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Flying Under the Radar

Engagement and Retention of Depressed Low-income Mothers in a Mental Health Intervention

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A randomized trial of in-home psychotherapy for depressive symptoms that targeted low-income mothers of infants and toddlers used innovative design features to reduce stigma and enhance acceptability. Despite these features, advanced practice psychiatric mental health nurses used specialized, relationship-based strategies to engage and retain these high-risk mothers in the intervention. Data revealed that the nurses needed to diligently maintain contact, provide encouragement, use empathy for rapid assessment and response, and control the intensity of the relationship-based contacts in order to retain mothers. **Key words:** *depression*, *infants*, *intervention*, *mental health disparities*, *mothers*, *toddlers*

HEALTH disparities arise from sustained societal pressures on selected populations.[1] Pressures such as racism and poverty interact with the structure and function of the healthcare delivery system to limit the use of health services.[2,3] The same societal forces that create health disparities also spawn other stressors that compromise mental health, and yet members of underserved populations are often reluctant to seek mental health services because of the stigma of being labeled as mentally ill.[4,5] As a result, those who have the greatest need for mental healthcare go without it.[6]

The design of mental health services can pose additional hurtles.[7] For example, facilities that are open only during regular daytime business hours exclude minimum wage hourly workers who lose income if they leave work for health appointments.[8] Providers may not have sufficient language skills, experience, and sensitivity needed to work with people from distinct ethnic or cultural backgrounds, thus alienating entire groups of consumers. While barriers to healthcare such as these ultimately harm consumers from all economic strata, low-income populations suffer the most direct and extensive damage.[9] This article focuses on the central importance of relationship-based strategies that psychiatric mental health advanced practice nurses used to deliver a mental health intervention designed to remove barriers to care and reach depressed low-income mothers, a population that is underserved.

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BACKGROUND

Low-income mothers of very young children have a 4-fold risk of serious depressive symptoms in comparison with middle-class mothers.[10] These depressive symptoms contribute to altered parenting interactions that have been linked to problematic outcomes in infants (0–12 months) and toddlers (13–36 months).[11,12] These outcomes include delayed development of language, poor socialization skills and emotional disregulation in the form of chronic irritability, inconsolable crying, and severe tantrums.[12–15] Later child outcomes that have been linked to maternal depressive symptoms include learning difficulties, conduct disorders, and vulnerability to depression as adults.[16] However, the good news is that despite the capacity of depressive symptoms to reduce parenting effectiveness, a few studies have demonstrated that targeted intervention can significantly reduce maternal depressive symptoms.[17–22] The alleviation of maternal symptoms would favor the healthy development of vulnerable infants and toddlers during a critical phase of their growth.

Low-income mothers with depressive symptoms have difficulty accessing traditional mental health services. Obvious barriers include stigma associated with mental healthcare as well as limited money, transportation, and time. Less obvious barriers are related to the way low-income mothers adapt to the challenges of their disadvantaged status. Faced with competitive priorities and few resources, low-income mothers often place food and healthcare for the children ahead of mental healthcare for themselves.[23] Without sufficient money, mothers develop present-oriented, flexible time management patterns organized around seizing supplies when they are available. These survival tactics typically conflict with the service delivery patterns of traditional appointment-based mental health clinics.[24] In the United States, mothers who accept public assistance must participate in TANF-mandated* hourly work with changing time schedules that are out of their control, making it even harder to keep regular appointments with providers.[23]

This article presents data analysis from a portion of 2 larger randomized-controlled studies designed to overcome known barriers to mental healthcare for an underserved population—depressed low-income mothers of infants and toddlers. The institutional review board of the principal investigator's (PI's) university approved these studies and mothers were identified through a partnership between the researchers and Early Head Start (EHS). The EHS is a federally funded and trusted enrichment service for infants and toddlers of low-income families where nursing care is part of the standard array of services. Partnering with the EHS had the distinct advantage of allowing the advanced practice psychiatric mental health nurses who delivered the intervention to "fly under the radar," that is, connect with mothers as part of the EHS provider team and conduct the interpersonal psychotherapy intervention without drawing attention to the stigmatizing aspects of receiving mental healthcare.[25] In meeting with the "nurse from Early Head Start," the mother did not have to explain to family and neighbors that she was receiving help for her depressive symptoms. This method of delivery helped remove the stigma of seeking mental healthcare.

