latter style was the one identified in this study.

Another form of distancing the health visitor and client from the advice, and a possible confrontation, is the "other people" ploy. Thus a health visitor could suggest, " other mothers have found.." or "some people are surprised when..". The health visitors interviewed by Chalmers [1993] identified a similar process, that of

"using illustrations from other client situations", as a way of opening up needs or problems which they had identified or suspected were present in clients. The clients in this study could use the same technique in making a roundabout enquiry.

Giving a client the choice could entail a preamble before offering advice. For example, when discussing diet, one health visitor [HV 6] made her views known but avoided the trap of authoritarianism by a less threatening introduction:

"My feeling is, you can do whatever you want, but my feeling is, if you get her used to a sweet taste, she is not going to take the vegetables..."

[V 18]

The same health visitor continued later:

"If you do it then that's up to you, we can't say - well we can say something"
[client laughs]
"We would say something, but we wouldn't be able to stop you or anything. We have to work within guidelines."

[V 18]

This health visitor further distanced possibly unwelcome advice, to place the source as an outside authority.

The visit tapes did reveal long passages of information-giving from the health visitor. When the client spoke for long passages it was generally an anecdote to help demonstrate a point.

The health visitors used probes, or reflecting a client's statement, to elicit the client's feelings. It was only occasionally that health visitors proceeded to provide information without determining the extent of the client's knowledge, for example advising vitamin drops without ascertaining the baby was already receiving prescribed vitamins, and on each occasion the client inserted a phrase to demonstrate her competence or prior knowledge.

Another obvious strategy of health teaching is demonstration, and this was used when the health visitor was carrying out a practical procedure, e.g. testing the child for a squint by the use of a torch.

Praise was used as a positive reinforcement, that the client was doing the right thing, and as a reassurance. As already stated, criticism was avoided. However, advice could also be used as an awful warning to the mother, for example when the health visitor related the story of a child falling down the stairs in a baby walker when discussing home safety. Another health visitor assured a mother that she could tell the difference between babies with whom the parents played and talked, and babies who were just placed in their prams, in order to stress the importance of play and stimulation. This latter story also demonstrates the element of judgement, and perhaps possible criticism, involved in assessment.

All these strategies demonstrate the variety of devices used by the health visitors in giving advice.

Advice should also be tailored to individual circumstance. In response to the criticism by Tuckett et al. [1985] about failure of health education in G.P. consultations, a number of situations were identified in this study in which health visitors tailored advice or instructions to individual circumstance.

One situation in which the same health visitor gave differing advice was about starting the baby on cows' milk. The babies were both bottle fed, of the same age, and on one, the client was advised to start cows' milk, while on the visit to client 23:

HV: *"And what kind of milk is he on?*
C: *Cow and Gate Plus*
HV: *Does he take normal milk during the day?*
C: *I've not tried him yet.*
HV: *You just want to keep him on the baby milk?*
C: *Well, he is quite a windy wee soul as well. I thought it might be best.*
HV: *Leave him till the new year."*

[V 23]

The health visitor gave the advice in the form of a question, but followed up the cues from the mother, then reinforced the mother's decision.

Advice about home safety was ideally suited to be tailored to individual circumstance. Local hazards such as a very busy road, or dangerous stairs, triggered off discussion about appropriate measures. When asked about a baby walker, one health visitor was very cautious about recommending one to a mother until she had ascertained how the mother intended to use it. Establishing a client's knowledge was rarely done directly, but rather approached by an open question, or in a casual conversational manner, as in the following extract when the client response is elicited by a pause:

C: *"What I was wondering, can I use baked beans?*
HV: *Yes. The only thing to watch is that some of them have added salt in them, and if they have salt...*
C: *If they have salt, don't use it.*
HV: *Uh-huh. "*

[V 37]

Individual advice is well demonstrated when comparing the health visitors' discussions with the mothers about leaving their babies. One mother about whom the health visitor later reported concerns about bonding, was encouraged to take her baby with her when visiting relatives. The more usual reaction was empathy with the client, and discussion of individual activities for the mother, creches, babysitters, and the notion of personal space.

Many of the health visitors had come prepared to these visits to give out health education material in the form of leaflets. According to the health visitors, this was their regular practice, but it may be that the health visitors made more plans for these three visits than was usual. The leaflets were concerned with areas which involved a lot of information-giving, such as immunisation, introduction of solid food, and fluoride supplements. When asked about any advice they had received, the clients did not specifically mention a leaflet as a source of help, but some later mentioned such literature as useful as an aide-memoire. It was the specificity of the advice to their particular situation that the clients recalled and reported as most satisfactory.

6.6 SUMMARY

To summarise, the clients expressed a need for individual choice in regard to the manner and method of advice-giving, and, on the whole, the health visitors expressed and displayed an awareness of that need.

The four themes that arose from the review of the literature were recall, compliance, participation and satisfaction. In this study, both participants appeared to have no problem in recollection, but it could be argued that the discrepancies in the two tables, where the dyads had made differing replies, could be due to differences in recall. However, a more likely explanation is differences in perception. Concerning compliance, the reported intention of the clients was to use the advice [44 out of 45 clients]. This enthusiasm may have waned in practice, but it at least demonstrates that the clients would consider using the advice. Participation, from the visit data, was variable, with some mothers participating more than others. However, from the interview data, it can be seen that the wishes of the clients in regard to receiving advice showed a wide variation, with some wishing advice on everything while

others wanted only to be given advice on topics about which they had specifically asked.

Satisfaction emerged as a key concept in connection with both recall and compliance. Attitude change theory [Festinger 1957] has long recognised the importance of the personal characteristics of the communicator in promoting behavioural change, in that the credibility of the teacher has an important influence, so satisfaction with the advice given by the health visitors was of great interest. The evidence from this study shows a high level of reported satisfaction, both with the content of advice, and style of advice-giving. The highest level of satisfaction occurred when the advice given was what the client wanted to hear. This supports recent research suggesting health visitors should respond to a mother's concerns, rather than following a medical model of health education [Foster & Mayall 1990, Sherratt et al. 1991]. This has implications for the next chapter, when the nature of the health visitor / client relationship is discussed.

In the introduction to this chapter, the four principles were listed upon which health visiting is based [C.E.T.H.V. 1977:9]. Can these be demonstrated in practice? The **first**, "The search for health needs", could of course be exemplified by the health visitor initiating a home visit, but such a simplistic reply negates some of the complex and varied approaches described in this chapter. The **second**, "The stimulation of awareness of health needs", could be demonstrated by the section on acceptability of advice, and strategies of advice-giving The **third**, "The influence on policies affecting health", was absent from the visits, but a few health visitors mentioned in the later interview activities connected with local policies or community involvement. The **fourth** and last principle, "The facilitation of health-enhancing activities", can perhaps be more easily identified in the longer, more leisurely visits, where the conversations were wide-ranging over topics not

necessarily connected with the baby. It is the second and fourth principles which rely most heavily on client response, and it was this factor which determined for the health visitors the success or failure of their visits, and how they judged the acceptability of their advice.

Therefore, the first, second and fourth principles could be demonstrated in practice in this study. The Health Visitors Association's position statement, "Principles into Practice" [H.V.A. 1992], stresses the primacy of health promotion, and the importance of a proactive service, responsive to the views and perceptions of the clients. These priorities have been demonstrated by the data presented in this chapter.

The next chapter discusses perceptions of the health visitor's role, and the health visitor / client relationship, and explores some of the issues of power and possible conflict raised in this chapter.

CHAPTER 7

THE HEALTH VISITOR'S ROLE, AND HEALTH VISITOR AND CLIENT RELATIONSHIP

7.1 INTRODUCTION

This chapter explores the perceptions of the participants about the health visitor's role [7.2], and the wider aspects of their relationship [7.3]. It concludes with a discussion about power within the relationship [7.4], which is a recurring theme within this work.

Any professional/client relationship can present difficulties and dilemmas where the values and goals are dissimilar, and this is especially so of the health visiting service which is unsolicited, and has to demonstrate its worth to potential clients. Both participants bring to an interaction a set of norms and expectations of themselves and each other. In the literature presented in chapter 2.7, there was evidence of a confusion among the clients about the health visitor's role. That this confusion about the role is not confined to clients is demonstrated by an early article by Jefferys [1965], entitled "The uncertain health visitor", who found that many health visitors in Buckinghamshire felt that their job was not clearly enough defined.

Dingwall [1977a] has described the socialisation process that health visitor students undergo during their training. He describes three alternative approaches offered. The first is likened to a medical approach, which incorporates biological certainty. The second was an "evangelical" approach, which could be compared to the missionary aspect of early health visiting activity, where the health visitor was the purveyor of the only correct version of reality, which she could share with her

clients. The third group were the latitudinarians, who were doubtful of the possibility of such a truth and certainty. With such a variety of contrasting approaches, it is not surprising that newly qualified health visitors may experience a "reality shock" when comparing what is taught on their training course and their experience of the actual work situation. McClymont [1980] found that 76% of recently qualified health visitors changed their perception of their role shortly after beginning practice. Dingwall [1977a] suggested that they were influenced more by the attitudes of health visitors in the field than by the values transmitted in the educational system. Robinson [1982] argues that practising health visitors experience role conflict because of two interdependent factors, which are failure to delineate a clear theoretical orientation, and subsequent conflicting role expectations. One definition of a profession is a clearly defined body of knowledge. Health visiting, however, draws on a variety of medical, nursing and sociological knowledge, and has found it difficult to mark clearly distinctive boundaries. Models of nursing may be inappropriate for health visiting because, as Clark [1985] has pointed out, in contrast to nursing, health visitors focus on families or communities rather than individuals, and on a continuing process rather than a discrete period of illness. Some researchers [Clark 1985, Cowley 1991a and 1991b] have attempted to fill the gap of a lack of theoretical model of health visiting, but they have the disadvantage of appearing to offer very little applicability to practising health visitors. A more realistic alternative is that offered by Mason [1988], who suggested that health visitors should recognise their existing practice model, which incorporates clinical and relationship centred aspects, and use the knowledge gained from differing disciplines constructively in everyday practice. What then, are the expectations of health visitors and clients about the role and relationship?

When health visitors are asked about their goals, they consistently mention the importance of a good relationship [Clark 1985]. The central importance of the relationship was that it enabled things to happen and goals to be achieved which could not be achieved without it. Some of the health visitors studied by Robinson [1987] described the making of a relationship as a primary aim.

The client, too, by emphasising the importance of the personal qualities of the health visitor, is stressing the social aspects of their contact. In the evaluation by Robinson [1982a], "success" for the client is dependant on the establishment of a satisfactory relationship. She identified two approaches, a problem-centred approach, based on a medical model, and a relationship-centred approach, based on the social sciences. Clients in Clark's study [1985] varied in whether they wanted a friendly or professional relationship. The parents' views reported by Pearson [1988] identified a variety of roles: an official judge/assessor, an adviser/information source, a gatekeeper to other resources/services, a pathfinder, facilitator, supporter and friend. In initial contact with the client, the role was one of dealing with problems, in a judging or supporting manner, while at the final interview when the baby was 7-8 month old, the relationship itself was valued. The value placed on the health visitor's involvement appeared to reflect the degree of divergence or otherwise of her views as compared with the parent's. The strength of the relationship was linked to the health visitor matching her approach to the perceived needs of the parent.

In a study of first meetings in a social services context, Tessler [1975] described how clients' satisfaction with the relationship were dependent on a number of variables, such as identification with lifestyle and values, and an informal approach. In a consumer perspective of mental health work, Sheppard [1993] found

that satisfaction was related to the use of interpersonal skills such as those of communication, empathy, listening, openness and genuineness.

Orr [1980] presented the view that the clients valued a warm, friendly relationship as a medium for giving advice. The mothers' accounts of their relationship in the study by McIntosh [1986] suggest strongly that the advice of a health visitor who was regarded as a "friend" was much more likely to be accepted and acted upon than that received from one where the relationship was perceived as more formal. Respondents in the study by Karmali and Madely [1986] were more likely to attend the clinic frequently if they had a good relationship with their own health visitor. The effects of a good relationship are therefore wide-ranging.

The literature is more sparse, however, when one attempts to define a "good" health visitor / client relationship. What does this mean for the participants? This chapter first considers the health visitor's role, and through these perceptions, proceeds to examine the respondents' views of their relationship. The implications of the findings are discussed in terms of power and client autonomy.

7.2 THE ROLE OF THE HEALTH VISITOR

7.2.1 Health Visitors:

When describing their role and how they would like their clients to see their role, the health visitors spoke overwhelmingly in terms of support.

"Well, somebody who's there to advise, somebody you can call upon if you're needing any help and advice."

[HV 1]

They spoke about reassurance, advice, a source of information, and practical help. The practical help could consist of supplying baby clothes or baby milk, or referring on to other agencies, such as housing. This practical help was seen as fulfilling the clients' needs, and thus making the health visitor's role more credible and acceptable. One health visitor specifically mentioned, that with some clients, the practical help was a "trade-off", as though supplying a practical need would encourage a client to fulfil a health visitor's request, such as encouraging a former defaulting client to bring her baby for immunisation.

The health visitors also repeated the views about client autonomy that they had expressed in connection with advice-giving, that it was up to the client to decide what they wanted from the service, and it was the health visitor's role to be approachable and responsive to the client's need.

" I think she finds me now, I hope as a friend as well, but as somebody who comes in that she can confide in, I think I would say that she would see us, as ....maybe a resource type person, someone that if she had a problem she could ask."

[HV 4]

They were aware that an authoritarian style discouraged sharing and confidences. There was a reluctance to acknowledge the monitoring role.

7.2.2 Clients:

There was some uncertainty expressed by the clients when they were asked to describe the role of the health visitor. Not unnaturally, they usually described the role as defined by their personal experience, in connection with babycare.

Opinion was divided as to whether the health visitors were there for the mother as well as the baby:

" I thought they were just here for the babies. Immediately after you've had them, you've got the midwife who checks up on you, and then the health visitor. They do ask, and I know they're there just to make sure that everything's O.K. up to a certain point, like maybe two months after the baby's born, and then after that I think they're there just for the baby. You're back to normal so to speak, so then they're there for the baby. You go to the clinic, if you phone them up it's to do with the baby, so that's what I thought their job was, just mainly for bringing up the children, making sure they get their jags, get their eyes tested and so on."

[C 9]

The general impression was that the health visitors were more concerned with the baby than the mother. This confirms the data of Dalziel [1990], who studied women's self-help health groups and found that her respondents felt that their health visitors were primarily concerned with the needs of the children, and saw the women's needs only in relation to their role as mothers.

Of the 45 clients interviewed, all felt that they could discuss problems concerning the baby, and a majority felt that they could discuss their own health, but it was a minority who felt that they could discuss highly personal issues outwith the mothering role. After one visit [V 9], where the client had talked at length about her relationship with her husband, and both client and health visitor felt they had a good relationship, the client volunteered that she felt she had been "imposing" on the

health visitor, and didn't feel that it was really the health visitor's job to listen to her problems.

In contrast to the supportive role envisaged by the health visitors, the clients, on the other hand, spoke about the role in more authoritarian terms. Their stated preference for arranged visits might argue against the interaction being viewed in a social "friendly" light. At least a third of the clients mentioned the health visitors' "checking" role, in connection with child abuse:

"Just to make sure, that you're all right with the wean, or how you're coping and things, and how he is, if you've nae worries, just to put your mind at ease if you'd anything to worry about.....My mother used to say things like, "oh the health visitor is nothing but a social worker sort of thing" but I don't find that at all, you know, that's my mother's point of view"

[C 10]

None of the health visitors had volunteered this aspect of their role. [It must be noted that part of the data collection was carried out when there was national publicity being given to child sexual abuse cases in Cleveland.]

Many displayed hypersensitivity to this aspect of the health visitor's role by volunteering explanations of how a child had received a bruise in play, or joking, "You'll think I'm battering him!" when a baby had blue dye on his arm. Such unsolicited comments reveal an underlying anxiety about this topic, also identified by Mason [1988] and Cowley [1991a]. However, like the women interviewed by Blaxter and Paterson [1982], clients agreed that health visitors should visit everybody.

The clients appreciated the practical help offered by the health visitors. For example, for some clients where transport was a problem, the health visitors had volunteered to deliver baby milk.

Some health visitors had given their home phone numbers so that clients could contact them outside of office hours. [No 24-hour health visiting service is available in this area.] Their help was appreciated in social terms, when they could inform about local activities, or provide introductions to other mothers. Some clients expressed a desire for more practical help, for example in finding babysitters.

In connection with the medical services, health visitors were often used as an intermediary to, or instead of, the doctor:

"I've had a couple of things as well with him, wee things that you wouldn't necessarily bother the doctor about, because you feel well, you're wasting his time, quite important to you, but probably quite trivial to him, that you could actually speak to the health visitor"

[C 1]

The health visitor was therefore more accessible, less threatening, had more time, and could be used to solve minor ailments. They could confirm the mother in her decision of whether or not to consult the G.P., could explain medical instructions, or provide an alternative opinion if the mother disagreed with advice. The strengths of this communication have been pointed out by Kasch [1986a] and Clarke [1991], and need to be considered when exploring the expansion of the nurses' extended role, and that of the nurse practitioner.

This was not an area considered in the interview schedule, but three mothers individually volunteered that the health visitor's advice about babycare had been better than the doctor's [in connection with colic, sleeping problems, and a cold.] Because these were views volunteered by the clients independently, the counter to this argument is absent.

One possible reason for the health visitor being used as the first point of access to the doctor, is because of the feelings of warmth and friendliness present, when the clients felt they had a good relationship. Health visitors were seen as being more personally concerned, and more understanding that trivial things could assume great importance to a new mother, and because of the home setting, the clients were, so to speak, on their own territory.

Replicating a question asked by Orr [1980], the clients were asked to describe their "ideal" health visitor. Similar to her findings, the responses emphasised elements of professional knowledge and skill, and attributes of personality. Personality factors were of greater importance.

In summary, therefore, the health visitors spoke about their role in terms of "support", while the clients spoke about the role in more authoritarian terms. At least a third of the clients mentioned the "checking" part of their role.

7.3. HEALTH VISITOR / CLIENT RELATIONSHIP

Both client and health visitor were asked what they thought made a good relationship, and its converse, a poor relationship.

7.3.1. Health Visitors:

For the health visitors, the criterion in judging a good relationship was the same as for a successful visit: client response.

"Well I think if someone appears always to be pleased to see you, who is willing to ask you about things and you feel that you're able to give some information about whatever, and who seems to be willing to have you back again, I think that's probably what you can base it on."

[HV 2]

The client response was therefore assessed by the health visitors on acceptability of the service that was offered. The advice need not be accepted in a good relationship, if the client was open in the rejection and still welcomed the health visitor's input. For the health visitors as well as the clients, a good relationship could be traced back to a specific instance or crisis when the health visitor felt she had been helpful, and so a warm relationship ensued. If, on the other hand, a crisis occurred and the health visitor was not aware of it at the time, this was a sign that the relationship was not close. If a client could share personal details or problems, and topics outside of babycare, then the health visitor felt they had a good relationship.

Both clients and health visitors volunteered the importance of losing the "health visitor" label and being treated as a person. This statement is interesting as it points to the health visitors, too, being aware of some of the negative connotations associated with their role and the "professional" label. Some health visitors were aware of using self-disclosure as a means of establishing warmer contact and demonstrating empathy. However, one health visitor related her shame after one visit when in an extremely stressful situation she had burst into tears in distress about a case of child neglect. This health visitor obviously felt that showing her feelings in this way was unprofessional. As Salvage [1985] has pointed out, when discussing the expectations about the nurse's role, a "good nurse" is supposed to display dedication, service to others, patience, compliance, and a refusal to show feelings of anger or hurt. By demonstrating her humanity and vulnerability, this health visitor was violating these norms of behaviour, and felt that this was something that should never be repeated. However, she did go on to say that it had a beneficial effect on that occasion, as it had demonstrated to the mother that she was not just a professional carrying out a task, but a human being showing her extreme anxiety and worry, and later visits were easier in consequence. This incident also highlights the possible lack

of support for health visitors, as this was an incident that had never been discussed with anyone else, and clearly had been a pivotal one in this particular client relationship.

Another health visitor reported early contact and clear explanation was important:

" To me a good relationship is you can help, or create a kind of atmosphere where people can be free, be comfortable with you and open up to you and this is where confidentiality comes in to it and also the health visitor has got to be very careful with what she says. I try to see all the mothers antenatally, and at the antenatal visit I always tell them exactly what the health visitor is, where she came from, what she knows, and I would try to reinforce that at notification, so I try to make it very clear our role. I would also say, we're not social workers, because a lot of people think, we are.....So I think that so long as you're honest with a person as to why you're there. You've also got to be relaxed as possible, take a cup of coffee if its offered, I suppose to be friendly without actually being a personal friend."

[HV 4]

This health visitor tried to prevent possible misunderstandings by a detailed explanation of the role, by stressing honesty, and adopting a friendly approach. The acceptance of coffee is an example of the personal, friendly relationship, where the professional role is subjugated to the personal, and "sharing" rather than "helping" can take place. In contrast to this study, Bowers [1992b] found that the community psychiatric nurses sometimes refused hospitality as a way of creating a slight distance between the nurse and client, and emphasising the professional nature of the contact. It might be inferred that the nurses studied by Bowers were trying to avoid the routine of a social visit, while some health visitors actively foster a friendly social interaction.

For the health visitors, a poor relationship occurred when they felt they had little or antagonistic response from the clients, "when there is this feeling of a closed door that is impassible". The relationship could be superficial, or the health visitor's

services unwanted. This could arise, not just because of contact with this health visitor, but because of previous negative contact with the health visitors or others "in authority".

The length of time they had known the client was not necessarily a factor, but doing the notification visit [the first postnatal visit] seemed important. This corresponds with the clients' views on the importance of the first contact with the health visitor. Families who moved in later were more difficult to get to know, in that there were less contacts, less of an obvious need for their services, and therefore a less warm relationship.

The clients' personal situation or qualities influenced the health visitors' feelings about their relationship:

" I tell them all that they don't have to let me in. I have a statutory visit to pay, and once that's done you don't have to let me in, and so far, I've only had one person in my career who has not let a health visitor through the door, she wouldn't even open the door, she screamed behind the door, but that was the only one who hasn't let me in. I don't feel you can make an instant rapport with everybody, and there are some people that are easier to get on with than others, no doubt about it, and some people must say the same thing about me. I know I should visit so-and-so and you put off visiting because you just don't feel comfortable, you know."

[HV 2]

Two examples where the health visitor could not be comfortable demonstrate the threat to the twin aspects of the health visitor role. One story related about a difficult relationship was to a professional mother, who had fixed ideas of childcare, knew all the recent research, and challenged the health visitor's knowledge base. This client was a threat to the professional aspect of the role. The other story related was of a visit where the health visitor had previously met the client in the clinic, formed a good relationship, and yet on the home visit to a room full of people, found the mother uncomfortable and monosyllabic. The health visitor left hurriedly, feeling the

relationship had taken a step backwards, and the "friendly" aspect was challenged. This story again demonstrates the influence the client's family can have on the interaction.

Another area which can cause problems to the idea of a "friendly professional" is the area of child abuse. The health visitors said that they coped with this stressful situation by being honest and open about their reasons for visiting. One health visitor expressed the view that this was of far greater concern to her as a newly qualified health visitor, than later in her career. Health visitors were aware this was a source of antagonism, and saw it as encouraging negative, instead of positive, attitudes towards their role. They felt uncomfortable being the "policewoman", but did not seem to see it as diametrically opposed to being the mother's "friend". They saw it as a necessary evil. Sociologists such as Taylor and Tilley [1989] have pointed to the basic contradiction arising from being concerned with child protection while maintaining client confidentiality, and the ethical dilemmas concerning civil liberty [Dingwall 1982]. The health visitors in this study felt the relationship would survive if the health visitor was honest with the client, and the majority felt that their profession should retain both aspects of their role. They coped with any possible antagonism by calling again on the client, being open about her reasons, and either confronting, or proceeding on from the present to concentrate on the future. Ways of coping with a poor relationship included offering the minimum service, clearly delineating the role, and seeking alternative styles of approach e.g. clinic appointments rather than home visits.

The line between being friendly and professional was drawn in different places for different health visitors. The health visitor who had cried during a visit felt she had overstepped her role by becoming emotional, despite the eventual benefits.

It was a loss of authority. Another health visitor related with disapproval a colleague's delight in helping a family by taking over during a difficult feed. The respondent felt that, although her colleague might have felt she had helped in the short term, in the longer term she had taken away the client's coping abilities and self-esteem. The health visitors' intention, stated or unstated, was to be there for the clients when needed, but to try to reduce that need until the service was no longer required.

For the health visitors, then, a good relationship is a mixture of the friendly and the professional, allows change to occur, and eventually allows her to discontinue visits, because the family will call on her if needed. Where this good relationship is not present, the health visitor will try to maintain contact, offer the minimum service, such as immunisation reminders and developmental checks, but the warmth is absent.

7.3.2 Clients:

For the clients, the personality factor was most important, with professional ability in secondary position. In agreement with the findings of Orr [1980] and Mason [1988], if the client liked the health visitor, found her friendly and easy to talk to, other factors such as age of health visitor, and whether she had had children, did not seem to matter.

"She's very easy to talk to. I mean, with her being the health visitor, she doesn't sort o' show her authority over you, I mean she's just like one of us, I mean she is really easy to talk to. I mean, when she comes along, she'd never sort of rushes away, oh I've got to go, I've not got any time, I mean she'll sit, and even if you're not talking about the baby, even if it's just for company or that, she will sit and talk. I mean I feel she is very good to talk to. I feel we've got quite a good relationship."

[C 5]

One woman, with a good relationship with her health visitor, one of the older health visitors, said she could not talk so easily to a younger health visitor. The corresponding situation, of a client talking about her younger health visitor, was when the mother said she could not imagine sharing her feelings with an older woman.

It was when the relationship was not so warm that other factors mattered.

"Really easy to talk to. If you're easy with a person, and they can understand you and you can understand them, then you can let your emotions out, like I find her really easy to talk to. It's just like she's a sister or something "

[C 7]

Where the relationship was good, the health visitor was therefore seen as a friend, a sister, a mother, or a helpful neighbour, all human relationships which are easy to understand and describe. Where the clients' feelings were not so warm, the health visitor was described in more "professional" terms, in connection with tasks connected with childcare, such as making sure the babies were immunised. In agreement with the literature on perceived similarity [Secord and Backman 1964b, Tessler 1975], clients frequently volunteered aspects of the health visitor's life which were close to their own, indicating that the health visitor, being "on the same wavelength", would have a greater understanding of their problems. These aspects could include having children, moving house, or a pet dying. These feelings were similar to the views expressed in Chapter 6, about advice, when the clients liked to hear about the health visitor's own personal experience.

The client's personal circumstances had an influence on how they saw their relationship. The social role was seen as more important by those with fewer social

support systems like partner, friends or extended family. Where the relationship was good, the health visitor was seen as being interested in the personal worries of the client, and could be used to support the mother against outside family pressures. Where the relationship was not so good, family and friends would be consulted before the health visitor, and the health visitor could be seen as a cause of pressure.

A relationship may need time to develop. Warner and Forryan [1988] describe how it was only over time, that a painstakingly maintained relationship between a health visitor and a mother developed, and the client very slowly gained a sufficiently high self-image to begin developing effective parenting skills. Pearson [1988], too, described the way the relationship can change over time. The design of this study precludes evidence of a developing relationship, but can present the women's views. Many clients in this study volunteered that understanding and trust could only come with time. Openness and honesty were appreciated, that the health visitor was "just herself, not putting on an act", and the clients could "sit and talk to her about anything, not hiding things." It was an act of trust on the client's part, when, in spite of their views on the "checking" role of the health visitor, they could volunteer feelings of frustration and inadequacy about their mothering role. One relationship was strengthened when the health visitor admitted in self-disclosure her own problems in childrearing.

The converse of these feelings, a poor relationship, occurred for the clients, when the friendliness was absent.

"If you've got a health visitor who doesn't really care, that's just there to do her job, then I don't think I'd get on with her, because I like a person that gets involved with you and your child, that's not just there, to say right, she's O.K., I want a person that will sit down and discuss things with you, not so ratty, ken? That really takes her time to explain things."

[C 7]

Similar to the findings of Chalmers [1990], a poor relationship could also be traced back to a bad start, when the health visitor had somehow caused a bad impression at her first visit, or to a specific instance, where the health visitor had failed the client in some way. Mason [1988], too, found that a specific incident could adversely affect their whole relationship. One mother, who had been given advice which she not only disagreed with but also thought was harmful to her baby, felt that she could never place her trust in the health visitor again.

One way of exploring the health visitors' role is to look at what the women knew about health visitors before they met them, or the stories that are told about them. The term "atrocity story" was first used by Stimpson and Webb [1975 and 1976] in discussing the way in which patients talk about doctors, whereby they can retrospectively interpret their encounters with the medical profession, negotiate norms for behaviour, and redress the imbalance in the relationship between doctor and patients by voicing complaints, even if only indirectly. Dingwall [1977b] relates stories told by health visitors about doctors, nurses, and social workers, while Baruch [1981] reports stories told by parents of encounters with the health professions, and Jackson [1986] relates anecdotes about health visitors. These reports are of great interest in the study of relationships, and their equality.

Many of the clients in this study had heard stories about health visitors, e.g. they're "nosy busybodies", "coming to look at the house", and "they ask to wash their hands so that they can look at your bathroom to see that it's clean." One client antenatally had been concerned because she had heard that they looked at the kitchen, and she did not have one! The clients went on to relate that it was different when they met the health visitor, "their" health visitor was not like that, and expressed their relief that they could be themselves. They were still left with the

impression that other health visitors could still conform to their former negative image.

Another story told was of one woman who failed to answer the door when the health visitor called, because she did not want her to visit. This story was of interest because it demonstrates that although the home is the client's own territory, she did not feel able to politely deny access, but instead preferred to avoid a confrontation. Conflict is avoided through non-cooperation, or escape or avoidance, similar to the findings of Bloor and McIntosh [1990], where the most common form of client resistance is concealment. The health visitor, therefore, from these reports, can be seen as an agent of social control.

In summary, for both participants, a good relationship was seen as a reciprocal arrangement. To the health visitors, however, a good relationship was not necessary to carry out their work, while to the client, a good relationship was of prime importance, emphasising friendliness and approachability. In contrast to the two alternative approaches to the relationship suggested by Robinson [1982a], the findings of this study support the views of Mason [1988] and Chalmers [1990] that health visitors use components of both in their work with mothers and babies. In agreement with Twinn [1993], health visiting could be defined as both an art and a science, incorporating elements of both a technical/rational model and the concept of reflective practice.

7.4 POWER

Central in relationships is the concept of dominance, who has the power. Illich [1973] has argued that professionalism ties up knowledge in discrete bundles and sets up rituals for its dissemination by certified practitioners. Knowledge is power. Freidson [1986:172] has pointed out the power professionals have over their clients, in that professionals have shared agreements and strategies, while "the client is an outsider seeking what may not be possible or convenient" for a professional to give. Ranson [1977] discussed professional identity as opposed to personal touch, and saw the health visitor role as central in the sharing of medical knowledge with the public. Robinson [1982b] discussed power in relation to the health visitor and her clients, and pointed out that although most health visitors would deny that their authoritative position contains an element of social control, yet information and knowledge provide power.

The nurse/patient situation has been defined as one where the patient's dependancy places him in a vulnerable position [McGilloway 1976]. In health visiting however, there is no right of access, and the service is usually unsolicited. The health visitor has to negotiate with the client to define acceptable rules of behaviour, including frequency of contact, place of contact, and style of contact. Each participant brings to the interaction a set of experiences and expectations about roles. Because of the voluntary nature of the service, Dingwall [1977a] has pointed out that much of the health visitor's work involves establishing the relevance of her tasks to the client. He considered that this inevitably led to a negotiation paradigm, whereby a relationship can be maintained in spite of a lack of shared perspectives or goals.

However, within this negotiation, there may be a stronger partner. The evidence from this study is that the health visitor is definitely the stronger, more powerful participant. The clients accept the health visitors' visits, even though they may not have been explicitly consulted, know why they are coming, or what they intend to do. They accept a visitor who may well be "checking" on their mothering abilities, a role which has been shown to be unpopular but regarded as necessary. It is surely a triumph of the health visitor's skills that the service has been shown to be so relatively popular and acceptable. This appears to have been achieved by becoming a friend, as opposed to a professional role.

The patterns of contact between health visitors and clients have been shown to demonstrate frequent contact during the baby's early months, decreasing as the child grows older. Pearson [1988] has demonstrated how in this process parents' feelings can move from a loss of independence and autonomy early in the postnatal period, to a feeling of self-confidence in her own parenting abilities. In this study, by stressing the parent's right to choose, the health visitors are demonstrating another aspect of this change of role, that of empowerment. Gibson [1991], in her literature review, has defined empowerment as a process of helping people to assert control over the factors which affect their lives. Results for the client include " a positive self-concept, personal satisfaction, self-efficacy, a sense of mastery...and improved quality of life" [1991:359]. To achieve this, can be a developmental process. Kieffer [1984] conceptualised empowerment as a "process of becoming". Four stages were defined. The "era of entry" was compared to the developmental stage of infancy, where the participation of the individual was exploratory and power structures demystified. The next two stages were the eras of "advancement" and "incorporation", through late childhood and adolescence, leading to the adult "era of commitment", where the individual integrates new personal knowledge and skills

into the reality and structure of the everyday life world. These ideas could be compared to the metaphor of Kasch [1986a], who described the professional in the primary care encounter as the master craftsman, and the patient as an apprentice who is provided with the resources to be a more active and informed health care participant. These analogies explicitly demonstrate that the power belongs to the professionals, whose decision it is whether to share this knowledge with clients. In this study, some health visitors described "helping the mothers to cope", or "talking through any of her worries", as an aim for their visit. The clients felt able to raise any subject of concern and did not report feelings of inferiority. However, there is mixed evidence concerning the negotiation [or lack of it] in arranging contacts, that the clients felt some compulsion to accept the service in order to demonstrate that they were "good" mothers.

One aspect not yet considered is that the health visitor/client relationship is usually between women. Dingwall [1977d:315] has described the roots of the profession as a "radical women's occupation run largely by women for women". He traced these feminist origins through its change to a paternalist collectivist approach, and compared social work as private and state individualism, with health visiting's private and state collectivism. Gibson [1991], in discussing empowerment, stated it reflects a female view of power, wherein power is conceptualised as a condition of being able to achieve some object in cooperation with others, in contrast with a male view of power where there is a limited supply that must be struggled for and defended against others. The evidence in this study, from the interview data and, for example, satisfaction with the number of contacts in spite of the demonstrated variation, points to an individual rather than collectivist approach, based on individual need. The interactions described in "advice-giving" and in the next chapter

do not demonstrate a struggle for power, but on the contrary, elaborate strategies to avoid an appearance of dominance and control.

In discussing power within a relationship, one index is to describe the way the participants talk about their interaction. Is the health visitor a friend, or an interfering professional? The "atrocity story" would suggest the latter, and other favourable views the former. The health visitor can be different things to different people.

To the health visitors, the role of friend is achieved so that they can carry out their professional role. The contradiction comes when the two roles conflict, when the professional takes over. As it is the health visitor who makes this decision, and sets the rules for the encounters, it is the health visitor who has the power. However, the balance is complicated by the reciprocal nature of the reported relationship. The health visitor may ultimately have the power, but she goes to great lengths to conceal it or render it acceptable. The clients have the ultimate sanction of not using the service, and so are the final arbiters, but within these limits, each contact contributes towards a health visitor / client relationship which is interactionally achieved, alters according to circumstance, and adapts to new influences. Some practical measures to encourage empowerment are discussed in the final chapter.

7.5 SUMMARY

When describing their role, the health visitors spoke about support, reassurance, advice, a source of information, and practical help, whereas the clients spoke about the role in more authoritarian terms. At least a third of the clients mentioned the health visitors' " checking" role, in connection with child abuse. The health visitors, however, were valued for childcare advice, and were generally accessible and approachable.

A good or bad relationship was judged by the health visitors on the clients' response. The clients assessed their relationship on personality factors such as friendliness, with professional factors very much secondary.

The health visitor has been shown to have the greater power in defining the relationship. If, or how, this power is translated into practice is discussed in the next chapter, which continues the theme of power and client participation within the interaction, through conversational analysis of the tapes of the home visits.

CHAPTER 8

CONTENT OF HOME VISITS

8.1 INTRODUCTION

This chapter introduces conversational analysis [8.1], compares this work with previous research [8.2], describes the findings [8.3] and the use of verbal ploys [8.4], and finally concludes with a discussion about control of the interaction [8.5] and a summary [8.6].

This chapter explores the content of the home visits through a conversational analysis of the transcripts of fourteen tapes [tapes were not available for one of the health visitors.] Following the example of previous researchers [Kendall 1991, Sefi 1985], the complex notational symbols are omitted.

Conversational analysts drew their inspiration from the work of Garfinkel [Heritage 1984a]. Garfinkel's work contrasted with the work of Parsons [1937], whose theories on the nature of social action and social organisation were based on role analysis. Parsons viewed social actors as sharing complementary role expectations following a preordained script. Garfinkel, on the other hand, rejected the idea that social action can be analysed as "governed" or "determined" by straightforward rules, but instead sought an analysis of social organisation built "solely from an analysis of experience structure". Thus social occasions are continuously constructed by their participants. Garfinkel [1967] studied the nature of language use and the reasoning behind it. He coined the term "ethnomethodology" in the mid 1950s, which has been described by Heritage [1984a:4] as referring to the study of a particular subject matter: "the body of common-sense knowledge and the

range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves."

Following the principles of Garfinkel, Sacks et al. [1974] observed some grossly apparent facts about naturally occurring conversations.
The first six are listed here as examples:

1. Speaker-change recurs, or at least occurs
2. Overwhelmingly, one party talks at a time
3. Occurrences of more than one speaker at a time are common, but brief
4. Transitions [from one turn to a next] with no gap and no overlap are common. Together with transitions characterised by slight gap or slight overlap, they make up the vast majority of transitions
5. Turn order is not fixed, but varies
6. Turn size is not fixed, but varies

To obtain the full benefits of conversational analysis, a detailed notation is used in the transcripts. This was omitted in this research, thus losing such fine detail of pause-length, hesitation, overlap and intonation. This decision was made because of two factors: first for reasons of research, and secondly on pragmatic grounds. Taking the practical viewpoint first, it has been estimated that for the full transcription as used by Jefferson [Atkinson & Heritage 1984] the tape time to transcription time ratio is more than 1:20, as opposed to a normal transcription ratio of 1:8 or 1:10. This time was not available to the researcher. Secondly, looking at what the research questions were asking of the data, it was decided that a detailed notational transcription was an overelaboration of the level of information required. It was not intended that the study of linguistics be included in this study. All the

tapes, and the 14 transcripts in particular, were studied instead for common features of the conversations, which did not include details of pause length or intonations. The decision was made therefore to omit the detailed notation. The unit of analysis, discrete pieces of conversation, was retained. The unit could consist of a word or sentence[s], consisting of a turn, utterance, or exchange. [An example of the transcript notation is given in Appendix N].

Within an ethnomethodological framework, and using the principles of conversational analysis, the tapes of all the visits were studied, but the transcripts of 14 used for detailed analysis, as they were available for accurate reproduction.