Despite the reduction of stigma and removal of several other barriers to care (transportation, childcare, rigid appointment schedules), the data demonstrate that the successful completion of the intervention with mothers required the nurses to establish a therapeutic interpersonal

*Temporary Assistance for Needy Families (TANF) or the "welfare reform" legislation brought with it the requirement for employment outside the home. The jobs available to the mothers in our studies were minimum-wage service, manufacturing, or meat processing jobs that required rotating shift work.

relationship quickly within which highly skilled relationship-based strategies sustained the intervention protocol. This required nursing flexibility and persistence as well as skill. This article focuses on the strategies used to establish and maintain a therapeutic interpersonal relationship that enabled nurses to successfully engage and retain mothers during the 5-month duration of the intervention. We also describe barriers to establishing and maintaining care.

RESEARCH QUESTIONS

This study addressed 2 research questions:

- What barriers to care were reported by nurses as they implemented the psychotherapy intervention?
- What relationship-based strategies were used by nurses with mothers who participated in the intervention and how were these strategies used?

THEORY

Within the interpersonal theory of nursing,[26,27] depressive symptoms are viewed as security operations enacted as a response to interpersonally generated anxiety.[28–32] This theory holds that depression arises from interpersonal conflicts that lead to anxiety. As anxiety increases, the individual develops security operations or relief behaviors such as overeating, or staying in bed all day, or withdrawing from social interactions. Depending on the magnitude and duration of the anxiety, the individual may develop a whole spectrum of maladaptive behaviors in an effort to ward off the depression. Frequently used relief behaviors cluster into symptoms over time and exacerbate the original interpersonal conflicts that generate them. Ultimately, these clusters assume the form of depressive symptoms.[31] To resolve the symptoms of depression, the nurse must go to the source of the interpersonal relationship disturbances that are causing the anxiety.[32] This healing is most likely to occur within a thriving therapeutic relationship. Thus, in this study, the therapeutic interpersonal relationship between the nurse and the mother created a context in which the mother's relationships with her closest significant others could be carefully examined according to a specific intervention protocol. The intervention was designed to help the mother interrupt her symptoms, address difficult issues and relationships in her life, override the depressive symptoms to improve her parenting, and increase social support. We proposed that the mother would build self-efficacy, reduce her anxiety, and experience a reduction in the depressive symptoms.[32]

The therapeutic relationship is central to mental health nursing.[33] The centrality of the nurse-patient therapeutic interpersonal relationship is seen in the work of many nurse scholars whose writing were dominant in the last quarter of the 20th century.[34–36] During this era, the concept of the nurse-patient relationship was described as central to the relief of loneliness and suffering of fellow humans.[35,36] More recently, some have argued that therapeutic relationships remain central to a "person-centered nursing framework."[33,37]

The power of a therapeutic *interpersonal* relationship lies in its transformative nature, that is, the relationship creates a milieu, so to speak, in which the totality of the patient's experience is witnessed without judgment, and the skillful responses of the nurse affirm and encourage the patient's inherent longing to grow and be free from suffering.[38] Within the therapeutic interpersonal relationship, knowledge of the client's needs, revealed to the nurse by the client, drives the skilled nurse's intervention.[35,36,38]

METHODS

Setting

We recruited mothers from 5 EHS programs in 2 states located in the northeastern and

southeastern United States. The EHS is a federally funded program that serves low-income families from pregnancy through the child's third birthday. It provides infant/toddler development enrichment resources, parent guidance, socialization opportunities, and family development resources, as well as helps the child make the transition to preschool, which is often a Head Start program for 3- to 5-year-olds.

Design and sample

The data for this article were from 2 randomized-controlled studies* in which one group of mothers received the intervention along with the usual care from the EHS. This group was compared with another group who received a control condition consisting of close monitoring and the usual EHS care, but no psychiatric intervention. Mothers in the intervention group received 10 face-to-face sessions in their home during which the major impact of the intervention was expected to occur. Five additional booster contacts were provided to deliberately attenuate the intensity of the face-to-face contact and allow the mother to carry out intervention strategies on her own. The nurse conducted a final termination session at the conclusion of the intervention in which she provided a summary to the mother and made any necessary referrals for additional therapy. Mothers randomized to the control condition waited until they completed their participation in the data collections and then received the full in-home intervention.

After EHS staff screened mothers for depressive symptoms, we recruited eligible mothers into the study. Interested mothers signed a consent form and completed the Center for Epidemiological Studies Depression Scale. Mothers who scored 16 or higher on this scale (standard cutoff for significant depressive symptoms) were invited to participate in the intervention trial. After mothers signed a second consent, we randomized them to intervention or control/usual care conditions.

Table 1. Characteristics of sample mothers ($N = 29$)

Average years education	10.2 (SD = 3.3)
Average age Early Head Start child, mo	20 (SD = 11.9)
Ethnicity	
Black	8
White	3
Latino	17
Native American	1
Marital status	
Single	13
Married	14
Divorced	1
Separated	1
Living with spouse/partner	22
Living alone	7
Work status	
Working	9
In-home	2
Away	7
Full-time	5
Part-time	2
Unemployed	20

At the time of this analysis, the sample consisted of 29 mothers assigned to the intervention who had completed their contact with the projects. The mean age of the mothers was 27.9 years (SD = 6.4). Twenty-one (72%) of these mothers had finished 8 or more face-to-face intervention sessions and had successfully terminated contact with the nurse. Other demographic characteristics of the sample are given in Table 1.

Seven of the advanced practice psychiatric nurses who delivered the intervention were white and 1 nurse was African American. In

*"Reducing Depressive Symptoms in Low-Income Mothers" (RO1 MH 65524-01), National Institute of Mental Health and "EHS Latina Mothers: Reducing Depressive Symptoms and Promoting Infant-Toddler Mental Health" (90YF004201), Early Head Start-University Partnership Grant, Administration for Child and Family/Administration for Child Youth and Family, Department of Health and Human Services.

contrast to the low-income mothers, all of the nurses were well-educated, middle-class women. These nurses held other jobs, either full-time or part-time, or were retired. Each nurse worked with 2 to 4 mothers in this study at a time. Ongoing group supervision, conducted in a weekly conference call, encouraged greater sensitivity among the nurses to cultural concerns and to the experience of low-income individuals. In addition, nurses identified their personal biases, cultural stereotypes, or clashes in worldview that arose during the delivery of the intervention. In these discussions, nurses were encouraged to examine what impact any bias or stereotype might have on their relationships with the mothers. In the supportive atmosphere of the supervision group, nurses expanded their understanding about cultural or stereotypical misperceptions, thereby setting the stage for the therapeutic relationship to flourish further. Peplau's theory dictates an approach that maintains that an "...awareness by the nurse of her own behavior is important, for it is all that she can change. Nurses do not 'manage' patients; instead they manage the relation of the nurse to the patient vis-à-vis awareness and control of the nurse participation in the nurse-patient situation."[39(p234)]

DATA GENERATION

This article identifies the strategies that nurses use within a therapeutic interpersonal relationship to address depressive symptoms in low-income mothers. While we believe that the essence of a therapeutic interpersonal relationship cannot be quantified given its fundamental nature, this essence can be known as experience-based knowledge by those who live it. Thoughtful and rich nurse narratives convey this tacit knowledge. Therefore, an analysis of the nurse narrative provides an empirical-based description of aspects of the nurse-patient relationship. Identification of these empirical-based nurse strategies are integral to understanding what we do as nurses and to knowledge development in the profession.

After every contact with a mother, the advanced practice psychiatric nurses recorded the relationship-based strategies they used on a standardized form called the component checklist (CCL). The CCL, developed in large part from an analysis of nursing progress notes written during the pilot for these studies,[25] included assessment data, clinical progress, adherence by the mother, and cost estimation data. Nurses also wrote in it a chronological account of each visit from start to finish. These narratives described the home setting, the nurse's interactions with the mother, the specific intervention protocols used, as well as the nurses' thoughts and feelings. Finally, the CCL contained a list of 19 relationship-based strategies. These strategies were identified, along with their operational definitions, from a content analysis of nursing progress notes written during the pilot study[25] and from intervention theory development papers by the investigator and colleagues.[32,40,41] Nurses documented on the CCL which of the 19 strategies they used during each session. Table 2 presents the 19 strategies and their operational definitions.

Completed CCLs were reviewed by the PI (L.S.B.) and co-I (R.C.) prior to the weekly peer group supervision conducted through conference call with the intervention nurses from all 5 sites. During supervision, the PI made field notes and simultaneously compared nurses' verbal report of the visit with their written CCL record. The PI and each nurse reconciled discrepancies between the nurse's verbal account and written CCL, thus making the text narratives as accurate as possible.