8.2 COMPARISON WITH PREVIOUS RESEARCH

Because of the voluntary nature of the service, Dingwall [1977a] has pointed out that much of the health visitor's work involves establishing the relevance of her tasks to the client. He considered that this inevitably led to a structure in the visit which allows clients to introduce a wide range of problems that they have, which may not strictly be "health visiting problems", but the health visitor will talk about them as part of a trade-off with the client, so that the client will allow the health visitor to introduce her own topics. Using this negotiation paradigm, a relationship can be maintained in spite of a lack of shared perspectives or goals. This interaction could be compared to another of his papers [1980], when he used conversational analysis to study speech exchange systems in tutorials in a school of health visiting. He argued for a wider interpretation of the uses of this type of analysis, to include contextual features, and concluded the interaction in the tutorials had the character of an "orchestrated encounter", as one party had a subordinate status, and the other had the right to uphold thematic coherence and to distribute speaking/listening rights.

In the conversational analysis of first visits by Sefi [1985], although the health visitors described their visits as "popping in" and "chats", when analysed in detail, it was in fact the health visitor who effectively controlled the topics that were chosen and the extent to which they could be discussed. These findings are markedly different from the self-reporting by health visitors by Clark [1973] and the observation of Watson [1981] who felt that the client introduced many topics and there was equality in the relationship. Similarly, in interviews with health visitors, Luker and Chalmers [1990] reported that the respondents felt that they attempted to focus on the key need or problem as perceived by the client, as a way of "entering" more fully into the client situation. Chalmers [1990] suggested that by focussing on the routine delivery of a service, the health visitor thus legitimated her presence and established herself as a helper providing a desired service.

The fact that first visits were studied by Sefi [1985] and Robinson [1987] may have influenced their results on participation. The latter researcher found individual differences due to the context of the visits, but described encounters that were remarkably similar in structure and organisation. Her analysis most closely fitted the model of the "orchestrated encounter", although with some elements of mundane conversation. It was the health visitor who played the larger role in organising the talk. The clients made a substantial contribution to the context of the talk, but this was conversational and personal in style, while the health visitors' contribution was generalised and careful. Atkinson [1981], in inspecting classroom talk, found classroom encounters to be orchestrated, in that one party has the right to determine when the other participant[s] may speak. In mundane, or ordinary conversation, the allocation of turns is an open matter. Like the analyses of Sefi and Robinson, Kendall [1989] too, found that while the health visitors expressed very

favourable attitudes towards participation, in fact there was a low incidence of parental involvement.

It is possible that time may influence dominance. Watson [1981] found that the health visitor was dominant in the shorter visits, while the client was dominant in the longer visits. The setting, too, may have implications, as in Warner's study [1983] of interaction in baby clinics, health visitor initiated topics tended to be briefer than client initiated topics, implying that clients had considerable control in shaping what occurred during the encounter. She did, however, conclude that the balance of power lay with the health visitors.

Warner [1983] also identified some strategies or techniques used by the health visitors in influencing the interaction. With the belief that individuals rapidly learn interactional ploys which are effective in achieving goals, and because effective ploys are repeatedly used [Lofland 1975], she examined the interaction for observable patterns. She identified ploys in baby clinics such as the use of humour [1984a] and the use of the phrase "How are you?" [1984b]. These were observable patterns repeatedly used.

With these findings in mind, the questions that could be asked of interaction on home visits might be:

Was there evidence of verbal strategies or ploys?

Was the health visitor or client dominant - who had the greater power in influencing the interaction?

Is a home visit an orchestrated encounter or a mundane conversation?

8.3 FINDINGS

The 14 tapes were studied for observable patterns. Because three visits were available for each health visitor, and only one for each client, more health visitor ploys than clients' were identified. A variety of patterns emerged, and the categories identified are described in the following section.

The categories are: openings, topic progression, talking to the baby, laughter, praise, pauses, recognitions, dealing with rejection, pursuing a response, communication skills, closings, and clients' ploys.

8.3.1 Openings

In this study, it must be remembered that the tape was switched on only after the health visitor and client were sitting down, so some of the opening of the encounter is absent. Even so, there were still some common introductory phrases: "How have things been..", "So, what have you been up to", or, "So you were saying.." Usually the visit started with a general open question from the health visitor.

Warner [1984b], in studying interaction in baby clinics, observed the frequent use of the phrase "How are you?" and postulated that the health visitors used it to manage possible difficulties arising from differences in professional and client short term goals. By using a routine format, the health visitor could move from the general to the particular, to establish a first topic of conversation. Warner found that the more specific the opening, the greater was the chance that it would receive continued discussion, as it reduced the risk as perceived by the client of making an inappropriate response. It was only rarely in the visits studied here, that a health visitor would start a visit by stating her objectives [V 28], or by inviting the client to

set the agenda, e.g. "Was there anything that you particularly wanted to talk about?" [V 14].

Both in openings and closings, Schegloff and Sacks [1973] have noted the use of **adjacency pairs.** Adjacency pairs consist of sequences which have a two utterance length, adjacent positioning of component utterances, and different speakers producing each utterance. In the following extract, the visit opens with an adjacency pair, and the conversation proceeds form the general to the particular:

HV: *"So how are you*
C : *Fine. That's a very uncomfortable chair.*
HV: *You sort of sink into it. So how are you doing now?*
C : *Well I think now I'm settling down*
HV: *She is three months now, isn't she?*
C : *13 weeks exactly*
HV: *You said she was having a rusk. Is she still having that?"*

[V 18:1]

There then ensued a lengthy discussion about feeding.

The health visitor might start off with her general query relating to the mother and then the baby, or there might be some general social chat about the client's activities. There was not a lot of this latter feature, perhaps because, from the interview data, some of the women [both professional and client] were very aware of the tape recorder at the beginning of the visit, but gradually forgot about it as the visit went on.

In openings, it generally appears that the segment starts like an orchestrated encounter, and then proceeds into something approaching a mundane conversation.

8.3.2. Topics

In ordinary conversation, both parties can freely introduce new topics. Harvey Sacks, as cited by Jefferson, has described this flow of topics, as a **stepwise progression**:

" A general feature for topical organisation in conversation is movement from topic to topic, not by a topic close followed by a topic beginning, but by a stepwise move, which involves linking up whatever is being introduced to what has just been talked about, such that, as far as anybody knows, a new topic has not been started, though we're far from wherever we began."

[Jefferson 1984a:198]

In this extended sequence, from the middle of a visit, the conversation arose from a discussion about play and stimulation, and proceeded in stepwise progression to many other topics. [The following extract is repeated in Appendix N, including the transcript notation.]

C : *"she is awfully alert.*
HV: *uh-huh*
C : *Every house that I take her in she's, her eyes are everywhere, every corner of the house, she is awfully alert.*
HV: *And now when she is 8 or 9 months she will be crawling about everywhere, getting into all your things.*
C: *That's the bit I cannae wait for. [laughter]*
HV: *And peek-a-boo? Even at 6 months peek-a-boo.*
C : *Aye*
HV: *They love it. [laughter]*
C: *She loves her bath now, she loves that.*
Splashes away.
HV: *Does she?*
C: *Oh aye. She has always liked a bath. She's never been feart of the water. I may start at the swimming pool with her.*
HV: *Which pool do you go to?*
C: *I don't even know where they are.*
HV: *There is one at the school*
C : *Aye, that's right*
HV: *and about 5 miles away there is a lovely baby pool.*

C: *I have been there about 5 years ago. I was there like, and I noticed they had a baby swimming swimming pool then*

HV: *Yeah, it's really nice*

C : *I'd like to, is there anywhere, eh, that you could go I would love to start swimming myself like.*

HV: *uh-huh*

C : *Is there anywhere that there's, what do you call it, a creche?*

HV: *mm*

C : *That they could look after babies while you're in the swimming baths*

HV: *Well, the sports centre has a creche and you could join the classes.*

C : *mm*

HV: *Do you get the local free paper?*

C : *Aye*

HV: *Have a look there and see what it says about the pool because they may well have creches for certain times of the day.*

C: *I want to start doing something.*

HV: *The other sports centre has got a creche but you can't swim there. And there is different things on there which might attract you.*

C : *mm*

HV: *It is a good thing, that you get something to do as well, doesn't it.*

C : *Aye*

HV: *Get the balance right*

C: *I used to go swimming a lot like.*

HV: *Did you?*

C: *Mm..I haven't the time now.*

HV: *Well I think you have to be a bit selfish at times, take an hour or two for yourself, it is not too much to ask is it not? You know? I think women are absolutely hopeless taking a bit of time for themselves, they are martyrs to the family and cooking and housework.*

C: *That's true.*

HV: *Yeah. When you think what you used to do before the baby came along.*

C : *I know*

HV: *Suddenly you get all domesticated and..*

C: *You have got this to do, you have got that to do.*

HV: *I know. What's an hour to yourself in 24? It is not much, is it not. Just an hour for yourself in 24 hours, an hour out of 24.*

C: *An hour? It's no' much [C laughs]*

HV: *I know, but you are saying, I can't do that, because I haven't got the time. But you should have the time, shouldn't you?*

C: *I have no' really, believe it or not. [laughs]*

HV: *I know, but you should. Just imagine it*

C: *I could if I wanted it, if I just left everything else like.*

HV: *uh-huh...But the centre is quite near and it has a creche hasn't it? Have a look and see what's on there. Maybe it tells you in the paper. And then you could pop in. There's a nice library, and soon she could be introduced to little groups you know.*

C: *Mm. I'll have a look."*

[V 14:30]

The conversation thus proceeded from general play, to specific stimulation like swimming, to positive support for a mother to have some life of her own, back to stimulation again, in a stepwise flow.

An alternative to stepwise progression, is **segmented topic flow**, where conversation is divided into separate topic sequences, and topics may be separated from each other by recognisable opening and closing components. The use of "**topic initial elicitors**" [Button & Casey 1984] establishes a chosen topic of conversation. These usually consist of three turn-alternating parts, first an enquiry, second a positive response, and third a topicaliser, in that it "topicalises the prior possible topic initial and provides for talk on the reported event" [page 167].

As described in Chapter 4, the data were originally examined for segmented topic flow, following a tradition well established by past researchers into communication. This proved to be extremely complex, as as there were frequent elements of a stepwise progression of topic introduction, so that separation into discrete categories became more problematic, and lack reliability. In the previous extract, for example, in line 8 [V 14], the client introduces the new topic of her baby loving her bath, with a topic initial elicitor. However, because of the stepwise flow, it would be difficult to ascertain how the topic of swimming developed into support for the mother having more time for herself. The data from the tapes offer examples of both types of organisation of topics.

Usually it was the health visitor who initiated the start of a new topic. A common pattern might be an opening, followed by a segment of talk, often about a topic practical in nature, followed by a more stepwise progression.

However, the longer the visit, or the more strongly the client felt, the more the client initiated topics. In the following opening extract, the client had many things on her agenda for the visit, and very much guided the introduction of topics:

HV: *"Now when I just came in and you were feeding him, how is he doing with that, Eva?*
C: *He's just as bad as he's always been. He is worse today but I think he is getting thrush again.*
HV: *Can you, have you seen it in his mouth?*
C: *There is wee spots of it I still have got some cream left from the last time the doctor gave me.*
HV: *Is it on his bottom or in his mouth?*
C: *In his mouth.*
HV: *Right.*
C: *So that cream there, has been put away in his wee thing. I am going up to the doctor in the morning, so I will see him tomorrow to see if he can give me any more, plus he has got a chest infection.*
HV: *I noticed that yesterday when I was in.*
C: *Aye. He has got a chest infection, he has a nose infection and he is teething.*
HV: *Everything at once.*
C: *Not very happy.*
HV: *Right.*
C: *But I didnae ken what causes thrush. I mean even his dummy tits. Everything is sterilised and yet he's still getting it."*

[V 12:1]

In this visit, it was the client who introduced the new topics of the baby's thrush and chest infection. Thereupon there ensued a lengthy discussion about thrush before the health visitor pursued the question about feeding, and later returned to the topic of the baby's health and medication.

The use of topic initial elicitors were used by both client and health visitor, but in a different manner. To some extent it was the health visitor who took charge of the interaction, and the client who acquiesced. It was the health visitor, therefore, who could ask, "Is there anything you wanted to talk to me about" [V 19], or "The other thing I was going to say is.." [V 14]. It was the client who used the more hesitant phrase, "It was just that.." [V 18], or "Another thing I was going to ask you is.." [V 30]. The health visitor could "say" or "talk about", but the client would "ask". These slightly shaded differences demonstrate that the health visitor does hold the balance of power, but in a well-disguised way.

Returning to earlier topics was accomplished by either health visitor or client. In both cases it was usually signalled by a topic initial elicitor, so that the other participant was made aware that this was a new segment in the conversation. A common usage was referring back to a specific phrase e.g. " So you were saying..". This returning to an earlier topic could be to ask for further information or clarification, or might demonstrate that one participant did not feel that the topic had been completely dealt with. By signalling the return to an earlier topic the participants avoided rendering the raising of the subject inappropriate. Unheralded, going back to a topic might have suggested overt dissatisfaction with an earlier discussion.

On the whole, the conversation moved in a stepwise progression, from topic to topic, but evidence of an orchestrated encounter was present in the segmented topic flow, as illustrated by the use of topic initial elicitors.

This contrasts with the results of Sefi [1985] and Robinson [1987] on notification visits, who found that topic flow was segmented, like an orchestrated

encounter, and that the health visitor was the dominant partner in control of the interaction. In this study, there was more equality of contribution. The use of topic initial elicitors frequently occurred after a break in the stepwise progression. This break could occur after some specific ploys, or verbal strategies used to influence the interaction [cf. Warner 1983]. The ploys identified are "talking to the baby", the use of laughter, praise, or pauses.

8.3.3. Talking to the baby

A new finding in this study is this "talking to the baby" as a ploy. Robinson [1987] identified instances of the health visitor talking to the baby as a boundary, but she only commented on it as being indirectly related to the previous talk. In this study, both participants used this strategy for many different reasons.

Davis and Strong [1976] noted the phrase, "Aren't children wonderful?" in their study of allocation of identity in developmental assessment. They noted that children lack adult legal and interactional status, but doctors normalised the experience of assessment by joining the parent as a willing and appreciative adult audience for the child's "performance", transforming tests into "tricks" and "party-pieces", and leaving the clinical agenda hidden. This contrasts with the finding in this study, where again the child was not a full participant, and health visitor and parent could join in wonderment at a child's achievement, but usually the clinical agenda was made obvious, and the mother's contribution welcomed.

When considering "talking to the baby" as a ploy, this is not intended to include when the health visitor would talk to a baby to entertain the baby or carry out an assessment, but when either the mother or health visitor would turn to talk to a baby for no apparent reason. Babies were generally ignored unless they really

intruded themselves vocally into the conversation. They also appeared to be ignored verbally if the adults were in the middle of a topic. The mother would perhaps react non-verbally to the baby, e.g. from the sound on the tape she would pick the baby up, but it was the health visitor who sanctioned the action by including the baby in talk. In one case, the health visitor even said, "do pick the baby up if you want to", as though the mother needed permission to break off the conversation. An alternative interpretation of this incident might be that it could have been one way of giving advice indirectly.

The health visitor might talk to the baby as a way of showing that one topic was closed, and would then start another. After a discussion of the merits of disposable nappies as opposed to terries:

C: *"I noticed when I took the disposable off one night that he had, it was like wee bits of jelly on his skin*
HV: *on his skin, yes*
[B gurgles] [which he had been doing through the previous talk]
HV: *You're a full-up boy aren't you? Do you get little mouthfuls coming down?*
C: *Yes"*
[goes on to discuss posseting]

[V 5:12]

If either client or health visitor talks to the baby, the other can take that as a signal that one topic is closed and another can be introduced. Talking to the baby can be one way to approach either a personal subject, or as a way of giving indirect advice:

HV: *"He is rolling?*
C: *He's not going right over, but he's halfway there.*
HV: *This is the age when all of a sudden they're starting to be on the move, and they suddenly know how to roll their way over to the video, or to something like this*
C: *yes*

HV: *[to baby] This is the age when we have to be careful, isn't it , eh? 'Cause you start to do things before we know it*

C: *Yeah, he has started to move about."*

[V 9:21]

The discussion then went on to the topic of home safety. By talking to the baby, the health visitor can also give praise or reassurance to the mother. After a discussion about salt in the baby's diet:

C : *"He doesn't get sugar either.*

HV: *Great.*
[to baby] See you've got a very good mum here, haven't you?

C : *A lot of people get very angry with that.*

HV: *No, well I wouldn't. I think you're doing a great job."*
[health visitor laughs]

[V 9:5]

The client, too, would talk to the baby, as an indirect way of continuing a difficult subject. In the following extract, the mother used talking to the baby as a way of complaining indirectly about her baby:

C: *"I don't know what I would do, ken, if I was stuck here all the time. At least I've got the pram and I can get him out. He is getting there. He is not as whingey anymore. No' really. Just sometimes.*
[to baby] Eh? Just sometimes you are a whinge. "

[V 12:19]

This research makes the first identification of the ploy of talking to the baby in its variety of uses.

8.3.4. Humour

Warner [1984a] identified the use of humour in baby clinics. She noted that humour allowed the professional to test out or negotiate the acceptability of potentially difficult topics with clients. Chalmers [1994], too, reported that health visitors consciously used humour in potentially conflicting situations as a strategy

employed to present a viewpoint while preserving the relationship. Humour allows the participants to set aside assumptions about their roles so that they can negotiate what is safe subject matter for each encounter. The data from this study confirm her findings, but in contrast to her finding, and that of Robinson [1987], that it was always the professional who introduced the humour, in this study in the home it could be either participant. She also found it was often at the opening of the encounters, rather like a warm-up, a preceding section before the real work, but in this research in the home setting, it could be anytime in the encounter, but often after they had been talking for some time.

There were several instances of shared laughter, when humour demonstrated a feeling of fellowship or shared experiences as women. For example, in a discussion of a father's role:

HV: *"Now I think, for the men as well, they don't know how to cope sometimes*
C: *No*
HV: *And I think, because you're there, it's an easier option to say, well you do it.*
C: *Usually when the baby starts crying, my husband says, Judy, Judy, he's crying*
HV: *Well, you're in the room!"*
[Both laugh]

[V 9:35]

In the same way, when talking about letting babies feed themselves they could both laugh at the thought of the ensuing mess.

Laughter can help both parties discuss potentially serious subjects in a less threatening way. One mother, when talking about her reasons for leaving her baby with babysitters, used humour to help her talk about it more easily:

C: *"It was a shock to me, a total shock. I had no idea it was going to be like this. Now I do. I swear I will never have any more in case it is worse than this.*

HV: *They are all different*

C: *It could be worse! He could scream a' day and a' night!" [laughter]*

[V 12:16]

After this extract, the client went on to explain how her mother helped her with the care of the baby and how a friend had challenged her why she was "giving her baby away". The health visitor supported her in her decision to have time to herself. This demonstrates two phenomena identified by Jefferson [1979 and 1984b] about the organisation of laughter. Her first paper described how the speaker might laugh upon the completion of an utterance, thus allowing the recipient the opportunity to accept or decline the invitation to join in the laughter. In this example [V 12:16], the client laughed, but the health visitor declined the invitation to laugh. In another paper [1984b], Jefferson discussed the use of laughter in talk about troubles. The troubles-teller produces an utterance and then laughs, and the recipient does not laugh, but produces a serious response, so that the troubles-teller is given the cue to continue with the subject. This extract immediately follows the one above:

C: *"I think that is the worst thing. People say, "I don't know how you can do that, give him away". Ken, it's my Mum and Dad, well I said, "My mother had four of us, she's brung me up". "I don't know how you can do that".*

HV: *I think it is a really sensible thing to do.*

C: *It is easier to give them up to somebody, than just sat there and really...*

HV: *Seem as if you are driven mad. I mean you can really understand how people - you know..*

C: *I know, I mean it is hard when you say that, but you look at things like and say "My God, they do push you" and that, but I could not, I know I could never hit him because he just stares at you with those big eyes..*

HV: *I can easily understand how someone could just snap.*

C: *Oh aye. I mean he is good, and now he sits and he will play and everything, but at the start, my first child anyway, I had no idea it was*

going to be like that, I didn't. I had no idea whatsoever. I probably wouldn't have had him if I thought it was going to be like that. Honestly I would not. But never mind, it can only get better.

HV: *And yet you have always seemed so, able to talk about it and very rational about it. You have never seemed to me to get really depressed, maybe that is wrong."*

[V 12:16]

In this instance, the conversation travelled to how someone could be tempted into physical abuse of a child due to stress from crying, a subject that might have been too sensitive to raise without an opening cue. The health visitor supported the mother in her avoiding tactics of "time out", repeated her phrase that she could readily understand how someone could snap under the strain, and in the last sentence made a statement to produce a comment or contradiction from the client. The conversation proceeded by the mother describing her feelings about motherhood, past and present, and future plans for coping.

The following extract demonstrates how laughter can contribute to a shared decision that a topic has been concluded, and another can start. The conversation was about development:

C: *"He says Mum and Dada. He goes "Oh", that's his latest thing, and "Nana" as well*

HV: *So he's saying two syllables*
Baby: Ahah
[laughter]

C: *That is the latest. I don't know where he gets it from. Last night as well he clapped his hands together and I cannae get him to do it again...*

HV: *You often find that, they'll do one thing and then don't repeat it for ages*

C: *I have been trying, I take him over to my mother-inlaw's to get him to clap his hands and he won't do it [laughter]*

HV: *How many teeth did you say he's got?"*

[V 23:3]

The clients used laughter when they might be slightly embarrassed [e.g. when a health visitor commented on the baby's large size [V5:2] or introducing a potentially difficult subject, such as her smoking [V 9:6].

The health visitors used humour as well as a way of telling a story against themselves, relating their own problems on a certain subject, or making advice less didactic. This might again be interpreted as a way of making themselves personal to the client, rather than a distanced professional.

8.3.5. Praise

In describing successful dyadic relationships, it has been said that "to show positive regard for someone is to accept him, thereby increasing the chances of him accepting you" [Wilmot 1975:109]. The norm of reciprocity also exists, whereby the behaviour of either party is contingent on the perceived behaviour of the other. To put it crudely, if a health visitor praises a mother or baby, she is thereby making herself more acceptable to that client.

In the following discussion, it was usually the health visitor who praised, and the client who concurred. A client would praise her baby in connection with the topic under discussion, but rarely out of context. It was the health visitor who could introduce praise inconsequentially.

The baby was praised frequently both during and at the end of an assessment, thus reassuring the mother, and as an indirect compliment to her mothering skills. It acted as a positive reinforcement. Often the client too, was praised, usually in connection with her role as mother, and coping abilities. Praise of the baby could occur as part of an opening sequence, as though praise was part of the social

expectations of the visit. In the following extract, taken from the opening of a visit, it is only after the social niceties of praise have been accomplished that the "real" work of the visit can begin:

HV: *"Now then... He's looking super there actually*
C : *He's doing great*
HV: *Yes, seems to be fine. Lovely.*
And how are you getting on with the mixed diet?"

[V 5:1]

A significant feature was the frequency with which praise was used as a transition to another topic. It was the health visitor who praised, but either client or health visitor could then introduce a new subject. The following passage illustrated both praise and talking to the baby as a ploy before the introduction of a new topic. After a discussion about the baby's routine:

HV: *"Well I mean he certainly looks fine to me, and I think you know, from what you're saying you do know what you should be doing.*
You know, he's a smashing little chap and he looks smashing [to baby] Don't you? You look super. Eh, you really do, you look great, yes. Are you getting many sounds from him, Judy?"

[V 9:19]

They then proceeded to talk about his vocalisations. Praise was also used by the health visitor prior to the introduction of a potentially difficult subject, so that goodwill is demonstrated. For example, in one visit [V 23:1] the health visitor first praised the baby before enquiring about a bruise by asking, "What has he done to his head?", thereby making it clear the lack of suspicion in the question.

In the study by Davis & Strong [1976], doctors used praise of the child to avoid talking to parents, as a way of excluding the adult to concentrate on the child. This only seemed to occur on one visit [V 43], where the health visitor had a hard

time making any contribution because of the number of other contributors [3 adults, 1 toddler, 1 baby, and 1 dog!]. On that visit, the health visitor praised the baby continuously while she was carrying out the developmental assessment, perhaps as a way of demonstrating the competence of herself and the baby.

8.3.6. Pauses

Pauses were very rare in the interaction, as the conversation usually flowed, so when they occurred it was quite significant. Of course, the tapes do not include nonverbal interaction, but the words usually gave clues when other actions were taking place.

Pauses could allow time for thought, as when the health visitor was calculating expected weight gain [V 36:3] but generally one of the participants filled the silence with some contribution, whether introducing another topic, or talking to the baby, so silence was very rare [see Table 13, Chapter 4]. Pauses therefore often occurred before a change of subject.

8.3.7. Recognitions

Like praise, recognitions function as positive social reinforcers in informal interaction [Rosenfeld 1966]. Recognitions demonstrate verbal responsiveness, and can be described as a broad class of brief verbal reinforcers. During these visits, recognitions like "mmm" , "right" or "yeah", were used frequently either to encourage a topic, or agree, or just to show that they were listening.

In the following extract, the health visitor demonstrates her understanding by recognitions:

C : *"Well it is hard to work it out, having a baby.*
HV: *Mmm*
C : *Sometimes I get fed up with it all, 'cause I've got the job, I've got the house, and the work and one day it's just like a mad rush*
HV: *Mmm mmm. It's like your own treadmill.*
C : *It is , yes. I'm going round in circles and I'm still not caught up with myself."*

[V 9:33]

8.3.8. Dealing with rejection

It has been noted [Potter & Wetherell 1987] that people prefer to head off undesirable acts like rejections before they happen. It may be to the speaker's advantage to make a request indirectly because it allows the recipient to reject it without making the rejection obvious [Drew 1984]. There may also be a gender divide, as one study demonstrated that women, in contrast to men, attempt to indicate lack of approval to others by reducing the intensity of their behaviour, but not by changing its direction [Rosenfeld 1966].

The data presented in Chapter 6 about the strategies of advice-giving demonstrates the way health visitors were very aware about the dangers of confrontation, and went to great lengths to avoid it. Usually in advice-giving the advice proffered was done so tentatively, or with a preamble e.g "It is entirely up to you" [V 14]. On the one occasion when a health visitor made the straightforward statement, "I would not put that in his mouth" [V 12], it was because there had been a misunderstanding about a potentially serious matter: the mother was talking about putting medication in the baby's mouth to treat thrush, and the health visitor thought she was speaking about nappy cream.

On one occasion, mentioned earlier in section 8.3.5, when the health visitor was raising a possibly threatening subject of a bruise on a child [V 23], she did so by first praising the child, then asking, "What has he done to his head?" By placing the onus on the child, she was removing possible blame from the mother.

Thus, like the health visitors studied by Chalmers [1994], confrontation was not a common intervention, and only used when other interventions had proven ineffectual or when there was some urgency.

The client, too, even if disagreeing with the health visitor, would avoid confrontation. In this extract about teething, the client disagreed with the advice, but then presented an alternative:

HV: *"Do you give her a cool drink out of the fridge to help with her mouth?*
C : *She doesn't like anything too cold..*
HV: *Often just if their mouth is sore the cold helps numb the gum a bit*
C : *Well that's why I got the teething ring for her*
HV: *It is a really good one that."*

[V 37:5]

In this manner, the client could decline the advice, but honour is kept on both sides, and after seeing the advice was not welcome the health visitor praised the client's choice.

8.3.9. Pursuing a Response

As described by Pomerantz [1984], there may be three reasons why, when a speaker performs an action that solicits a response, it may not succeed. The recipient may not hear the talk or understand it. The speaker may have mistakenly assumed the

recipient had some prior shared knowledge. The recipient may not agree with the speaker's assertion. The speaker may pursue a response by clarifying a problem of understanding, by checking presumed common knowledge, or by changing her position.

During the interaction of the visits, it was usually the health visitor who pursued a response. The following passage occurs after a long discussion about dental health and diet:

HV: *"Did you think about giving her fluoride drops to strengthen her teeth?*
C : *I keep forgetting to ask every time I go to the clinic.*
HV: *Are you needing a bottle?*
C : *Aye. I have never had any.*
HV: *Right*
C : *Everytime I went down it just went clean out of my mind.*
HV: *Right. I am always there on a Wednesday morning clinic so if you are down I will remember when I see you."*

[V 14:15]

On another visit, the client tried to pursue a response about a problem she had in getting her child to eat lumps in savoury food. After a long discussion about how the child would eat lumps in sweet food, and the health visitor's repeated advice to take things slowly and to persevere, the health visitor ignored her repeated complaint by addressing the baby, and then proceeded to discuss his development:

C : *"I think he is just fussy. He just doesn't want to take savoury things.*
HV: *It is just a case of persevering.*
C : *Aye. I do try every now and then*
HV: *[to baby] Come in then. There's a clever boy. Up you come.*
C : *Every time you put it in his mouth he just boaks.*
HV: *[to baby] Are you going to stand up on your feet?*
Come on then"

[V 23:3]

It is therefore the prerogative of the health visitor to pursue a response.

8.3.10 Communication Skills

Under this general heading, can be included the variety of verbal devices catalogued in the social skills literature [Hargie 1986 & etc]. The use of **open questions** to elicit feelings is well documented, and demonstrated under the previous heading of topic initial elicitors. **Reflecting a statement** made by the other participant demonstrates understanding, interest in continuing the discussion, or just a request for further clarification. **Agreement** with the previous speaker can demonstrate positive reinforcement of a course of action, or just show that the listener has heard and understood e.g. when the health visitor during V30 acknowledges the seriousness of a milk allergy by saying, "I take your point." **Summarising** her own words by the health visitor can reinforce previous advice or summarising a client's story can confirm the history and clarify what the main concerns. **Repetition** can demonstrate the strength of feeling involved, as for example when a client returns to a topic such as crying or sleeping, that is a continuing worry. Repetition of a phrase can show agreement and understanding, or encouragement to continue a topic:

HV: "*Do you miss your work?*
C : *Very much.*
HV: *Very much, are you?*
C : *I would love to go back to work, but there is no way I could go back to work.*
HV: *No?*
C : *I have not got anybody to look after her".*

[V 14:26]

Earlier in the same visit, it can also be used as a teaching tool, to repeat advice:

HV: *"By six months she should be wanting to eat lumps.*
C : *Aye*
HV: *You are nearly at the stage where she should be eating lumps*
C : *That's what I was wondering as well. When do I start giving her the lumps?"*

[V 14:3]

Repetition can also be used when a participant has run out of things to say, as, for example, the health visitor during V 30, repeats advice twice, when pressed on a subject she felt she had already covered.

Using a statement to provoke comment was another way of eliciting response from the other participant. In the following extract, the health visitor starts with an open question, then uses a statement to encourage more feedback.

HV: *"How do you feel you get along with the baby yourself?*
C : *Fine. I was expecting, with her being a first baby, I was expecting it to be a lot harder*
HV: *You feel quite relaxed about handling her and bathing her, and feeding her...*
C : *At first I wasn't. First, see, she was awfy wee, now she is wriggly and she can move."*

[V 27:3]

In the last extract, the health visitor summarises her visit, then makes a qualification, which would leave an opening to allow the client to contradict her:

HV: *"But all in all, she comes over to me as a well content, easygoing child. Then I am seeing her at good times..*
C : *She is not too bad, actually. She doesn't cry all that. That's not so bad - the now."*

[V 19:15]

8.3.11 Closings

Schegloff and Sacks [1973], after noting the use of adjacency pairs in openings and closings, went on to describe closing sequences. For the achievement of proper closing, there must be a terminal exchange, and a proper initiation of the closing section.

The closing of each visit is incomplete on the tape, but even so some patterns emerged.

It was a finding of Baldock and Prior [1981], that social workers were not so good at terminating conversations, in comparison with the G.P.'s studied by Byrne and Long [1976] who had very few difficulties.

It was a marked feature of this research that it was generally the health visitor that initiated the closing section, thus signalling that the visit was concluding. For example:

HV : *"Well, will that do us?*
C : *I think so."*

[V 14:32]

Similarly:

HV : *"Well, is there anything that I haven't talked about or you wanted to know about?*
C : *I don't think so*
HV : *OK."*

[V 41:17]

Another way of concluding was by reprising or summarising what had already been said, signalling that the subject was over, or by a final praise of the baby.

There sometimes was a practical reason for finishing e.g. the baby was crying, or had fallen asleep, or had finished a feed. Again it was usually the health visitor who made the first verbal cues to conclude the visit. If the client demurred or raised another subject, the topic was followed until one of the participants [usually the health visitor] initiated the closing sequence again.

Another method is to make arrangements for future contact e.g. "I'll see you at the baby clinic next week", or "the next thing to think about is the baby's second immunisation in 3 weeks". In this instance, there was also the local arrangements of the research e.g. the researcher will be coming to see you tomorrow. On the more rare occasions that the client initiated the closing sequence, it was usually to make queries about the arrangements for the research. For example:

C : *" The girl comes tomorrow*
HV: *Right she will be here in the morning. ...I have to leave you this - it is a little test. [C laughs] No, not really. It is a questionnaire that you have to fill in as soon as possible after I leave.*
C : *I'll fill it in once you're away.*
HV: *And then she will have it off you tomorrow.*
Thank you very much."

[V 18:15]

The health visitor could also use the explanation that she had to be somewhere else: "I'd better go, I've to see another baby," or "I'd better go, I'm supposed to be at the baby clinic".

Because it was usually the health visitor who initiated the sequence, it may be concluded that it was the health visitor who was orchestrating the interaction. Alternatively, this also fits in with "the health visitor as guest" way of thinking, where it would be outside the normal rules of hostess/guest behaviour for a hostess to hurry a guest away.

8.3.12 Client ploys

As already stated, more health visitor ploys than clients' were identified, as three interactions were available for each health visitor. [It must also be acknowledged that there may have been an unconscious bias of the researcher towards an analysis from the professional viewpoint.] This is not to say that health visitors used ploys more often or more skilfully than clients, just that they are more easily identified.

Many of the strategies already discussed were used by clients. Openings were more often used by health visitors at the beginnings of visits, but thereafter equally. The interview findings confirm the evidence from the tapes that the clients felt no constraint in introducing new topics or contributing to the health visitors'. In particular, ploys commonly used by clients included talking to the baby, humour, and recognitions. This last verbal mannerism, characterised by "mm" or "uh-huh", was frequently used to show agreement, or that she was listening.

In "dealing with rejection", the client, like the health visitor, went to some lengths to avoid confrontation or overt disagreement. On one visit, after receiving information that she disagreed with, one client used the "other people" ploy, by saying, "It's funny how people have different ideas about that" [V 30:12], so that she could contradict the health visitor without being too confrontational. Open disagreement was avoided.

One client verbalised in her interview her reaction to the health visitor introducing subjects:

"She just sort of like gives me headings of a topic and if I want to discuss it, I discuss it, and if I don't, I don't. She leaves it like that, and then she'll sort of, like ask me something else. She know she's only like going to get about a line answer from me, and she knows obviously that I don't want to talk about it so she'll just go on to talk about something else, and she generally covers most things that I want."

[C 9:16]

This client [and health visitor], therefore, used failure to respond to indicate when to avoid some topics.

Closings were initiated by clients, too, by referring to future contact.

8.4 PLOYS: CONSCIOUS OR UNCONSCIOUS?

Were client or health visitor aware of some of the strategies employed? From the interview data, some volunteered their awareness of the conscious use of strategies.

From the client point of view, they appeared to feel no constraint about introducing new topics or discussing things other than the baby. They felt the relaxed nature of the home visit allowed freedom to explore.

"A general chat, but things pop up, you wouldn't remember off the top of your head, but through talking it all comes forward."

[C 11:8]

Several health visitors volunteered that this was the atmosphere they attempted to create.

One client was obviously aware of "the talking to the baby" ploy:

"What I've liked is, we can't seem to do anything wrong, you know, it doesn't matter what I've done, if she wants to give a gentle rebuke to me she'll say it to the baby, to Hayley! She'll say, "Hayley, your mother mustn't say you're chubby, she mustn't say that to you, you're just perfect." That's probably a quote from what Isabel said to me, and I think that's really nice, because you feel, whatever you've done, she's not getting at you, she's trying to help you."

[C 45:14]

An interesting contrast of views is the pairing of Alice, HV 3, and Judy, C 9, talking of the same visit. Alice thought Judy had "worked her way round to talking about her problems" and that she, the health visitor, had helped by listening, and by "prompting, try to find out what she wanted to lead her into." Judy had a remarkably similar verdict of the visit:

" I feel that Alice brings it out quite well, she brings it round to you, so that you don't feel you're giving a whole mundane story. She sort of asks you a whole lot of questions...Yesterday I wanted to talk about me and my relationship, although I didn't know how to go about it, and we just seemed to get onto it..."

[C 9:14]

The clients in general are not aware of specifics of the interaction, but remember general impressions.

The researcher reported these findings at two health visitor professional meetings and two teaching sessions to fieldwork teachers, some of whom had participated in the study. The health visitors were not consciously aware of most of the ploys used, but recognised them as familiar once identified. Participating in this sort of feedback gave all concerned the opportunity to test what Schon [1983] has termed "reflection-in-action", whereby competent practitioners may:

"Reflect on the tacit norms and appreciations which underlie a judgement, or on the strategies and theories implicit in a pattern of behavior. He may reflect on the feeling for a situation which has led him to adopt a particular course of action, on the way in which he has framed the problem he is trying to solve, or on the role he has constructed for himself within a larger institutional context."

[page 62]

Further discussion of verbal ploys, in training and practice, will encourage reflective practice and wider knowledge of the complexity of health visitor / client interaction.

8.5 DISCUSSION

In contrast to the findings of Sefi [1985], Robinson [1987], and Kendall [1991], where the health visitor controlled the interaction, the data from this study have shown more elements of "ordinary" conversation. As shown in Table 13 [chapter 4], the gross verbal input of health visitor and clients was not usually one-sided. The health visitor had the larger gross verbal input in 19 of the visits, and the client, in 20 visits.

The present chapter has shown some orchestration by the health visitor in the introduction of topics, but the longer the encounter, the greater the contribution made by clients in the introduction of new topics, and use of pauses, laughter, etc. to direct the conversation. Unlike the findings of Sefi, segmented topic flow was not the dominant mode of topic progression. While sometimes present, especially at the start of a visit, far more common was stepwise progression, so that, in the words of Sacks, the participants ended up "far from wherever they began".

The suggestion was made by Dingwall [1977a] that there may be a "trade-off" whereby parties may take it in turn to discuss issues so that each may raise the topic

of their choice. In these tapes, such orchestration of the interaction was not identified, but from earlier evidence in this study [e.g Table 6 in section 4.3.3 comparing the participants' views about the most important areas discussed], despite differing aims and perspectives both parties felt free to introduce topics and felt satisfied that they had discussed all they had wanted. This implies each participant had carried out their own agenda for the visits, and points to the presence of a "collaborative relationship" as defined by Kasch [1986a]. This author has pointed out that the agendas of both the patient and the nurse must receive an equal hearing, and:

"to establish a collaborative relationship, the nurse must be skilled at interaction management - the ability to start, maintain and regulate conversations in a way that encourages the elicitation and elaboration of the patient's perspective"

[1986a:45].

There is evidence of negotiation within the interaction, as for example, in the extract already quoted in Chapter 6, when with one client with a baby the same age, the health visitor had already recommended cows' milk, but in this instance, she followed the cues from the client and tailored her advice:

HV: *"And what kind of milk is he on?*
C: *Cow and Gate Plus*
HV: *Does he take normal milk during the day?*
C: *I've not tried him yet.*
HV: *You just want to keep him on the baby milk?*
C: *Well, he is quite a windy wee soul as well. I thought it might be best.*
HV: *Leave him till the new year."*

[V 23:5]

In this study, the interaction was in the home setting, between participants who knew each other, and within a relatively long time-scale, which might explain the contrast to the findings of Sefi [1985], and Robinson [1987], about parental

involvement, and confirm the findings of Watson [1981], who noted that the client was more dominant in the longer interactions.