DATA ANALYSIS

Our data analysis focused on barriers encountered by the nurses and strategies used to engage and retain mothers in the study. We identified barriers by using the data generated from the nurse narratives of all 29 mothers who had completed or dropped out of the intervention at that time. The PI extracted short

Table 2. Interpersonal strategies in the component checklist

Interpersonal strategies	Operational definition
In-person contact	Any deliberate face-to-face interaction with the mother, irrespective of length of time
Written contact	Any paper-and-pencil communication with the mother
Telephone contact	Telephone contact including message on the mother's voice mail or message left with a family member
Control of intensity	Increasing or decreasing pressure on the mother to engage with anxiety-laden issues in her life
Social ritual	Greetings, goodbyes, handshakes, introductions, accepting food or drink, or any action associated with social situations; typically done at start and finish of session as an "icebreaker" early in the relationship
Social conversation	Positively commenting on children, home decorations, talk about the news of the day; typically done at start and finish of session as an "icebreaker" early in the relationship
Culture specification	Any behavior done to acknowledge or support a dimension of ethnic, cultural, religious, or group affiliation
Role clarification	Instructing about the nurse or mother's role in the therapeutic relationship
Self-disclosure	The nurse shares personal information about herself for the purpose of normalizing the mother's experience, engaging the mother, reducing a perceived barrier, or other strategic reasons
Empathy	The nurse perceives an affective bond with the mother and a heightened sense of understanding of the mother's issues but does not lose the sense of separateness between herself and the mother
Encouragement	Offering positive statements intended to shore up the mother and motivate her to continue a struggle or attempt a new strategy
Anticipatory warning	Noting a consequence that might occur or a planned part of the intervention that is going to occur
Facilitation of grieving	Normalizing, promoting affective expression, facilitating catharsis around issues of loss
Summary	Condensing the major themes of a session, areas of concern for the mother, or evidence of progress over several sessions
Facilitation of catharsis	Facilitation of expression of affect
Gesture (describe)	Nonverbal expression by the nurse; includes hand gestures, body positioning, and movement
Facial expression	Deliberate facial gestures
Physical touch	Placing hands on the mother or hugging
Boundaries maintenance	Verbal or behavioral emphasis or clarification of a division between self and mother; facilitation of a division between the mother's sense of self and significant others, roles, environment

descriptive phrases describing barriers to engagement and retention of the participants from these narratives. The PI then grouped these identified barriers into themes as well as refined and validated them against the field notes from the weekly conference calls. Finally, the intervention nurses reviewed the themes for concurrence and the PI made adjustments on the basis of their feedback.

To identify and rank order the strategies used by nurses, we analyzed the 222 completed CCLs from the 29 mothers. We identified the number of times the nurses used each of the 19 relationship-based strategies,

calculated the percentage of the total CCLs in which each strategy was used at least once, and rank ordered them.

To achieve a richer description of the strategies used, we analyzed a purposive sample of the nurse narratives in the CCLs. Five nurses who had been delivering the intervention for at least 1 year selected a complete set of CCL narratives for one of their mothers who had completed the intervention. The nurses chose an exemplar set that had a rich and thick description of their application of the strategies. This purposive sample provided 49 visit narratives. The narratives were compiled in Microsoft Word and assigned code numbers. Content analysis was used to analyze the narrative data.

Content analysis is concerned with testing an existing hypothesis and assumes that the phenomenon of interest is already within the data.[42] The narratives were read by a first reader, a doctoral-prepared intervention nurse on the project who was experienced in using content analysis. The first reader read each narrative twice to identify content consistent with the operational definitions of the 19 previously described strategies in the CCL. As a second reader, the PI reviewed the identified content for consistency with the operational definitions of the strategies. To maintain integrity, at each stage of analysis, the first and second readers discussed discrepancies until they reached consensus. Finally, the intervention nurses reviewed the analyses describing the nurse strategies for feedback. This group discussed discrepancies until they reached consensus. Ryan and Bernard[42] suggest that the validity of a concept depends, in part, upon the collective judgment of the individuals familiar with it.

RESULTS

Barriers to engaging and retaining mothers

Nurses described 3 primary barriers to engaging and retaining mothers. The first barrier was the challenge of making the initial face-to-face contact with the mother. The second barrier, occurring after the nurse had made contact, appeared to be related to the mother's multiple severe life events and chronic pressures that made it hard for mothers to keep appointments and remain in the study. The third barrier, which contributed to the attrition of some mothers, appeared to be elicited by the "work of therapy"—the nurses' work to form an interpersonal relationship and engage the mothers in examining and changing the factors that generated their depressive symptoms. This work engendered anxiety in the mother and appeared to contribute to attrition in some instances. This phenomenon is not unique to this population but occurs for many who engage in psychotherapy.