The use of the variety of ploys confirms the findings of Warner [1983], who observed that health visitors used the minimum necessary power to achieve their goals, and demonstrates in action the suggestion of Kendall [1991] that health visitors need to develop the skills of facilitation, negotiation and advocacy to empower clients and make participation a reality.

In conclusion, therefore, conversational analysis of the home visits has shown marked differences from a similar analysis of first [notification] visits by Sefi and Robinson, and shown more similarities with the study by Warner of interaction in baby clinics. As the setting of the present research is in the home, the encounters were longer, and showed more elements of mundane conversation.

8.6 SUMMARY

The findings presented in this chapter have demonstrated the variety of verbal strategies used during the interaction on a routine home visit. Some ploys identified are used by both participants, but the usual guider of the interaction was the health visitor. The categories identified are openings, topic progression, talking to the baby, laughter, praise, pauses, recognitions, dealing with rejection, pursuing a response, communication skills, and closings. While many of these ploys have been previously identified, "talking to the baby" is a new addition to the variety of verbal strategies employed.

The conclusion is that it is the health visitor who holds the balance of power, but only with the consent of the client, and the health visitor goes to great lengths and subtleties in negotiating to obtain and retain that cooperation.

CHAPTER NINE

CONCLUSION

This final chapter continues the theme of the relationship between health visitors and clients through a discussion of partnership with clients, including policy issues such as the health visiting process, parent-held records, and health visitor/client contracts, and concludes with a discussion about power [9.1]. After a reminder concerning the limitations of the study [9.2], the aims of the study are re-examined [9.3], and recommendations arising from this research are listed [9.4]. The thesis concludes by answering one question, are home visits worthwhile, and raising another question for the future, where do we go from here [9.5]?

9.1 PARTNERSHIP WITH CLIENTS

The data from this research must be considered in the light of various policy issues concerning health visiting, the wider world of community nursing, and the National Health Service. Changes and initiatives have occurred in the last ten years which have influenced some of the findings and recommendations in section 9.4. These initiatives have had an impact on practice and have contributed to the argument presented here in defence of home visits, and the proposal to create a health visitor/client contract. The issues considered are the health visiting process, parent-held child health records, the Child Development Programme, and finally the health visitor/client contract.

The data in Chapter 7 presented a picture of lack of agreement about the health visitor's role, the preference of both participants to move towards a closer relationship, and a discussion about power demonstrating that, although the health

visitor is the more powerful participant, she professes a belief in, and preference for, a more equal partnership.

A need for greater partnership with clients has been stressed strongly both in the health visiting literature, and in the wider arena of professional/client relationships. How have these stated beliefs in equality in the relationship been demonstrated in practice? The answer to that question, has to be, variable at best. This was exemplified by the mixed response of the profession to the introduction of the health visiting process.

Health Visiting Process

The health visiting process, or the nursing process as applied to health visiting, was intended to involve the clients in the formulation of their own health care plans. The joint setting and achievement of objectives was intended to contribute to client satisfaction with the service by encouraging client participation in the planning and process of care [Henley 1986]. However, this model failed to achieve universal acceptance, one reason being, perhaps, because of the time-consuming nature of the record-keeping involved. Kendall [1991] found that the health visiting process did not appear to make any appreciable difference to health visiting practice. Many health visitors would argue that the health visiting process has been absorbed into their thinking, rather than their record-keeping, but this would bring the argument around to the beginning again, in asking not just what health visiting has done, but what has it been seen to be doing, about making a sharing of power a reality?

Parent-held Records

One initiative has been the introduction in some areas of a parent-held child health record. For example, Lakhani et al. [1984] published an evaluation of a home based health record booklet devised by the West Lambeth Health Authority. It was used by parents, doctors, and community nurses to build up an independent chronological record of a child's birth statistics, health, growth, immunisations, developmental assessments, and contacts with health services. Among the benefits of the use of such a document were the improvement of communication between professionals, crossing the boundaries of disciplines and authorities, and improving the relationship between parents and professionals. This initiative has been similarly followed in Oxford, Surrey, Newcastle, and elsewhere [Greene & Macfarlane 1985, Owen 1982, Pearson 1985, Saffin 1986], and a consequent improvement in communication has been reported. The most commonly used booklet available commercially was produced in 1979 by the Society of Area Nurses, Child Health [now the Society of Nurse Advisers {Child Health}].

However, these were generally records held by parents in addition to the usual records, instead of replacing them. Medico-legal problems and practical difficulties have prevented a complete conversion to the concept, and technological advances in computerisation may in the future render duplication of records unnecessary, but the move towards parent-held records does demonstrate a willingness among health visitors, general practitioners and others, to share knowledge and power with parents. This early initiative, once thought revolutionary, is now gaining official sanction [Hall, 1989]. A national child health record has recently been launched, to a mixed response [Jackson 1990, Dauncey 1991.] A parent-held record, while a worthy aim in itself, could and should be indicative of a wider move for openness and equality in professional-client relationships.

Health Visitor / Client Contract

A further move in this direction, I suggest, would be the introduction of a health visitor / client contract, similar to those used by social workers in case-work [Reid & Epstein 1977, Reid 1978, Corden & Preston-Shoot 1987].

The majority of health visitors in this study claimed to have explained their role to clients, and some reported giving all their clients a pamphlet entitled "The role of the health visitor", and yet, as reported in Chapter 7, there still exist some misconceptions or conflicting ideas.

In the traditional professional/client relationship there already exists an implied contract, linked to the traditional epistemology of practice, and the behaviour of each party to the interaction is governed by a set of shared norms and expectations [Schon, 1983:292]. A contract implies agreement between parties about a definite course of action, or a certain standard of performance. In the preface to the "Working for Patients" document, "Contracts for Health Services: Operating Contracts" [D.O.H. 1990], the N.H.S. Chief Executive Duncan Nichol was discussing a more formal contract, but the views are as valid when applied to the present proposal. He suggested the following should be taken into account: "how the views of patients can increasingly influence the management and delivery of service at all levels", " how the standard and level of communication with patients and relatives can be improved", and "how clinical effectiveness can be reinforced". A contract between health visitor and client could arguably influence all these factors, and help to fulfil the Government's objectives, as stated in the White Paper "Promoting Better Health" [D.H.S.S. 1987], of making services more responsive to the consumer and of raising standards of care.

What form should this contract take? To return to the views of Schon, about a reflective contract:

"[The client] agrees to join the practitioner in inquiring into the situation for which the client seeks help; to try to understand what he is experiencing and to make that understanding accessible to the practitioner; to confront the practitioner when he does not understand or agree; to test the practitioner's competence by observing his effectiveness ... and to appreciate competence demonstrated. The practitioner agrees to deliver competent performance to the limits of his capacity; to help the client understand the meaning of the professional's advice and the rationale of his actions, while at the same time he tries to learn the meanings his actions have for his client; to make himself readily confrontable by his client; and to reflect on his own tacit understandings when he needs to do so in order to play his part in fulfilling the contract."

[1983:297]

The contract is therefore very much a two-way transaction, with rights and obligations for both contributors. Chalmers [1992] identified giving and receiving in health visitor/client interactions, where the health visitor "gives" her service and, in exchange, the client is expected to "give back" information and interest.

The language of marketing has been well demonstrated in a grounded theory study by de la Cuesta [1994]. From interviews and participant observation of 21 health visitors, she identified two major areas where the health visitors were using marketing techniques: to gain a clientelle and to influence behaviour. Tactics included promoting the service, adjusting delivery, and tailoring the product, all intended to enhance the relevance, accessibility, and acceptability of health visiting. Such tactics could contribute to a dialogue with clients concerning the type of service offered, and be included in the terms of the contract.

In the Standards of Care Project of the Royal College of Nursing [R.C.N. 1989:12], the service to be offered to the client by the health visitor is "discussed by

the health visitor with the client, and is jointly agreed". The client "needs to be aware" of what is available from the service, be given "written information" about the health visitor's function, receive an explanation about the nature and the level of the service available, and the health visitor "incorporates the agreement in the client's written health care plan." In other words, the client is told what is available by the health visitor. Where is the negotiation? It appears to give the client the sole right to accept or refuse, and an outright refusal is very rare in practice. The health visitor remains the arbiter. The desired outcome is that "the client welcomes and is able to use the health visiting services" [page 13]. This may be the case, but surely such criteria only offer the health visitor's perspective, with very little choice or initiative for the client.

Samuel Goldwyn once said, "A verbal contract isn't worth the paper it's written on". Words sometimes do not express the speaker's intentions clearly, or can be misunderstood or forgotten by the hearer. A written contract, while still subject to miscomprehension, could be held by the parent for later consultation, concerning where and how to contact the health visitor, the clinic hours, and the service offered. After discussion, the frequency of desired contact could be decided, and whether this should be home or clinic contact. Both parent and health visitor could therefore have the opportunity to state their preference, and come to a joint decision. In many cases, this is already happening in practice, without the formality of a written contract, but such overt negotiation makes obvious the sharing of power, and gives the client an opportunity to make her own choices.

The vocabulary is less important than the spirit of the discussion. Where the professional might use the terms goal, objective, desired outcome, expected outcome, or target [Kemp and Richardson 1988], a client might talk about hopes, aims, wants,

wishes, purposes, or ambitions [Little and Carnevali 1976]. This contract, discussed here in the context of child health, could of course be adapted for any recipient of the health visiting service.

This contract cannot be said to be an equal one, in that the client can contribute her own opinion of the service offered, but the ultimate borders are defined by the health visitor. The client cannot, for example, receive daily visits at weekends, out of office hours, or express a preference for another health visitor, except in exceptional circumstances. If choice in the health service is to become a reality, the time may have come for health visitors to have more flexible working areas, to allow clients the freedom to choose a particular health visitor.

The government's White Paper, "Working for Patients" [D.O.H. 1989a], attempts to introduce some elements of choice about the services offered by general practitioners'. As Freidson has pointed out [1970], in a situation where isolated professionals in private practice seek to attract and keep enough clients to generate sufficient income, the power of the client is potentially maximised. The professional must be responsive to the client or suffer financially, and the client feels she has a right to be heard. However, in health visiting, as in the other professions employed in the Welfare State, the professional is employed not directly by the client, but by the health authorities.

The demands of clients could also be said to outstrip supply. The contract with clients as envisaged here, could only work where the professional has sufficient time and resources to offer an adequate service to mothers with children under five. Such a contract could be used by health visitors, too, to demonstrate a need to their employers for smaller, or different, caseloads, and demonstrate to clients the extent,

or limits, of their remit. With pressing demands from other health groups, such as the elderly, disabled, and the "well" population, and other ways of working, such as community development, perhaps only health visitors with a specific remit to the under-fives could utilise this way of working. A "contract" system could, however, work wherever the employers, healthe visitors, and clients had agreed the type and frequency of service offered.

One innovative way of working has been devised by the Bristol Child Development Programme [Barker 1984]. Intended to offer support to parents in their child rearing task, it consists of an intensive home visiting programme by a trained health visitor or other professional. Semi-structured visiting strategies and a variety of illustrated materials are used with the aim of empowering parents, and enabling them to develop their parenting skills. The programme has pointed out that professional help has in the past been focussed on averting crises, and overcoming delay and damage, rather than in building up skills. Support without empowerment can lead to ever greater dependence on professional services. Topics discussed during visits include a range of parenting skills such as awareness of preventive health, nutrition, language stimulation, and social, cognitive, and early educational development. Results from the programme have included reduced rates of child abuse and hospitalisation, and improvements in nutritional status and immunisation rates. Fundamental to the programme is the clear equality between visitor and visited, with the parent being the senior partner. The one-to-one relationship, and the home environment, are vital to this equality. There is a written agreement on what the mother is going to attempt in the next month, thus making plans concrete, and the cartoons allow potentially difficult subjects to be raised in a direct, yet non-threatening way. The Child Development Programme now involves 12% of the health authorities in the U.K., but its principles of structured home visiting and

empowerment, could be adapted by any home visiting programme. A written contract with a client could be incorporated within such a programme.

Another new innovation suggested by the Early Childhood Development Unit, Bristol University, has been the creation of the role of "community mothers", a term used to describe local, experienced mothers, who work in partnership with health visitors, and visit first-time parents. Mason [1988], in her work comparing health visitors in Ireland to public health nurses and community health aides in Jamaica, also suggested using "just local mothers" to narrow the gap between health visitors and clients. The introduction of such a role has had a mixed reception [Jackson 1992, Suppiah 1994] but has the advantage of overcoming professional, social and cultural barriers.

The Cumberlege Report [D.H.S.S. 1986] proposed that community nurses should work in a neighbourhood team. This concept, for example, would encompass health visitors and district nurses of differing specialities working together and sharing expertise, in one geographical area. Such teamwork would liberate health visitors from the seemingly endless demands on their time, to a more defined role, with, for example, antenatal women, children under five, and the elderly, who in any case make up the majority of the health visitors' caseload.

The Cumberlege Report has also proposed that a child development learning pack should be available for new parents, to enable them to understand how they can help their child's progress. Sandars and Rees [1987] evaluated an information booklet on the management of minor illness in a randomised controlled trial, and found that overall, maternal knowledge increased, help-seeking intentions decreased, but anxiety levels remained unchanged.

Such health education material, if combined with a parent-held record, as described above, could be used frequently as a source of information for both parent and professional.

What is suggested, therefore, is a parent-held record, with some information about development and minor ailments, which includes a page in which the health visitor and client can mutually agree goals, and make arrangements for their future contact. A copy of this agreement can be retained by both parties. This contract may improve communication, and contribute towards the maintenance of equality in the relationship. The aim would be to improve the quality and responsiveness of the health visiting service.

A further advantage of such a contract would be, that by mutual agreement of goals for their relationship, evaluation can take place, standards can be set, and quality assurance maintained. Quality assurance has been defined as " a system of activities for ensuring the production of a defined service to agreed standards within given resources" [Morgan & Marchment, 1990]. The purpose of quality assurance has been defined by the same authors, as being to achieve agreement between the parties interested in a service about what service should be provided, what is done to ensure that the service will be provided to this specification, and whether or not all this is actually being provided. Copies of health visitor / client contracts might define the service offered, and assist in the evaluation expected in the process of quality assurance.

Another new instrument of assessment has been the introduction of Health Visiting Monitor [Whittaker & Goldstone 1991], which audits the quality of the

service, and also asks the views of clients. This can provide a numerical "score" of quality, but is not yet widely adopted and has the disadvantage of again perhaps reducing a "good" relationship to a checklist of tasks achieved.

Health visitors now provide community or caseload profiles and health needs assessments to define local health need, which can be utilised by locality management teams to be included in comprehensive packages of care. With the new emphasis on selling the service in part created by purchaser/provider agreements, a contract would assist in setting and measuring outcomes, which could be included in such packages and increase their marketability.

Power

Finally, who has the power?

The obvious answer is the health visitor. She has the knowledge and the professional socialisation to impose her own view or definition of the situation on the client, which might effectively inhibit the client from expressing her views or feelings. However, the client is on her own home ground, with a consequent increase in confidence and rights of access. Where the relationship is good, neither participant reported constraints in the interaction, and the content of the visits appeared to substantiate an open and relaxed atmosphere. In less close relationships, instead of conflict, there was avoidance by both participants of potentially threatening situations. Many health visiting "ploys" have been identified that were used to introduce, continue, or return to a topic that might have caused some difficulty. The potential conflicts in the relationship have been avoided by the health visitor appearing to be "open", "friendly" and "approachable" ; qualities that may be seen as the opposite of a formal, "professional" approach.

This raises again the dilemma of answering the question of when does the professional demands of child protection take over from the personal needs of the mother. Child protection entails social control, in that it is essentially about ensuring parents raise their children in a way that conforms to the patterns of childcare approved by society. The rights of the child have to be paramount, in that there must be some professional whose prime role is to protect the rights of vulnerable children, but the argument remains if that professional should be the health visitor, whose role also includes care and support of the whole family.

If this role is to continue, then this research supports Twinn [1991] and Cowley [1991a] in pointing to the need for more training and support for newly qualified health visitors to be prepared in a way that takes account of conflicting paradigms, and the need to develop skills in dealing with dissonance and dissent.

"Choosing" which families will be offered home visits could be termed positive discrimination, or alternatively stigmatisation [Dingwall and Robinson 1993]. It could be argued that the practice of universal home visits to all mothers has to continue if sharing of power with clients is to become more of a reality.

9.2 LIMITATIONS OF THE STUDY

Before reconsidering the aims of the study, and the recommendations arising from it, some points need to be stressed. The data presented arose from a volunteer group of health visitors and their clients. It was not a selected group, but it may not be representative. The number of health visitors was small. The research also was

designed as a cross-sectional representation of the relationship, rather than a longitudinal study, which may present very different data.

The views expressed, and analysis of data, have been circulated to a wider audience through articles and presentations [see Appendices P and Q], and have been received with acceptance and recognition rather than denial, but these reservations have to be borne in mind when considering wider implications.

9.3 AIMS OF THE STUDY

The aims of this study, as described in chapter 3, were to explore the relationship between mother and health visitor through their perceptions of a home visit, describing their views of the same home visit, and exploring their similarity and dissimilarity of perception.

The objectives were to answer the following questions:

1. What is the interaction on a routine home visit by a health visitor to a primiparous client?
2. What are the participants' perceptions of the visit, and how do they compare?
3. What are the clients' and health visitors' perceptions and expectations about their relationship?

Through answering these questions, a fourth is raised:

4. What is the value of home visits?

Have these objectives been met?

The first objective has been met in chapter 8, describing the content of home visits, and to a lesser extent in chapter 6, when discussing strategies of advicegiving. The interaction has been shown to be complex, with both participants employing many verbal ploys to facilitate interaction, introduce new topics, avoid possible conflict, and enable easy social exchange in a relaxed manner.

The second objective has been explored in chapters 4, 5, and 6. The participants' views of the visit have been shown to be remarkably similar, with the professional taking a more critical stance. Clients judge a visit a success if they have discussed all the topics they had wanted to raise. Health visitors judge a visit a success in terms of the client's response, and if they felt they had demonstrated professional competence.

The third objective has been met in chapter 7 and explored further in chapters 8. A good relationship to the health visitors was decided on the basis of client response, but was not necessary to carry out their professional role. To the clients, however, a good relationship was of prime importance, with the personality factors of friendliness and approachability outweighing other considerations. This finding may have implications in the selection process and training for community nursing, where social skills must be an important component.

The fourth question raised in Chapter One, and arising out of the changes in organisation and possible threats to resources, was, "Are home visits worthwhile?" The preceding chapters have demonstrated their value, both to the clients, in terms of openness, time to talk and ask questions in a relaxed atmosphere, and to health visitors, with the opportunity to raise topics in a non-threatening manner, and facilitate easy exchange of information, thereby empowering clients. A home visit is

a situation where the health visitor still has the power of professional knowledge, but the interaction can only take place with the explicit consent of the client, who has her own means of influencing the interaction.

Many of the views stated by the clients concerning personality of the health visitor, and preference of style of advice-giving, have been said before, but the consumer perspective is worth restating to emphasise their importance, and to encourage a wider dissemination of such views, particularly perhaps in health visitor training courses.

This research is unique in contrasting both health visitors' and clients' views about the same interaction. The content of the home visits have been studied to reveal new insights into the interaction by the use of many verbal strategies or "ploys", which enable both participants, who have differing perspectives, aims, and priorities, to achieve an easy social interaction, and be satisfied that their needs have been met.

9.4 RECOMMENDATIONS

Education

1. The evidence from this and much previous research overwhelmingly argues for the importance of good interpersonal skills. The selection process for health visitor students should stress social skills and ability in interpersonal communication.
2. Training should have a large social skills component, including verbal and non-verbal communication. As Pearson [1988] has pointed out, the ability to

form relationships, convey information, and to respond to cues, are all central to the functioning of health visitors who are judged to be "good".

3. Training should include not just the substance of health visiting, but the "How to do it" variety. Fieldwork experience can vary, from the limited to the extensive, and training could include examples of different methods.

   Descriptions can be used of, for example, styles of advice-giving, to demonstrate the varying verbal strategies or ploys that can be used to increase acceptability. This might increase self-awareness of strategies that can be employed to increase acceptability, and contribute to "reflection in action", which is considered essential to professional competence [Schon 1983].

4. The consumer perspective stressed, in the demand for choice, and dislike of authoritarian attitudes.

Practice

1. The pattern of visiting most popular with this group of clients included early contact, antenatally, and frequent visits after the baby was born. This has implications in the current debate about the extended role of the midwife, who may visit for longer periods. The clients also expressed an overwhelming preference for arranged visits.
2. The role of the health visitor is still a matter for some confusion to the clients. This recurring issue needs to be debated within and without the profession, but in practice, the role needs to be explained to the client at the initial contact, and preferably a written description given.
3. If partnership with clients is to become a reality, a concrete expression of this sharing could be parent-held child health records, including a health visitor/client contract.

4. The clients' views in this study stressed personality factors including friendliness and approachability. The health visitor is seen as, and should not be afraid to be, a person first, and a professional second.

Health visiting management

1. Home visits are an expensive use of health visitor's time, but this research has shown them to be popular, valued, and a unique opportunity to empower the client, allowing more equal interaction which would be unlikely in other settings. The practice of universal home visiting is worth defending.
2. If clients are to be given choice, and partnership made a reality, the implication is that this should include some choice of health visitor. This has always presented administrative problems, but opportunities of a more flexible approach could be presented by the adoption of Neighbourhood Nursing teams [D.H.S.S. 1986], jobsharing, or the community development approach to health visiting.
3. Some of the uncertainties expressed by the health visitors concerning the acceptability of their service, and the potentially difficult juggling act of maintaining contact throughout these doubts, requires support, advice, and greater discussion. This might be accomplished most effectively by the facilitation of peer group support.

Future Research

The detailed study of health visitor/client interaction through conversational analysis has revealed many insights into home and clinic interaction, but there remains a wealth of detail remaining to be discovered. This study has concentrated on health visiting strategies. Increasing the self-awareness of the use of these strategies might enable health visitors to maximise their effectiveness in achieving

interactional goals, and a future researcher could examine how this insight might influence practice. The clients' perspective requires further study, including conscious use of verbal strategies to engage in the interaction, and avoid potential disagreement. The nonverbal aspects of interaction in the home also remain a largely unexplored field.

9.5 LOOKING TO THE FUTURE

The introduction of Project 2000 [U.K.C.C. 1986], is altering the emphasis of nurse training from a philosophy of curing sickness to promoting health. The government's N.H.S. policy has moved towards a more proactive health promotion role [DoH, 1992]. In response to some of these challenges, a recent position statement by the H.V.A. [1992] has emphasised the importance of empowering as a form of health promotion, stressing a full, equal partnership between health care professionals and the people they serve. The statement highlighted three key areas:

> "° the primacy of health promotion and prevention is essential
>
> ° the service must be proactive and responsive to identified need
>
> °the views and perceptions of service users are paramount"
>
> [H.V.A. 1992:12]

These are the areas the profession may need to defend in the light of new changes brought about by trust status, a possible purchaser/provider split, the implementation of community care, part of the N.H.S. and Community Care Act [DoH 1989b], and the widening of G.P. fund-holding, to allow G.P.s to contract for community nursing services [N.H.S.M.E.1992]. Skill mix, too, can be viewed by a

defensive profession as threatening their status, while to a manager it might represent the best value for money [Lightfoot 1994]. The anxiety and insecurity these changes have produced have been well documented [Traynor 1993]. Such insecurity may be lessened by a wider debate of the role of the health visitor, both within and without the profession, creating agreed standards and outcomes, and demonstrating these in a concrete form, such as a contract.

The evidence from this study has demonstrated the popularity of the health visitors' services, and some of the skills involved in forming successful professional-client relationships. The present combination of skills and roles practised by one professional is functioning well with evident popularity, and has been effective for many years.

However, the time may have come, with the health visiting profession already facing so many questions, changes, and self-agonising, for a radical re-think about the profession, and to consider the question of separating child protection from family support. By removing the "checking" aspect of the health visitor's role, this would have the consequent gain of rendering a closer relationship possible between two participants, one of whom might previously have considered the other to have a secret agenda. If this aspect is not removed [and it has to be acknowledged that some professional has to casefind and protect vulnerable children] then training has to include overt, rather than covert, techniques, and support and training in possible confrontation.

As discussed in Chapter 7, the health visitors accepted their role as agents of social control in the context of the problem of child abuse. Amidst the present changes among primary health care, when general practitioners' incomes are related

to targeted immunisation rates, health visitors who are members of primary health care teams may come under subtle pressures not only to discuss and inform about immunisation schedules, but also to persuade. This is in conflict with the health visitors' stated views about client autonomy and the right to self-determination.

In another context, if faced by lack of resources to supply adequate community care, health visitors may add a powerful voice to a demand for further action. Is the health visitor an agent of social control, or a client advocate?

This debate continues [Kent 1988, Goodwin 1988, Twinn 1991, Dingwall & Robinson 1993], and will continue to raise similar questions in the future, while the health visitor's remit remains so wide, with conflicting demands from differing individuals and groups. Goodwin, indeed, saw "health visiting trapped to a large extent in the traditional routine home visiting, child-health centred model of practice, with no specific objectives or targets which could allow health visiting outcomes to be monitored" [1988:381]. Countering this argument, Cowley [1989] has written in support of routine preventive care, and against allowing enslavement to "the tyranny of the urgent" [Hammond 1967], when urgent things crowd out the important, and crisis intervention takes over from primary prevention. The introduction of a yearly updated community health profile, based on epidemiological data, could lead to more easily monitored objectives, but also avoid the need to search for unmet health needs. If the community development approach and public health remit of health visitors is expanded [Drennan 1985, Symonds 1993], this may be at the expense of the more traditional home visiting patterns, supported by Appleby [1991] and Barker & Percy [1991], based on client need. The latter authors argue that the role of health visitors with the under-fives is central, as no other worker "has the insights, training and experience to do what health visitors do in the home."It is the most vulnerable in

society who may not seek help, and the health visiting service is the only group who carry out unsolicited visits to all women with children. The evidence presented here supports the universal outreach approach, although there may be a case for continuing intensive home visiting to the younger age groups of babies, and a community development approach for older babies and children, and adult health. Whether the health visitors should be based in primary health care teams or neighbourhood nursing teams, remains an undecided issue [Fatchett 1990].

Wherever the future lies, the evidence from this study has shown the value to both client and health visitor of carrying out routine home visits to all families with young babies, as they are a source of satisfaction and support, and provide through the interaction boundless possibilities for exchange of information and informal health promotion. The client has been shown to have considerable control over the interaction, and the home setting allows empowerment that would be more problematic in other situations.

The health visitor is the only health professional whose role includes home visits to all families, whatever their circumstances.

This study has demonstrated the depth and diversity of an interaction, which was initially described as "routine", but on closer analysis was revealed as one of multi-faceted complexity.

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APPENDIX A.

INTERVIEW SCHEDULE - HEALTH VISITOR

DE_____
TERVIEW DATE_____
TIME_____
LENGTH_____

VISIT DATES_____
TIMES STARTED_____
TIMES FINISHED_____
LENGTHS_____

Thank-you for completing questionnaire. Anonymity assured.

1. How did you go about choosing clients for the study? [What criteria, any refusals]

2. Which visit would you like to talk about - 1, 2, or 3? Why? [How did this visit differ from the other two?]

3. How do you think this client sees the health visitor's role?

4. How would you like her to see your role?

5. You have already stated in the questionnaire what your aims were for this visit. Thinking about your aims, were you satisfied with the visit? [Probe - achieved aims, how, why not]

6. What do you think your client hoped to gain from the visit?
[Probe client goals]

7. How did you meet these needs?

8. Who do you think did more of the talking?

9. You have stated what were the most important areas discussed in the visit. Do you think that the client learnt anything new about her own or her baby's health? [Probe advice given]

10. Do you think she will use this advice?
[Probe - what effect advice will have, was advice helpful, useful, appropriate.]

11. In the last month, what do you think the client's main concerns have been with herself or the baby?

12. What assistance were you able to offer?

13. What single most important thing do you think you've said or done for this client?

14. Do you find this client easy to talk to?
[Probe - relaxed, open, resistant, antagonistic]

15. Have you seen this client as often as you've felt necessary?
[Probe - constraints, easy or difficult to get in touch with]

16. How did you decide how often you saw each other?

17. How did you decide where you saw her, i.e. at home or the clinic?

18. If you had had more time to spend with this client, how would you have used it?

19. Turning to the questionnaire now, I would like to talk about your answers to questions 5, 6, 7, and 8. [Check answer in questionnaire about caseload numbers is number of families, not children]

You found the length of the visit.....
About the areas covered in the visit, you felt.....
About the usefulness of the visit, you felt....
The relationship you felt....

22. I would like to talk about these areas in more detail. Thinking about the visit, was it a successful visit?

23. How do you judge a visit as successful?

24. Can you tell me about a visit to any client that you know was not successful?

25. Thinking about relationships with clients, how do you judge a good relationship?

26. How do you judge a bad relationship?

27. How do you cope when you know you haven't a good relationship with a particular client?

28. Finally, some questions about the tape recorder. Did anything of importance happen before the recorder was switched on, or after it was switched off?

29. How did you feel about using the tape recorder? [Probe- affect interaction]

These were the areas I wanted to talk about. Were there any further areas you wished to discuss?

Thank-you very much for your time.

APPENDIX B

INTERVIEW SCHEDULE - CLIENT

NTERVIEW DATE_____ CODE_____
TIME_____
LENGTH_____ VISIT DATE_____

Thank-you for completing questionnaire. Anonymity assured.

1. Name

2. Baby's name
Baby's date of birth Baby's age.

3. Client's age last birthday

4. Housing private owned
private rented
public sector rented
voluntary sector rented

5. Just to complete your personal details, can you tell me, did you work in the 12 months before the baby was born? YES/NO

6.If yes, what was your job?
[What industry, training or qualifications, number of people supervised, employee or self-employed]
[If no, seeking work, off work due to illness, or student?]

7. Are there other adults in the house? [Who?]

8. [If a partner] What is your partner's employment?

9. Turning to the visit yesterday, I'm going to ask you what you wanted out of the visit, and what you think the H. V. wanted. So, what did you hope to gain from the visit?
[Probe - client's goals, why you wanted her to come]

10. Did the health visitor meet your needs?

11. Why do you think the health visitor wanted to come?
[Probe - health visitor's goals]

12. Do you think the health visitor was satisfied with the visit?

13. Who do you think did more of the talking?

14. What do you think the health visitor's job is?

15. Did you learn anything new from the health visitor

yesterday about your own or your baby's health? [Probe - any advice?]

16. Do you think you will use this advice? [Probe - was advice helpful, useful, appropriate]

17. In the last month, what have your main concerns been with yourself or the baby?

18. Has the health visitor helped? [Probe - did you tell her, was it the right response]

19. What single most important thing has the health visitor said or done for you?

20. Do you find the health visitor easy to talk to? [Probe - relaxed, open, cold, formal]

21. Have you seen her as often as you felt you wanted? [Probe - constraints, easy or difficult to get in touch with]

22. How did you decide how often you saw each other?

23. How did you decide where you saw her, i.e. at home or the clinic?

24. If you had had more time to spend with the health visitor, how would you have used it?

25. Turning to the questionnaire, can you help me to understand why you put these answers to questions 4, 5, 6, and 7.

You found the length of the visit.....
About the areas covered in the visit.....
About the usefulness of the visit you felt....
The relationship you felt.....

26. I would like to talk about these areas in more detail. Thinking about the visit, was it a successful visit for you?

27. Why did you feel that?

28. Have you had any visits that were not successful?

29. Thinking about your relationship, why do you feel your relationship is good/bad [depending on questionnaire answer]

30. Does anybody you know not have a good relationship with their health visitor? [Probe - negative comment]

31. Are there any changes you would like to see in the

health visiting service?

32. As a final question, how did you feel about being tape recorded? [Probe - constraints]

These were the areas I wanted to talk about. Were there any further areas you wished to discuss?

Thank-you very much for your time.

HEALTH VISITOR QUESTIONNAIRE

1. Name: .....

2. Mrs/ Miss/ Ms/ Mr (circle as appropriate)

3. Age: under 35/ 35-50/ over 50 (circle as appropriate)

4. Full-time/ Part-time (circle as appropriate)

5. If part-time, state hours per week: .....

6. Case-load numbers:

   - families with children under school age: .....
   - elderly persons visited (aged over 65): .....
   - other (please specify): .....

7. Is the area where you work (circle as appropriate)

   - mainly urban
   - mainly rural
   - mixture of urban and rural

8. In what year did you qualify as a health visitor: .....

9. How many years have you practised as a health visitor (if part-time, use full-time equivalents): .....

10. What are your professional qualifications: .....

    .....

    .....

Client \ .

1. How long have you known this client: .....

2. How many times have you:

   - visited her at home: .....

   - seen her at clinic: .....

   - seen her elsewhere (please specify): .....

   .....

3. What were your aims in this visit: .....

   .....

   .....

   .....

4. What do you consider the most important areas discussed in the visit: .....

   .....

   .....

   .....

Please put a cross (x) at the point on the line which best represents how you feel about the following:

5. I felt that this visit lasted too long.

   agree strongly _____ disagree strongly

6. During the visit we talked about all areas I thought were important.

   agree strongly _____ disagree strongly

7. I did not find this visit useful at all.

   agree strongly _____ disagree strongly

8. I feel that my relationship with this client is very good.

   agree strongly _____ disagree strongly

9. You may wish to record here areas you wish to discuss further: .....

   .....

   .....

   .....

I look forward to discussing some of these issues with you at our interview.

Client 2.

1. How long have you known this client: .....

2. How many times have you:

   - visited her at home: .....

   - seen her at clinic: .....

   - seen her elsewhere (please specify): .....

   .....

3. What were your aims in this visit: .....

   .....

   .....

   .....

4. What do you consider the most important areas discussed in the visit: .....

   .....

   .....

   .....

Please put a cross (x) at the point on the line which best represents how you feel about the following:

5. I felt that this visit lasted too long.

   agree strongly _____ disagree strongly

6. During the visit we talked about all areas I thought were important.

   agree strongly _____ disagree strongly

7. I did not find this visit useful at all.

   agree strongly _____ disagree strongly

8. I feel that my relationship with this client is very good.

   agree strongly _____ disagree strongly

9. You may wish to record here areas you wish to discuss further: .....

   .....

   .....

   .....

I look forward to discussing some of these issues with you at our interview.

Client 3.

1. How long have you known this client: .....

2. How many times have you:

   - visited her at home: .....

   - seen her at clinic: .....

   - seen her elsewhere (please specify): .....

   .....

3. What were your aims in this visit: .....

   .....

   .....

   .....

4. What do you consider the most important areas discussed in the visit: .....

   .....

   .....

   .....

Please put a cross (x) at the point on the line which best represents how you feel about the following:

5. I felt that this visit lasted too long.

   agree strongly _____ disagree strongly

6. During the visit we talked about all areas I thought were important.

   agree strongly _____ disagree strongly

7. I did not find this visit useful at all.

   agree strongly _____ disagree strongly

8. I feel that my relationship with this client is very good.

   agree strongly _____ disagree strongly

9. You may wish to record here areas you wish to discuss further: .....

   .....

   .....

   .....

I look forward to discussing some of these issues with you at our interview.

QUESTIONNAIRE - CLIENT

1. Name: .....

2. Mrs/ Miss/ Ms (please circle as appropriate)

3. I am very interested in your views about the visit. What do you feel were the most important areas discussed in the visit: .....

.....

.....

.....

Please put a cross (x) at the point on the line which best represents how you feel about the following:

4. I feel that this visit lasted too long.

agree strongly _____ disagree strongly

5. During the visit we talked about all areas I thought were important.

agree strongly _____ disagree strongly

6. I did not find this visit useful at all.

agree strongly _____ disagree strongly

7. I feel that my relationship with the health visitor is very good.

agree strongly _____ disagree strongly

8. You may wish to note down here areas you wish to discuss further: .....

.....

.....

.....

.....

.....

Thank you for your cooperation and I look forward to talking to you at our interview.

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INFORMATION FOR HEALTH VISITORS

HOME VISIT RESEARCH PROJECT

RESEARCHER: MS SHONA CAMERON, BA, SRN, SCM, HV.

I am a nursing research training fellow, based at University of Edinburgh, undertaking a project looking at home visits by health visitors.

THE STUDY

The aims of the study are to explore the interaction between the health visitor and first-time mother, and to describe the expectations and needs of mothers, and how the health visitor meets these needs. The methods are to tape record the visit, and subsequently to interview both participants about their views.

First-time mothers, with a baby aged 2-6 months, have been chosen as the client group, as the health visitor will already have formed a relationship with the mother in the first two months, and also will still be seeing her frequently.

WHAT IS INVOLVED

I would like your help first in selecting clients and enlisting their participation, secondly in tape recording a home visit, and finally in agreeing to be interviewed afterwards.

If you volunteer for the study, I will ask you to choose an age group between 2-6 months at which you would prefer to carry out the routine home visit. I will ask you to approach the first 3 primiparous clients with babies of

an appropriate age, supply them with the printed information, and request their participation. (You may wish not to approach a particular client for ethical or practical reasons. Suggested criteria for exclusion from the study are listed later.)

If a client prefers not to participate, I would ask you to approach the primiparous mother whose baby appears next in the birth book. If the clients agree to participate, I would ask you to request the mothers to sign the consent form.

After this agreement, the visit can be arranged with the mother at a time convenient to you both.

If you agree to take part, I shall supply details about the data collection and use of the tape recorder.

As I shall be interviewing you after your third home visit, I would ask you to complete a short (10 minute) questionnaire after each visit, so that at the interview we can discuss more general issues. I expect our interview to last about 30-45 minutes. If possible, I would like to tape record our interview, as I would prefer to spend the time listening rather than writing.

I hope to interview your client the day after your visit, talking about the same general themes.

ETHICAL CONSIDERATIONS

Criteria to exclude clients from the study are:

1. any family you wish to exclude for professional reasons
2. any family where there is a major medical problem
3. any family where the mother is under 16 and over 40
4. any family where there is an existing communication problem (e.g., ethnic minorities)
5. any family where the main childcarer is not the mother
6. any family where there has been a change of health visitor since the baby's birth.

Both health visitor and client can of course decide to withdraw from the study at any time.

All information received will be treated in the strictest confidence. Pseudonyms will be used in any report or publication, and conversation will not be used in a form which can be attributed to an individual.

Given the heavy health visitor workload, I appreciate the extent of the cooperation I am requesting. Due to the anonymity required, the only personal thanks I can offer is an individual profile for you from each visit. I hope the proposed study will contribute towards a description of the knowledge of the needs of the new mother from the health visiting service, and its implications for health visiting.

If you have any queries, or wish to discuss this further, I would be very happy to do so. I can be contacted at the above address.

If you are willing to participate, please sign the enclosed form and return it to me. Thank you for your cooperation.

Shona Cameron.

DATA COLLECTION

First, if you have any queries at all, I would be very pleased to talk with you in further detail.

I can be contacted:

- BY MAIL: Nursing Research Unit, 12 Buccleuch Place, Edinburgh, EH8 9JT
- BY PHONE: at Nursing Research Unit, 031-667 1011 ext 6770 (if no reply, messages can be left 9-12.30 **only** at ext 6836) or at home (~~evenings only~~) 031-332 8406.

Tape Recorder

This model, Sony TCM 11, is the "one-touch" type of recorder - just press the red button! If the tape does not turn, it could be that the orange "Pause" button has inadvertently been slipped on, i.e., to the left. It should be pushed to the right. The batteries are new, but if you have any problems and wish to replace them, I would gladly refund the cost.

The Visit

As I would wish to interview you both the day after the visit, could the visit be arranged to take place Monday to Thursday? If this were not possible, naturally I would fit in with your arrangements.