The first identified barrier, difficulty establishing initial contact with the mother, was related to the simple fact that many of these mothers did not have reliable telephone service. Some mothers lost service due to nonpayment of their bills, making it difficult for the nurse to reach the mother by telephone during the period of service interruption. For many, the reestablishment of interrupted service meant a new telephone number for the mother. These obstacles required the nurse to find the mother in person or contact the EHS program to obtain a new telephone number, leading to considerable delays in either initially contacting or maintaining contact with mothers. Other mothers could not afford a telephone, requiring the nurse to get in touch with relatives and friends while maintaining the mother's confidentiality. In these situations, the nurse could identify herself as "the nurse working with EHS" rather than "a psychiatric-mental health nurse", thereby once again "flying under the radar" by not revealing the mother's mental health status as the focus of the call. Once contact was finally established, barriers remained, created by the intense, depleting nature of acute and chronic pressures in these mothers' lives. Survival needs such as food, shelter, and medical care for the children came first for mothers and were constantly competing with mandated, low-paid shift

work required to maintain public assistance, legal procedures related to debt and child support, and the energy required to shop wisely and stretch their meager incomes. Mothers often responded to the "squeakiest wheel" in their lives or chose immediate survival needs over their work with the nurse.

The second barrier, keeping appointments and thus remaining in the study, arose from the multiple previously mentioned daily life pressures on these mothers. Managing competing demands required present-time, resource-seizing decision making that frequently took precedence over keeping appointments, even after the bond was established with the nurse.[24] For example, if a participant's child was ill and her neighbor offered to drive her to the clinic, survival priorities of the mother required that she go to the clinic when she had a ride, regardless of her wish to keep the appointment with the nurse. This example also illustrates the delicate, but necessary, network of social support that required bartering and paybacks that conflicted with mothers' meeting their own needs.[24] Severe life issues endemic to this population such as chronic, life-threatening physical illness in the mother or children, violent deaths of significant others, neighborhood threats to the mother's safety, eviction, and escape from dangerous partners also took priority over appointments with the nurses.

The third barrier occurred after the mother and nurse were engaged in therapy work. The data showed that depressive symptoms, particularly low energy, apathy, social withdrawal, and distracted thinking, interfered with retention. For some mothers who did initially engage in therapy, their struggle to confront the sources of the depressive symptoms and the anxiety that arose in that confrontation created an additional reason for avoiding sessions. Facing the tough life issues that surfaced in the therapeutic work was inevitable and frequently led mothers to cancel or avoid appointments, sometimes repeatedly, when facing difficult topics. This barrier to retention is not unique to this study; many choose to leave therapy rather than do the requisite work. What *is* unusual was the considerable effort by the nurse to preserve the therapeutic interpersonal relationship with the mother. Ultimately, the nurses respected the right of the mother to leave the relationship when she desired. However, the nurses did not give up easily. For example, they invited the mothers to continue their work, offered some time away from the therapy, avoided directly addressing sensitive issues for a period of time, offered to meet in a public place for a cup of coffee, and followed up with phone calls or cards. Working with mothers in their home provided a bigger palette of options for both mothers and nurses. Mothers could miss an appointment by simply not coming to the door or not being at home at the agreed upon hour, whereas nurses could pursue mothers by leaving notes at the home or dropping by the house to say hello when the mother might be at home. In the end, however, the nurse honored the mother's wish to terminate the therapy, whether expressed directly or indirectly.

Strategies employed to engage and retain mothers

So how did the nurse engage and retain these mothers under such stressful conditions? Nurses used all of the 19 strategies toward this end in the difficult work of therapy. However, the nurses used some strategies more frequently at certain points in the relationship than others. For example, in the beginning of the relationship when the focus was on establishing and maintaining connection with the mother, keeping contact and using encouragement were the most frequently used strategies. Table 3 presents the strategies in order of the frequency used by the nurses.

Examples of frequently used strategies

Making *in-person contact* (#1) was the goal of the in-home format of the intervention, and, expectably, was used in every session except a few in which an emergency telephone call was substituted for a face-to-face meeting.

Table 3. Strategies used by intervention nurses

Strategy	Order of frequency	% Visits in which strategy was used
In-person contact	1	98
Encouragement	2	90
Empathy	3	66
Social conversation	4	54
Summary	4	54
Facial expression	5	38
Physical touch	6	34
Control of intensity	7	33
Role clarification	8	30
Facilitation of catharsis	8	30
Gesture	9	26
Culture specification	10	25
Telephone contact	10	25
Self-disclosure	11	23
Anticipatory warning	12	22
Boundaries maintenance	13	21
Social ritual	14	20
Written contact	15	18
Facilitation of grieving	16	17

Because of previously described barriers, in-person contact was also the most difficult strategy to achieve. Mothers who did not complete at least 8 sessions lost contact with the nurse after only 1 or 2 face-to-face meetings. Even after contact was established, the nurses had to bond and immediately make the intervention relevant to the mother whose low energy and lack of interest were part of the pattern of significant depressive symptoms. For example, nurses helped the mother identify and write down specific goals to be accomplished during the next week. These goals, designed to engage the mother in the therapeutic process, were often as simple as watching a TV program with their children and talking about it, taking a walk once a day, calling a friend twice during the week, journaling about their feelings for 10 minutes a day, or listening to music every day.

Nurses used a variety of techniques to make the initial face-to-face meeting happen including repeated telephone calls and voice mail messages when a phone was available, leaving notes at the mother's door, dropping by the mother's home, and strategically planning to be at the EHS center at child pickup time in order to make direct contact with the mother. Even after the nurse had established the initial contact, the tie was fragile and easily broken by any number of imperatives, described earlier, that took precedence over the mother's work with the nurse. The nurse's tightly organized schedule often collided with the mother's "immediate-response" time management system, requiring the nurse to be gently persistent and flexible despite missed appointments by the mother. The example below depicts such a collision:

Week 1:

We were scheduled to meet at two different times last week. When I called to confirm, she told me the first time that she had to go to the ER to be with her husband's step-mother. The second time I called to confirm the rescheduled visit, her husband answered and told me she went to the ER because she thought she had broken her toe. I arranged with him to meet her on Saturday (the next day). When I called to confirm, she asked me to wait until Monday, as she was not feeling well. Her life is "always this crazy," she said. I agreed to meet with her on Monday.

The visit was successful and the mother went on to finish the intervention.

Empathy (#3) was often used as a shorthand route to a mother's internal experience, allowing the nurse to make quick, accurate assessments on very little data. The following examples show how the nurse's empathic response to the mother's grief over her mother's death guided the nurse to do a suicide assessment.

Week 1:

She said she missed her mom so much and at the time [of her mother's death] she, too, wanted to die. I expressed my sadness for her that she had lost her mother at such a young age. . . . I then asked if she still wanted to die when she thought about her mother's death and she said she did not.

Although we tend to think of empathy as a warm, integrating interpersonal process, the nurses' empathic response to these depressed mothers often opened them to uncomfortable

feelings that these mothers were experiencing. It was not always easy for the nurses to maintain the "sense of separateness" that typically describes an empathic response. What follows is a sequence of examples of how the nurse used her empathic experience of the mother's disorganization to help the mother gain focus:

Week 1:

[The 3-year-old son, father, neighbor] came in and interrupted . . . mom responded to all these interruptions by stopping our conversations and focusing on everyone else. . . . I continually refocused her until I got distracted myself and lost my focus. . . .

The nurse's empathic response to the chaos and disorganization in the home was not always easily set aside during and after a home visit. In week 2, the same nurse wrote the following about her experience:

Week 2:

I felt drained and exhausted. . . . I drove around for a while before going home to clear my brain.

By week 3, the empathic response of this nurse had come full circle. Her initial empathic identification with mom's disorganization now guided her response to the mother, directed her preparation for the home visit, and enabled her to help the mother increase her focus on the work at hand:

Week 3:

Before I left my house to see Mom, I did some meditation to center myself. Right before her house, I pulled off the road and again did some deep breathing. I wanted to enter the home more relaxed and centered so that the chaos and her energy level would not get me as distracted. I hoped that I could then center her better, and increase her focus.

Finally, the nurse relied on her awareness of her own anxiety and her empathic sense of the mother's feelings as a cue to implement an attention-focusing strategy that helped both her and the mother attend to one of the mother's pressing needs.

Week 4:

She then went on to vent about her week and the emotional outbursts she had had. I allowed her to vent for about 20 minutes, with only minor clarification and validation. Then I attempted to refocus her and to ground myself, as her emotion and the chaos of the household were beginning to raise my anxiety. I took several deep breaths and encouraged her to do so, also. Then I attempted to refocus the conversation on one topic, [meanwhile] explaining to her that we needed to focus on one thing.

In addition, these nurses used empathy as a rapid assessment strategy to create on-the-spot strategies that mothers could use to reduce their depressive symptoms or solve a pressing life problem. We knew from experience with this population that if mothers could feel immediate gains from the therapy, they would be more apt to remain in the intervention. Mothers needed to see that the investment of their limited energy would produce a reward. We came to understand this as a pattern of coping that conserved energy in the face of depressive fatigue and depletion. By choosing their investments according to how quickly they would gain a reward, mothers could survive the intense demands of their lives. This required that nurses move quickly and directly to areas of concern. The following example demonstrates the nurse's use of empathy as an assessment and rapid-planning strategy in response to the mother's grief over a recent miscarriage.