During the visit, the tape recorder should be placed in a central position between you, the optimum distance being about 3 - 4 feet. It would be of great assistance to me if the T.V. or radio could be switched off!

If at any time the client wishes the tape recorder to be switched off, then of course the tape should be stopped and the client withdrawn from the study. I would then ask you to approach the primiparous mother whose baby appears next in the birth book, to request her participation.

A new cassette tape should be used for each visit. Each side lasts 45 minutes. If the visit lasts longer than that, just turn over the tape.

When you complete your visit, please leave the questionnaire with the client and request her to complete it as soon as possible (preferably as soon as you leave!). I would also ask you to do the same with your questionnaire, as it is intended to gain your immediate impressions.

Our Interview

At our interview, although I have a list of things I want to ask you, I am very anxious that you have an opportunity to say all that you want to say, so do bring into the discussion anything you think is important.

I shall be asking general questions about your relationship with this client, and specific questions about the visit. You may find it convenient to have the client's records with you, in case you want to look at them.

I hope to interview you for about 30 - 45 minutes, somewhere fairly quiet and free from interruption. Would your place of work be suitable? Or can you suggest somewhere else? We can finalise arrangements over the phone.

Again, I would like to stress that if you have any questions or comments, I would be very happy to hear from you.

Thank you once again for your time and cooperation.

Shona Cameron

STEP BY STEP CHECKLIST

1. Read guidelines.

2. Select three clients.

3. Explain research, give "Information for Clients" sheet, and request their participation.

4. Request clients to sign consent form.

5. Sign your own consent form.

6. Return H.V. consent form and the three client consent forms to me in the envelope.

7. Arrange home visits.

8. Inform me of dates so that our interviews can be arranged. (You may wish to combine steps 6 and 8).

9. Tape record home visit. Please log the time you arrive and the time you leave. Start the tape by stating the date and time.

10. On completion of the visit, leave behind client questionnaire, and ask client to complete it as soon as possible.

11. Complete your own health visitor questionnaire as soon as possible after the visit.

12. Return cassette tape(s) of visit(s) to me at our interview.

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INFORMATION FOR CLIENTS

HOME VISIT RESEARCH PROJECT

RESEARCHER: MS SHONA CAMERON

I am a nurse researcher, based at the University of Edinburgh.

I am very interested in looking at home visiting by health visitors to women who are mothers for the first time, and how you both feel about the visit.

There is not much known about the home visits made by health visitors, or mothers' views of the visits, and we are hoping the results will help to improve the health visiting services for mothers.

WHAT IS INVOLVED

I am asking your health visitor to tape record a routine home visit. After this visit, your health visitor will leave you a very short questionnaire to fill in about your immediate impressions about the visit. I shall come to visit you, usually on the following day at an agreed time, to talk to you about your views and feelings about the visit and the health visiting service. I shall be asking your health visitor the same questions. Other than the recording of this visit, you will receive the usual health visiting service.

If possible, I would like to tape record our interview, as I would prefer to spend the time listening rather than writing.

I expect our interview to last about 45 minutes.

All information will be treated in the strictest confidence. Your name will not be used in any way, nor will your health visitor or anyone else be able to connect your name with anything you have said.

You may withdraw from the study at any time, and if you prefer not to participate, you will of course receive the normal health visiting service.

This research will, I hope, make a contribution to the future education of health visitors, and so help them with their work with mothers.

If you have any questions, I can be contacted at the above address, and would be happy to talk to you.

If you are willing to participate, please sign the enclosed form, and return it to your health visitor.

I look forward to meeting you!

Shona Cameron

UNIVERSITY OF EDINBURGH
Department of Nursing Studies
Adam Ferguson Building
40 George Square
Edinburgh EH8 9LL

Nursing Research Unit
12 Buccleuch Place
Edinburgh EH8 9JT

telex 727442
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Head of Department
Professor Penny Prophit
BSN, MSN, DNSc, PhD, RN

Director of Nursing Research Unit
Dr. Alison Tierney
BSc(SocSc)/Nurs, PhD, RGN

Correspondence to:

12 Buccleuch Place

CONSENT FORM - HEALTH VISITOR

HOME VISIT RESEARCH PROJECT

RESEARCHER: MS SHONA CAMERON, BA, SRN, SCM, HV.

This research project has been explained to me.

I understand that I am being asked to participate in research which will involve me tape recording three routine home visits to clients with young babies, and subsequently being interviewed.

I understand that the information will be collected but that my identity will not be made known.

I give my consent to take part in this project.

SIGNED: .....

NAME (Capitals): .....

DATE: .....

WORKBASE: .....

WORK TELEPHONE NUMBER: .....

UNIVERSITY OF EDINBURGH
Department of Nursing Studies
Adam Ferguson Building
40 George Square
Edinburgh EH8 9LL

Nursing Research Unit
12 Buccleuch Place
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Dr. Alison Tierney
BSc(SocSc)/Nurs, PhD, RGN

Correspondence to:
12 Buccleuch Place

CONSENT FORM - CLIENT

HOME VISIT RESEARCH PROJECT

RESEARCHER: MS SHONA CAMERON

This research project has been explained to me. I am willing to allow the tape recording of a home visit by the health visitor. I agree to a subsequent interview.

I understand that the information will be collected but that my identity will not be made known.

I understand that I may withdraw at any time, and this will not affect the normal service from the health visitor.

I give my consent to take part in this project.

SIGNED: .....

NAME: (CAPITALS): .....

DATE: .....

ADDRESS: .....

TELEPHONE NUMBER: .....

G.P.: .....

G.P.'s: ADDRESS & PHONE No.: .....

.....

UNIVERSITY OF EDINBURGH
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Head of Department
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Director of Nursing Research Unit
Dr. Allson Tierney
BSc(SocSc)/Nurs, PhD, RGN

Correspondence to:
12 Buccleuch Place

Re: _____

_____

Dear Dr

I am a nursing research training fellow, based at the Nursing Research Unit, Department of Nursing Studies, University of Edinburgh.

I am writing to inform you that the above-named patient has given her consent to participate in a research project on home visits by health visitors. This will involve your patient consenting to the tape recording of one routine home visit made by her health visitor, and subsequently agreeing to be interviewed about her views on the visit.

This study has been approved by the General Practice/Community Medicine Ethics of Medical Research Sub-Committee of Lothian Health Board.

If you have any queries about this research, I can be contacted at the above address.

Yours sincerely

(Ms) SHONA CAMERON, BA, SRN, SCM, HV.

APPENDIX K Table 1:I felt that this visit lasted too long.

agree strongly = 100 disagree strongly = 0

[i.e. the higher the score, the more negative the view]

	HV	CLIENT	[DIFFERENCE IN SCORES]
V1	76	0	[76]
V2	42	11	[31]
V3	8	0	[8]
V4	58	2	[56]
V5	56	0	[56]
V6	56	1	[55]
V7	7	1	[6]
V8	4	3	[1]
V9	0	1	[-1]
V10	25	9	[16]
V11	83	0	[83]
V12	12	0	[12]
V13	66	0	[66]
V14	0	22	[-22]
V15	68	15	[53]
V16	63	57	[6]
V17	56	1	[55]
V18	34	0	[34]
V19	0	0	[0]
V20	2	2	[0]
V21	1	0	[1]
V22	22	25	[-3]
V23	6	0	[6]
V24	20	3	[17]
V25	10	59	[-49]
V26	25	8	[17]
V27	52	1	[51]
V28	6	3	[3]
V29	3	14	[-11]
V30	100	2	[98]
V31	0	21	[-21]
V32	80	0	[80]
V33	16	2	[14]
V34	62	0	[62]
V35	10	0	[10]
V36	12	4	[8]
V37	17	0	[17]
V38	22	2	[20]
V39	4	1	[3]
V40	49	23	[26]
V41	4	30	[-26]
V42	14	0	[14]
V43	69	7	[62]
V44	3	0	[3]
V45	59	1	[58]

Table 2: During the visit we talked about all areas I thought were important

agree strongly = 0 disagree strongly = 100

[i.e. the higher the score, the more negative the view]

	HV	CLIENT	[DIFFERENCE IN SCORES]
V1	5	0	[5]
V2	23	2	[21]
V3	8	0	[8]
V4	14	1	[13]
V5	28	0	[28]
V6	34	3	[31]
V7	11	1	[10]
V8	28	2	[26]
V9	18	2	[16]
V10	16	5	[11]
V11	17	0	[17]
V12	12	0	[12]
V13	10	0	[10]
V14	4	26	[-22]
V15	18	27	[-9]
V16	31	0	[31]
V17	28	1	[27]
V18	19	2	[17]
V19	23	0	[23]
V20	38	1	[37]
V21	14	0	[14]
V22	10	13	[-3]
V23	15	0	[15]
V24	10	1	[9]
V25	16	6	[10]
V26	6	7	[-1]
V27	21	3	[18]
V28	19	2	[17]
V29	1	11	[-10]
V30	1	3	[-2]
V31	0	4	[-4]
V32	9	1	[8]
V33	7	25	[-18]
V34	9	0	[9]
V35	10	0	[10]
V36	9	1	[8]
V37	49	0	[49]
V38	31	3	[28]
V39	18	1	[17]
V40	16	4	[12]
V41	5	11	[-6]
V42	9	0	[9]
V43	85	2	[83]
V44	12	0	[12]
V45	44	2	[42]

Table 3: I did not find this visit useful at all

agree strongly = 100 disagree strongly = 0

[i.e. the higher the score, the more negative the view]

	HV	CLIENT	[DIFFERENCE IN SCORES]
V1	10	0	[10]
V2	6	89	[-83]
V3	8	56	[-48]
V4	5	2	[3]
V5	9	0	[9]
V6	8	61	[-53]
V7	0	1	[-1]
V8	1	3	[-2]
V9	0	2	[-2]
V10	21	0	[21]
V11	23	0	[23]
V12	10	0	[10]
V13	15	0	[15]
V14	0	9	[-9]
V15	83	11	[72]
V16	5	0	[5]
V17	10	1	[9]
V18	5	0	[5]
V19	1	0	[1]
V20	2	3	[-1]
V21	4	0	[4]
V22	4	10	[-6]
V23	30	0	[30]
V24	17	4	[13]
V25	33	57	[-24]
V26	12	21	[-9]
V27	36	2	[34]
V28	3	4	[-1]
V29	3	2	[1]
V30	1	2	[-1]
V31	0	5	[-5]
V32	5	0	[5]
V33	1	1	[0]
V34	13	0	[13]
V35	12	0	[12]
V36	8	5	[3]
V37	4	0	[4]
V38	3	3	[0]
V39	3	4	[-1]
V40	35	2	[33]
V41	4	0	[4]
V42	24	0	[24]
V43	31	4	[27]
V44	6	0	[6]
V45	84	0	[84]

Table 4: I feel that my relationship with this client/HV is very good

agree strongly = 0 disagree strongly = 100

[i.e. the higher the score, the more negative the view]

	HV	CLIENT	[DIFFERENCE IN SCORES]
V1	7	0	[7]
V2	62	8	[54]
V3	50	43	[7]
V4	13	1	[12]
V5	26	0	[26]
V6	55	4	[51]
V7	20	2	[18]
V8	3	2	[1]
V9	25	3	[22]
V10	25	3	[22]
V11	21	0	[21]
V12	28	6	[22]
V13	10	0	[10]
V14	38	34	[4]
V15	49	7	[42]
V16	32	0	[32]
V17	27	0	[27]
V18	23	2	[21]
V19	1	0	[1]
V20	4	3	[1]
V21	4	0	[4]
V22	12	20	[-8]
V23	27	15	[12]
V24	17	1	[16]
V25	48	75	[-27]
V26	20	2	[18]
V27	65	4	[61]
V28	15	2	[13]
V29	3	26	[-23]
V30	1	2	[-1]
V31	0	3	[-3]
V32	19	1	[18]
V33	8	19	[-11]
V34	22	0	[22]
V35	56	4	[52]
V36	19	2	[17]
V37	4	0	[4]
V38	17	5	[12]
V39	23	2	[21]
V40	37	8	[29]
V41	49	26	[23]
V42	40	0	[40]
V43	38	2	[36]
V44	37	0	[37]
V45	41	1	[40]

APPENDIX L

CHI-SQUARE TABLES

The visual analogue scale results were examined using the chi-square test. Two-by-two tables were constructed, noting the number of health visitors and clients who had scored over 50, or 50 and under. The same test was repeated for those scoring over 20, or 20 and under.

1. Length of visit

	over 50	50 and under
HV	15	30
CLIENT	2	43

df = 1, Yates corrected = 10.44, p = 0.0012310.

	over 20	20 and under
HV	23	22
CLIENT	7	38

df = 1, Yates corrected = 11.25, p = 0.0007962.

2. Most important areas discussed.

	over 50	50 and under
HV	1	44
CLIENT	0	45

df = 1, Yates corrected = 0, p = 1.00. Not significant.

	over 20	20 and under
HV	13	32
CLIENT	3	42

df = 1, Yates corrected = 6.16, p = 0.0130886.

3. Usefulness of the visit.

	over 50	50 and under
HV	2	40
CLIENT	4	41

df = 1, Yates corrected = 0.18, p = 0.6726038. Not significant.

	over 20	20 and under
HV	10	35
CLIENT	5	40

df = 1, Yates corrected = 1.28, p = 0.257890. Not significant.

4. Strength of the relationship.

	over 50	50 and under
HV	5	40
CLIENT	1	44

df = 1, Yates corrected = 1.61, p = 0.20. Not significant.

	over 20	20 and under
HV	10	35
CLIENT	5	40

df = 1, Yates corrected = 19.14, p = 0.0000122.

5. Correctness of replies to the question, "Who did more of the talking?"

	Correct	Incorrect
CLIENT	7	6
HV	8	5

df = 1, Yates corrected = 0, p = 1.00. Not significant.

APPENDIX M

Table 18 : Summary

Visit	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	76	5	10	7	0	0	0	0	4	31	3	4	5	8	1	2	1	1	1	0
2	42	23	6	62	11	2	89	8	2	27	3	5	6	14	1	1	0	.	.	.
3	8	8	8	50	0	0	56	43	3	29	3	5	6	16	1	1	0	.	.	.
4	58	14	5	13	2	1	2	1	3	27	3	6	4	11	1	1	2	.	.	.
5	56	28	9	26	0	0	0	0	3	24	3	5	7	9	2	2	1	0	2	0
6	56	34	8	55	1	3	61	4	5	27	3	6	4	11	2	0	1	.	.	.
7	7	11	0	20	1	1	1	2	4	22	1	3	5	13	1	2	2	.	.	.
8	4	28	1	3	3	2	3	2	2	27	1	2	6	14	1	1	0	.	.	.
9	0	18	0	25	1	2	2	3	5	25	1	7	11	18	1	2	1	1	1	1
10	25	16	21	25	9	5	0	3	3	21	1	4	4	7	2	2	1	.	.	.
11	83	17	23	21	0	0	0	0	2	20	1	4	6	7	2	0	3	.	.	.
12	12	12	10	28	0	0	0	6	5	22	1	3	2	5	2	2	2	0	1	1
13	66	10	15	10	0	0	0	0	4	29	2	5	4	10	2	2	2	.	.	.
14	0	4	0	38	22	26	9	34	4	22	2	5	3	7	1	0	1	0	1	0
15	68	18	83	49	15	27	11	7	3	23	2	4	3	8	2	1	0	.	.	.
16	63	31	5	32	57	0	0	0	2	29	1	5	5	8	2	1	1	.	.	.
17	56	28	10	27	1	1	1	0	3	17	1	4	3	4	2	0	0	.	.	.
18	34	19	5	23	0	2	0	2	2	20	1	4	3	7	1	1	1	1	1	0
19	0	23	1	1	0	0	0	0	3	28	2	4	4	8	1	1	1	1	1	0
20	2	38	2	4	2	1	3	3	3	32	2	9	4	19	2	1	1	.	.	.
21	1	14	4	4	0	0	0	0	3	27	2	7	2	5	1	0	1	.	.	.
22	22	10	4	12	25	13	10	20	3	30	2	8	5	13	1	1	1	.	.	.
23	6	15	30	27	0	0	0	15	3	26	2	8	6	14	2	0	1	1	0	1
24	20	10	17	17	3	1	4	1	2	31	2	3	4	10	2	2	2	.	.	.
25	10	16	33	48	59	6	57	75	4	28	2	3	6	16	2	1	0	.	.	.
26	25	6	12	20	8	7	21	2	2	30	2	2	4	12	2	0	1	.	.	.
27	52	21	36	65	1	3	2	4	3	32	2	2	3	9	2	0	1	1	1	0
28	6	19	3	15	3	2	4	2	3	28	3	6	6	20	1	1	2	.	.	.
29	3	1	3	3	14	11	2	26	3	31	3	6	3	10	1	0	1	.	.	.
30	100	1	1	1	2	3	2	2	3	25	3	8	7	26	1	0	2	0	0	1
31	0	0	0	0	21	4	5	3	3	21	2	2	6	13	0	0	1	1	0	1
32	80	9	5	19	0	1	0	1	5	25	2	3	4	10	0	3	1	.	.	.
33	16	7	1	8	2	25	1	19	3	25	2	3	3	6	0	2	2	.	.	.
34	62	9	13	22	0	0	0	0	2	24	1	4	6	17	1	1	1	.	.	.
35	10	10	12	56	0	0	0	4	2	17	1	6	3	7	1	0	2	.	.	.
36	12	9	8	19	4	1	5	2	5	19	1	4	4	6	1	1	0	0	1	0
37	17	49	4	4	0	0	0	0	3	36	1	5	9	16	2	2	2	.	.	.
38	22	31	3	17	2	3	3	5	3	22	1	4	7	15	0	1	2	.	.	.
39	4	18	3	23	1	1	4	2	3	20	1	9	8	23	0	1	1	1	0	0
40	49	16	35	37	23	4	2	8	2	28	2	36	3	9	2	1	2	.	.	.
41	4	5	4	49	30	11	0	26	2	29	2	2	2	9	2	1	2	0	0	0
42	14	9	24	40	0	0	0	0	5	21	2	4	4	11	1	1	3	.	.	.
43	69	85	31	38	7	2	4	2	5	24	2	6	6	33	2	1	0	1	0	0
44	3	12	6	37	0	0	0	0	3	16	2	4	5	10	0	0	1	.	.	.
45	59	44	84	41	1	2	0	1	2	29	2	5	4	14	2	1	1	.	.	.

KEY TO TABLE 18:

Column 1: Visual analogue scale: length of visit - *health visitor*

Column 2: Visual analogue scale: most important areas discussed - *health visitor*

Column 3: Visual analogue scale: usefulness of visit - *health visitor*

Column 4: Visual analogue scale: relationship good - *health visitor*

Column 5: Visual analogue scale: length of visit - *client*

Column 6: Visual analogue scale: most important areas discussed - *client*

Column 7: Visual analogue scale: usefulness of visit - *client*

Column 8: Visual analogue scale: relationship good - *client*

Column 9: Client social classification [social class I = 1,
II = 2, IIIN = 3, IIIM = 4, IV = 5, V = 6.]

Column 10: Age of client in years

Column 11: Age of health visitor: 1 <35, 2 = 35-50, 3 over 50

Column 12: Length of time health visitor had known client [in months]

Column 13: Number of home visits [Table 5]

Column 14: Total number of contacts [Table 5]

Column 15: Proportional verbal input [Table 13]
Data unavailable = 0
Health visitor greater verbal input = 1
Client greater verbal input = 2

Column 16: Comparison of views: most important areas discussed Number of topics listed by both health visitor and client.[Data from Table 6]

Column 17: Comparison of views: aims for the visit / number of topics listed by both health visitor and client.[Data from Table 8]

Column 18: Comparison of views: most important thing health visitor said or did for client [Data from Table 14]. / number of topics listed by both health visitor and client.

Column 19: Comparison of views: anything new learned during the visit [Data from Table 16]. Number of topics listed by both health visitor and client.