Week 1:

At this point she began to cry and I stated, "It is very hard to lose a pregnancy." The mother continued to cry and I asked her, "What do you need? What does your heart need?" She said, "I need to feel connected to my husband." I then did a little teaching . . . [about communication] and we practiced how she could talk to him. . . . She said she could talk to him and we set as a plan for the week using "I" statements and being specific when she talked with her husband about her needs.

Nurses used *gestures* (#9) and purposeful *physical touch* (#6) to amplify and emphasize verbal messages and to assist the mother to reflect on her feelings. These were useful strategies when mothers were in high emotional states or where language barriers were present:

Week 4:

She . . . launched into another very emotional venting because her son had gone into her mother's room and she did not want him there, because she is so mad at her mother. Her 3-year-old had left the adjoining room, opened the door to Grandma's room, and entered. The mother (client) tensed, looked very angry like she was about to explode, and started to get off the couch and storm into the Grandmother's room. I could hear the interaction between the grandmother and her son and it was actually a positive interaction. When she began to rise, I said her name, put my hand on her arm (firmly but gently), and said, "Are you sure you want to do that?" She stopped and then I said, "It sounds as if it is going well, don't you think?" She sat back down on the sofa, and then her son came back out of the room and went downstairs to play.

Moreover, nurses used gestures to help a mother focus on translating feelings into words. The following example shows the use of a gesture, employed in this instance to keep the mother focused on her "heartache."

Week 1:

I then said, "Tell me about you." Mom was perplexed by the question and I told her to tell me anything she wanted to. She said, "I have a pain right here." She pointed to her left upper chest. She reported that she had talked to the doctor who was not concerned. I touched my heart area and asked how often she felt the pain and she said the pain was off and on and that the quality of the pain was a dull ache. I then asked her to tell me about what she was feeling emotionally "in her heart".

Mothers were frequently struggling with severe life issues, resulting in the need for the nurse to *facilitate catharsis* (#8), while amplifying and emphasizing proactive strategies that the mother could take. The following example shows how the nurse deliberately used her *facial expression* (#5) to relay concern while guiding the mother toward insight into the interpersonal situation:

Week 5:

The mother reached out to her aunt who is a recovering crack addict. This mobilized her grief over her own mother's continuing crack and alcohol abuse. I conveyed tenderness in my facial expression when she was crying because I can really relate to her pain over this. I encouraged her to express her feelings of loss. She compared the aunt's success with recovery from crack use to her mother's "refusal to stop." I tried to help her understand the physiological and psychological dependence and the difficulties in "comparing" two addicts.

Control of intensity (#7), employed in 33% of the visits, was a critical relationship-based strategy the nurses used to help the mother stay engaged with anxiety-laden issues or, conversely, to help the mother step back when she was overwhelmed. In the following example, the intensity of the situation was encouraged and maintained by the nurse's *physical touch* and verbal response to a spouse whose violent outbursts were an ongoing source of fear, anger, and depressive symptoms for the mother.

Week 8:

Father then stated that he gets angry and has an outburst, and then he feels "remorseful" and is over it quickly. I observed that even though it was over quickly, the damage was done; he had hurt himself and his family. He agreed with this by nodding his head. I asked him what he might do instead of yelling the next time he feels this surge of anger. He said he guessed he could just stop the anger. . . . I put my hand on his hands, which were on the table and I said, "The next time you feel that surge of anger, remember the little boy you told me about who is still inside of you who was so scared and hurt when his parents were violent and yelled at each other. If you can remember that part of you and your hurt, you can stop your anger." His eyes had tears, but he did not cry. . . . He nodded "yes."

In contrast, during a very early point in the intervention before the therapeutic interpersonal relationship was fully established, the nurse reduced the intensity in order to prevent an emotional outburst between the study mother and her own live-in mother:

Week 2:

Grandmother (who was addicted to alcohol and crack cocaine) . . . tried to help with the child, but in fact, did not seem to know how. At one point, she gave the girl a glass that did not work correctly so when (the child) tipped it up all this milk came

out at once and the little girl choked. Once, we knew she was ok (mom handled the child well, but was upset and tense with grandma), I introduced a little levity about those complicated glasses, and grandma noticed it and said, "Some grandma, huh?" with a smile. This broke the tension. . . .