Column 20: Comparison of views: the client's main concerns [Data from Table 17] Number of topics listed by both health visitor and client.

APPENDIX N

CONVERSATIONAL ANALYSIS TRANSCRIPT NOTATION

The number at the conclusion of an extract identifies the visit, and page number of transcript, e.g. V14:30, is from the visit paid to client 14, on page 30 of the transcript.

The transcript notation demonstrated here is based on that first described by Schegloff and Sacks 1973, and Sacks et al. 1974, developed by Gail Jefferson, and listed in Atkinson and Heritage [1984].

GLOSSARY

[[	talk starting simultaneously
[	start of overlapping talk
]	overlapping talk ends
=	no gap in talk
(1.4)	silence, timed in tenths of a second. This is a gap in talk of one and four tenth seconds
(.)	a pause too short to be measured.
:	Word indicates emphasis; wo:rd indicates a lengthening of the sound or syllable it follows.
::	More colons, wo::rd, prolongs the stretch.
	Other punctuation indicates intonation, rather than grammar.
.	a stopping fall in tone
,	continuing intonation

?	a rising inflection
!	an animated tone
-	a halting, abrupt cutoff, or stuttering talk
^	an upward arrow indicates rising pitch, a downwards arrow indicates falling pitch.
<>	words between degree signs are spoken more quietly >word< talk delivered at a quicker pace
hhh	aspiration
.hhh	inhalation
( )	the transcriber is unable to hear what is said
(word)	transcriber is in doubt
((word))	transcriber comment

Extract from visit 14:

C : she is aw:fully alert.

HV: uh-huh?

[[

C : Every house that I take her in she's (0.3) her eyes are ev:erywhere, every corner of the house! she is aw:fully alert.

HV: And now when she is 8 or 9 months she will be craw:ling about everywhere, getting into a:ll your things.

C: = That's the bit I cannae wait for. [[laughter]] HV: And peek-a-boo? Even at 6 months peek-a-boo.

C : Aye

[[

HV: They love it. [[laughter]]

C: She loves her bath now, she loves that (0.5)
Splashes away.

HV: Does she?

C: = Oh aye. She has always liked a ba:th. She's never been feart of the wa:ter. (0.8) I may start at the swimming pool with her.

HV: Whi:ch pool do you go to?

C: I don't even know where they are.

HV: There is one at the school

C : Aye, that's right

[[

HV: and about 5 miles away there is a lovely baby pool.

C: = I have been there about (1.4) 5 years ago. I was there like, and I noticed they had a baby swimming swimming pool then

HV: = Yeah, it's really nice

C : I'd like to, (.) is there an:ywhere (0.8) eh, that you could go (0.6) I would love to start swimming myself like.

HV: uh-huh

C : = Is there anywhere that there's, what do you call it, a creche?

HV: mm

[[

C : That they could look after babies while you're in the swimming baths

HV: = Well, the sports centre has a creche and you could join the classes.

C : mm

HV: = Do you get the local free paper?

C : Aye

HV: Have a look there and see what it says about the pool because they may well have creches for certain times of the day.

C: I want to start doing something.

[

HV: The other sports centre has got a creche but you ca:n't swim there. And there is different things on there which might attract you.

C : mm

HV: = It is a good thing, that you get something to do as well, doesn't it?

C : Aye

HV: = Get the balance right (0.8)

C: I used to go swimming a lot like.

[

HV: Did you?

C: Mm..(0.4) I haven't the time now.

HV: We::ll I think you have to be a bit selfish at times, take an hour or two for yourse:lf, it is not too much to as:k is it not? You know? (.) I think women are absolutely ho:peless taking a bit of time for themse:lves, they are martyrs to the family and cooking and housework.

C: = That's true.

HV: Yeah. When you think what you used to do before the baby came along.

C : I know:

[[

HV: Suddenly you get all domesticated and..(.)

C: You have got this to do, you have got that to do.

[

HV: I know.What's an hou:r to yourself in 24? (0.2) It is not much, is it not? Just an hour for yourself in 24 hours, an hour out of 24.

C: An hou:r? It's no' much [[C laughs]]

HV: = I know, but you are saying, I can't do that, because I haven't got the time. But you shou:ld have the time, shouldn't you?

C: I have no' rea:lly, believe it or not. [[laughs]]

HV: = I know, but you could. Just imagine it

[[

C: I cou:ld if I wanted it, if I just left everything el:se like.

HV: uh-huh...(1.2) But the centre is quite near and it has a creche hasn't it? Have a loo:k and see what's on there. >Maybe it tells you in the paper< And then you could pop in. There's a nice li:brary, and soon she could be introduced to little groups you know.

C: Mm. (0.7) I'll have a look.
[V14:30]

Clients' Perception of

With the growth of the consumer movement, there have been an increasing number of studies into the patient's view of the health services. Investigations into the clients' views of the health visiting service were numerous a decade ago (Graham 1979, Orr 1980, Blaxter & Paterson 1982, Field *et al* 1982, Robinson 1982), and the many investigators revealed a generally positive attitude towards health visitors, but also several specific complaints. Such complaints included a dislike of being told what to do, and a confusion about the health visitor's role and goals. In the study of McIntosh (1986) of working class women in Glasgow, nearly half the women saw the health visitor's main function as monitoring abuse or neglect.

Concerning home visits, these have been found to be popular and satisfying for both participants, although the clients' satisfaction has declined as the baby grows older. Recent research has narrowed the focus from a broad survey of health visiting activity to a closer examination of the micro-processes involved in communicating with the clients. Warner (1983) has studied communication in baby clinics, and Clark (1985) and Montgomery-Robinson (1987), among others, have studied notification visits.

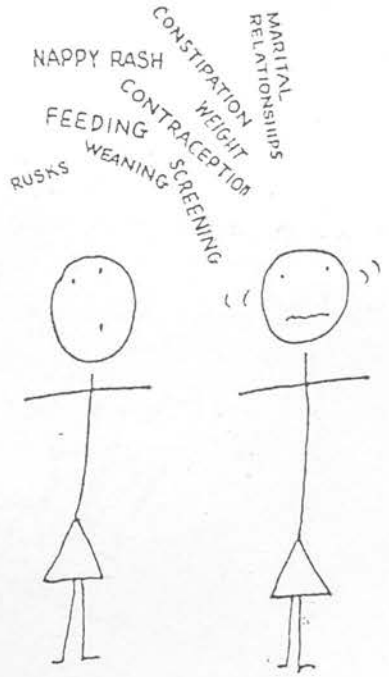
In response to this research, this study looked at home visits to mothers with slightly older babies, aged approximately 2-6 months, and aimed to examine the interaction and perceptions of both health visitor and client towards the same home visit.

Method

Fifteen health visitors from different areas volunteered to carry out a routine home visit to three first-time mothers with young babies from their caseloads. The visits were to be arranged in advance, for ethical reasons, and the clients' consent was obtained to tape record the visits. Both health visitor and client completed a short questionnaire immediately after the visit, and participated in an interview with the researcher on the following day, or in the case of the health visitors, after they had completed their third home visit. The areas discussed at the semi-structured interview included aims for the visit, the role of the health visitor, the most important areas talked about in the visit, and any advice given.

The overwhelming evidence from this study has revealed general satisfaction with the health visiting service for these 45 mothers.

When invited to suggest any changes in the service, very few wanted any alteration. Nearly all found the HV very easy to talk to. When asked what they might have liked to talk about if they had had more time with the HV, very few could think of any need or topic that they had not already discussed. When



asked to describe their ideal, perfect HV, many clients volunteered, "just like mine". Nearly all addressed each other by their christian names.

Several themes emerged, but here I have summarised five areas: some of the practicalities of service provision, the HV's role, advice and advice-giving, home visits, and the HV/client relationship.

Practicalities

When asked where they would prefer to talk to the HV, the majority expressed a preference for their own home. Reasons were either expressed positively, "the home has a more relaxed atmosphere", "there's more time", or negatively, "lack of privacy at the clinic", "there's too many people and distractions". The better and more private the clinic facilities were reported to be, the less the women felt strongly the preference for a home visit.

When invited to choose between the HV just "popping in" or making an appointment to visit, the majority of women said that they would prefer to know when they were coming. Reasons given included positive ones, such as being prepared with questions to ask, or negative ones, such as they wouldn't want the house to be in a mess. When asked if they thought that the HV was looking at the state of the house, the majority said no, but they would prefer the house to be tidy for any visitor.

Concerning the frequency of visits, although there was a wide range in the number of contacts, most clients were satisfied. There did not appear to be overt negotiation about arranging contact, but generally the clients felt that they decided how often they went to the clinic, and the HVs decided about the number of home visits. There was, however, some uncertainty:

"When she came round the first day, and she never said I'm your HV or anything, she just introduced herself, she never actually said I'm your HV and we're there if you need us, we come to see you every week, so I didn't actually know that first visit whether this was a regular thing and she would come round and see me or what. All she said was we have the clinic on a Thursday, and if you feel up to it, come and see us on Thursday, and that's how it is, and I've just assumed that she's there if I do need her. She's never actually said that, that was one thing, because I had to ask my sister, does the HV come round every week, but they don't, they're just on call if they need them."

The clients valued the phone as a means of contacting the HV if a problem arose, and there appeared to be no hesitation or difficulty in doing so. Many women expressed a desire for frequent visits in the early days after discharge from the hospital, and saw less of a need for visits later on. Later visits were seen as welcome from a social point of view, rather than for practical reasons.

The role of the health visitor

Clients spoke about the role in authoritarian terms. At least a third of the clients mentioned their "checking" role, e.g. "to see that you don'

a home visit

batter your bairn". (None of the HVs volunteered this aspect of their role.)

Many had heard stories about HVs, e.g. they're "nosey", but they said that "their" HV was not like that. They were still left with the impression that other HVs could be. Health visitors were often used as an intermediary to, or instead of, the doctor.

"I've had a couple of things as well with him, wee things that you wouldn't necessarily bother the doctor about, because you feel well, you're wasting his time, quite important to you, but probably quite trivial to him, that you could actually speak to the HV."

Opinion was divided as to whether the HVs were there for the mother as well as the baby. For example, after one visit, where the client had talked at length about her relationship with her husband, and both client and HV felt they had a good relationship, the client volunteered that she felt she had been "imposing" on the HV, and didn't feel that it was really the HV's job to listen to her problems.

Advice and advice-giving

To summarise, the overwhelming feeling was, clients do not want to be told what to do!

When the clients were asked if they had learnt anything new on the visit, nearly half could think of a specific instance. More often it was reassurance, confirming something the mother already knew, or going over a topic again. This topic was frequently linked with one of the client's aims for the visit, such as feeding, sleeping, immunisation or development.

When considering how they liked to be given advice, the clients were divided into a majority, who wished only to ask about a specific subject that was of concern, and a small minority, who wanted the HV to let them know what was best for their baby, "keep me right". A non-authoritarian style was definitely much preferred.

"She doesn't just say, you've got to do this or got to do that, you know she'll sort of say maybe something like, well maybe if you would try, you know, you don't feel you're being forced in to it. Her advice is good and I mean as I say if I want it I just ask for it and she gives it, which I think is quite good, instead of her coming along and sort of saying you're not doing this right or you're not doing that right, you know, do this or do that."

Home visits

The clients judged a visit a success when they had had an opportunity to discuss all they had wanted to:

"Because we talked about the things I wanted to talk about, put my mind at rest."

Unsuccessful visits were where the client had not talked about the areas she wished to, or where she felt the question had not been adequately answered.

Health visitor/client relationship

The clients were asked what they thought made a good relationship with a HV.

For the clients, the personality factor was most important, with professional ability in secondary position. If the client liked the HV, found her friendly and easy to talk to, other factors such as age of HV, and whether she had had children, did not seem to matter.

"If you're easy with a person, and they can understand you and you can understand them, then you can let your emotions out, like I find her really easy to talk to. It's just like she's a sister or something."

Conclusion

For these clients, therefore, the health visiting service was both acceptable and useful. A successful relationship was seen in social terms, and more criticism was levelled at style of health visiting rather than content.

However, there was still some uncertainty expressed about the role of the health visitor, which would indicate that we are still seen by some clients purely in terms of child protection, rather than support for the mother. Because of these clients' views, I believe there must be more repetition and explanation of the role. One suggested way to achieve this, might be to verbalise in concrete terms the profession's stated belief in client autonomy, and form a health visitor—client contract, so that both participants can express their aims and expectations of their relationship. All the health visitors in the study expressed their belief in the client's right to choose, but not all clients were aware of the health visitor holding such views, so a verbalised agreement might solve this seeming misunderstanding.

I conclude with the opinion of one mother, representative of many, who had found a service which met her needs:

"Well, I think I had the terrible impression that this health visitor was going to tell me what I was to do with my baby, when and why, and it hasn't been like that. It's just like going to see your friend . . . The relationship is good because she lets me decide what I want to do."

Shona Cameron, a founder member of the *Focus* committee, brings us up to date with a report on her research project. Shona is based at Edinburgh University.

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COMMUNICATION

Games health visitors play: interaction on home visits

Health visitors routinely use a number of verbal ploys to control and direct interactions with clients. SHONA CAMERON describes some of the findings of a recent study of conversations between health visitors and clients on home visits. *Health visitor 1992; 65, 7, 231-232*

Early studies of interaction between client and health visitor on home visits noted the participants' views separately. Researchers first asked the health visitors what they said they did, including the time spent, subjects covered and clients visited.[1] They then proceeded to ask the clients, the recipients of the service, for their response.[2-4] With the subsequent introduction of tape recorders it became possible to examine and code data by topic or communication skills used.

This body of knowledge recorded what health visitors talked about, but it did not describe how they carried out their work, nor compare different methods and techniques. It was not until the use of conversational analysis by researchers such as Una Warner, who studied interaction in baby clinics,[5] that specific techniques were identified.

Conversational analysts, working within the framework of ethnomethodology, examine naturally occurring conversations to find underlying rules and patterns.[6] For example, usually one party at a time talks in a conversation but where two speakers talk in error at the same time, there is a repair mechanism whereby one speaker stops prematurely.

Using this framework, a study was carried out to describe the interaction on a routine home visit between a health visitor and a primiparous client, and to compare the perceptions of the participants. Fifteen health visitors volunteered to carry out three home visits each, to primiparous clients with babies aged 2-6 months. The clients' permission was obtained in advance, the visits tape recorded and both participants interviewed shortly afterwards about their perceptions of the visit. A total of 45 home visits, 15 interviews with health visitors and 45 interviews with clients were recorded on tape.

This article describes some of the strategies and techniques used by health visitors to influence the interaction. Such observable patterns or 'ploys' already identified by Warner include the use of laughter,[7] and the phrase 'How are you?' in baby clinics.[8] In the home, in a perhaps more relaxed atmosphere with more time available, patterns identified include openings, talking to the baby, praise, pauses and closings. The verbal extracts are taken from the transcripts of the 45 tape-recorded home visits.

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Openings

Visits were taped only once the health visitor was in the door. However some common introductory phrases were still used such as: 'How have things been ...?'; 'So you were saying ...' A general open question from the health visitor would be followed by a short reply from the client before conversation proceeded to more particular matters. It was almost as though the participants were following the rules of an orchestrated encounter before they could relax and take up a pattern of mundane or everyday conversation.

Talking to the baby

This section does not cover patterns of conversation when a mother or health visitor would talk to a baby while carrying out an assessment, but when either the mother or health visitor would turn to talk to a baby for no apparent reason.

Babies were generally ignored unless they really intruded themselves vocally into the conversation. They were also ignored in the conversation if the adults were in the middle of a topic, although the mother would perhaps react non-verbally by picking the baby up. Even then it was the health visitor who sanctioned the action by including the baby in the talk; in one case, the health visitor even said, 'Do pick the baby up if you want to', as though the mother needed permission to break off the conversation. Alternatively, this may have been a way of giving advice.

A health visitor might talk to the baby in order to show that one topic was closed, before starting another. The following extract was preceded by a discussion of disposable versus terry nappies and progressed into a discussion of posseting:

Client (C): I noticed when I took the disposable off one night that he had, it was like wee bits of jelly on his skin.
Health visitor (HV): On his skin, yes.
(Baby gurgles, which he had been doing through the previous talk.)
HV: You're a full-up boy aren't you? Do you get little mouthfuls coming down?
C: Yes.

Talking directly to the baby was thus perceived by both as a signal that one topic was closed and another could be introduced. Talking to the baby was also used as a way to give indirect advice. For example:

HV: He is rolling?
C: He's not going right over, but he's halfway there.
HV: This is the age when all of a sudden they're starting to be on the move, and they suddenly know how to roll their way over to the video, or to something like this.
C: Yes
HV: (to baby) This is the age when we have to be careful, isn't it, eh? 'Cos you start to do things before we know it.
C: Yeah, he has started to move about.

The talk then continued on the topic of home safety.

The client, too, might talk to the baby as an indirect way of continuing a difficult subject. In the following extract the mother used talking to the baby to complain indirectly about him:

C: I don't know what I would do, Ken, if I was stuck here all the time. At least I've got the pram and I can get him out. He is getting there. He is not as whingey anymore. No' really. Just sometimes (To baby) Eh? Just sometimes you are a whinge.

Praise

In successful two-way relationships, to show

positive regard for someone is to accept them and is seen as increasing the chances of their accepting you; the behaviour of either party is contingent on the perceived behaviour of the other.' In a client/health visitor context, if a health visitor praises a mother or baby she makes herself more acceptable to that client.

In the taped visits it was usually the health visitor who praised and the client who concurred. A client might praise her baby in connection with the topic under discussion, but rarely out of context; the health visitor would introduce praise inconsequentially.

The baby was praised frequently both during and at the end of an assessment, thus both reassuring the mother and making an indirect compliment to her mothering skills. Praise acted as a positive reinforcement. Often the client too, was praised, usually in connection with her role as mother and coping abilities.

Praise of the baby would also occur as part of an opening sequence, as though praise was part of the social expectations of the visit. In the following extract it is only after the social niceties of praise have been accomplished that the 'real' work of the visit can begin:

HV: Now then ... He's looking super there actually.
C: He's doing great.
HV: Yes, seems to be fine. Lovely. And how are you getting on with the mixed diet?

Significant was the frequency with which praise was used as a transition to another topic. It was the health visitor who praised, but either client or health visitor could then introduce a new subject. The following passage illustrates both praise and talking to the baby as a ploy before the introduction of a new topic. The health visitor and client are discussing how much juice to give the baby:

HV: Well, I mean, he certainly looks fine to me and I think, you know, from what you're saying you do know what you should be doing. I wouldn't worry too much about it. You know, he's a smashing little chap, and he looks smashing. (To baby) Don't you? You look super, you really do. You look great.
(To client) Are you getting many sounds from him, Judy?

Both mother and baby are praised before the health visitor changes the subject to the baby's development.

Pauses

Pauses were very rare in the interaction; conversation usually flowed, so when they occurred it was quite significant. Pauses could allow time for thought, but generally one of the participants filled the silence with some contribution, either introducing another topic or talking to the baby. Silence was very rare and pauses tended only to occur before a change of subject.

Closings

It was usually the health visitor who initiated the end of the visit. This could be signalled by words or phrases such as 'Well', 'Anyway' and 'Was there anything else?'

Summarising or repeating what had already been said was also a signal that the subject was finished.

Sometimes there was a practical reason for finishing: for example, the baby was crying, had fallen asleep, or had finished a feed. Again it was always the health visitor who made the first verbal excuse to conclude the visit.

Another method was to make arrangements for future contact: for example, 'I'll see you at the baby clinic next week', or 'The next thing to think about is the baby's second immunisation in three weeks'. The health visitor might also use the explanation that she had to be somewhere else: 'I'd better go, I've to see another baby', or 'I'd better go, I'm supposed to be at the baby clinic'.

Conclusion

Some of the ploys identified are used by both participants but it is the health visitor who usually guides the interaction. Clearly it is the health visitor who holds the balance of power, but only with the consent and co-operation of the client. The range of ploys used demonstrates that the health visitor goes to great lengths and subtleties to obtain and retain that co-operation ■

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