Thus, the analysis of the narratives revealed that the nurses used a variety of specific relationship-based strategies that were particular to the developmental phase of the relationship as well as to the context of the home and family surrounding the interaction. Nurses used these strategies to support the intervention protocol, which, in turn, guided the content and focus of the face-to-face meetings. Furthermore, these relationship-based strategies supported the mother's retention in the study.

CONCLUSIONS

These data revealed an array of relationship-based strategies that advanced practice psychiatric mental health nurses used to counter barriers to intervention and to sustain a therapeutic interpersonal relationship with depressed low-income mothers. The data show that these strategies were essential for the initiation and maintenance of an effective nurse-mother relationship, which, in turn, was essential for the successful implementation of the study protocol. Although changing the form of the intervention to an in-home model reduced some of the barriers to psychotherapy, nurses needed a wide variety of strategies to create a flexible, trusting relationship in which to complete the study protocol. The shift to in-home psychotherapy required these experienced advanced practice psychiatric nurses who were familiar with traditional models of delivery to learn how to work in the ever-changing context of the home. This often meant that children, significant others, and contextual events entered the therapeutic work. Despite these challenges, location of the psychotherapy in the home enriched the data with contextual factors that the nurses observed directly and incorporated into the intervention.

While experienced nurses intuitively recognize the 19 strategies identified in this study as basic to nurse-patient relationships in most settings, the strength of this study lies in part in the empirical identification of these specific strategies as well as the elaboration in the nurse narratives of the multiple expressions of the strategies. For example, "control of intensity" might take the form of calming an angry mother with words and touch or encouraging a more intense expression of anger with a nod of the head and supportive words. "Facilitation of grieving" might entail giving the mother a journal with the goal of writing daily about her sadness or reassuring a child whose concern about her weeping mother is distracting the mother from expressing her grief. It is not new that nurses use multiple strategies in numerous ways to establish and maintain therapeutic interpersonal relationships with patients. What this article shows is that we can empirically identify these strategies with the intent of increasing understanding and expanding the knowledge base in nursing.

The results show that the most difficult barrier—the crushing lack of resources that placed the mother's mental healthcare behind more pressing essential family needs—was not solved by in-home intervention. Avoiding stigma by "flying under the radar" and getting into the mother's home was relatively easy when compared with the herculean effort to get *on* the mother's radar screen, that is, to get the mother to see the work as essential to her health and well-being. As such, making contact was the most frequently used strategy and required ingenuity and flexibility. An important factor was the present-oriented time thinking that made mothers' appear to respond to immediate rather than "future" gains. The high frequency with which nurses used encouragement was evidence of the need for mothers to hear that they were moving in the right pathway. The data supported that in successful relationships, encouragement may have provided enough immediate reward

to sustain the relationship until the mother could build self-efficacy and reliably produce replicable gains. Nurses also combined multiple relationship-based strategies such as empathy, physical touch, and gestures that facilitated quick assessments and "shorthand" communication between nurses and mothers.

Nurses used active demonstrations of empathy in two thirds of the home visits as a means of relaying that they were witness to the intense demands on mothers and the meager resources available to them. However, empathy also placed the nurse in jeopardy of overidentification with the mother's feelings of sadness, frustration, rejection, and loss of control. Essential to the nurses' process of sorting out the complexity of their empathic responses was the weekly peer supervision. As nurses discussed their experiences with these mothers, they were able to recognize their personal response to the mother's life circumstances, rethink their approach to the mother, and use the empathic response as an appropriate bridge for interpersonal connection, assessment, or to guide an intervention.

The data on the strategy of establishing contact suggested that the nurses needed to accept an asymmetrical commitment to the relationship and pursue the mother diligently. This type of relationship contradicts most traditional psychotherapy guidance. Our data showed that asymmetrical investment in the relationship occurred frequently, suggesting that it was essential to the engagement of mothers who have underutilized traditional mental health services. Given the intention of the projects to reach vulnerable infants and toddlers as well as these mothers, this and other shifts in traditional psychotherapy practices such as flexibility in scheduling may be shown to be effective modifications for this population.

In the process of doing research with underserved groups, we encounter anticipated barriers and discover new barriers through strategies to engage and retain participants in the research. Ongoing scrutiny of how a study is proceeding, such as looking at areas of success and challenge, may yield results that are as informative as the main study outcomes, thereby alerting the researchers to issues within the population being studied. As nurses encountered barriers in engaging and retaining mothers, they also responded in creative ways that were effective in retaining mothers who have underutilized mental health services. This information will be valuable in the analysis of the intervention outcomes and overall cost, as well as informing us about factors that will be important in the ultimate translation of these research results into practice.

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