

Négocié un terrain d'entente : les perceptions des soignants membres de la famille sur la dynamique des relations avec les prestataires de services de santé à domicile

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La prestation de services de santé à domicile aux personnes âgées exige la participation de nombreux professionnels et auxiliaires, mais elle dépend aussi largement de l'implication d'un réseau de soignants formé d'amis et de membres de la famille. Par conséquent, les relations entre prestataires à domicile et soignants membres de la famille constituent désormais un aspect essentiel de la prestation des soins. Les observations, toutefois, mettent en lumière des lacunes, des ambiguïtés, des tensions et des luttes de pouvoir. La présente étude avait pour but d'analyser les perceptions des soignants membres de la famille sur leurs rapports avec les prestataires de soins à domicile. Prenant appui sur la phénoménologie interprétative, les auteurs ont d'abord mené des entrevues en profondeur auprès d'un échantillon choisi à dessein constitué de soignants membres de la famille, puis employé une méthode d'analyse par immersion-cristallisation pour obtenir des données. On constate que ceux-ci conçoivent la construction du rapport avec les prestataires à domicile comme un processus dynamique, qui comporte des facteurs facilitants et des obstacles à caractère individuel et systémique. Ces facteurs d'explication permettent de mieux saisir comment se construisent les rapports entre prestataires et soignants membres de la famille dans le cadre des soins à domicile.

Mots clés : prestation des soins, famille

Working It Out Together: Family Caregivers' Perceptions of Relationship-Building With In-Home Service Providers

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Provision of in-home services to seniors involves the contributions of numerous professional and paraprofessional health-care providers but is largely dependent upon the involvement of caregiver networks consisting of friends and family members. Therefore, in-home provider/family caregiver relationships have become an essential component of care provision. However, evidence suggests that provider/family caregiver interactions often are lacking or are ambiguous and characterized by tension and power struggles. The purpose of this study was to explore family caregivers' perceptions of their relationships with in-home care providers. Applying interpretive phenomenology, the authors conducted in-depth interviews with a purposive sample of family caregivers and used an immersion/crystallization analysis strategy to elicit the findings. The findings reveal that family caregivers perceive their relationship-building with in-home providers as a dynamic process with facilitators and barriers encountered at both individual and system levels. The interpretive findings afford several insights into building provider/family caregiver relationships within the in-home context.

Keywords: caregiving, community health nursing, family, gerontology, nurse relationships/professional issues, therapeutic relationships

Over the past several decades, health-care delivery has shifted from institutions to community settings (Coyte & McKeever, 2001). The origins of this shift can be traced back to the deinstitutionalization of persons suffering from mental illness in the 1950s along with amendments to Canada's *Mental Health Act* providing for those who are not acutely ill to be cared for in the community rather than in hospital (Bibbings, 1994). Concern over the costs of institutionalization has also prompted the adoption of a health-care philosophy favouring community-based over institutionalized care (Weissert, Cready, & Pawelak, 1988). Hence, home care has grown exponentially across Canada.

As the population ages and life expectancy increases, seniors over the age of 65 presenting with multiple chronic conditions are expected to constitute the majority of those receiving in-home services. Provision of in-home services to seniors involves the contributions of numerous pro-

fessional and paraprofessional health-care providers but is largely dependent on the involvement of caregiver networks consisting of friends and family members. In fact, evidence suggests that these networks provide 75 to 85% of the personal care delivered to seniors (Fast & Keating, 2000), a role considered by family members as both essential and expected (Stajduhar, 2003).

Nevertheless, demographic and social changes raise concerns about the ability of family members to continue providing the bulk of care to seniors in the future. As families shrink in size (National Family Caregivers Association, 2003) and as increasing numbers of women enter the workforce (Wisensale, 2001), there may be fewer family caregivers available to provide the ever-growing amount of intensive unpaid care required. In-home provider/family caregiver relationships have become an essential component of care provision as health-care providers and family caregivers are required to coordinate their efforts to ensure that seniors' care needs are met on an ongoing basis (Ward-Griffin, 2001).

Accordingly, models of care provision have shifted away from the more individualistic "person-centred" or "client-centred" approaches that tend to focus on the client (Post, 2001) and towards models such as the "partnership approach" (Adams & Clarke, 1999) and "relationship-centred care" (Nolan et al., 2004), which extend care relationships to include clients, family caregivers, and others involved in the client's care management. In responding to this shift, providers have had to relinquish their traditional expert approach (Qureshi, Bamford, Nicholas, Patmore, & Harris, 2000) and adopt a more relational orientation based upon mutual respect, equity, and shared understanding (Clarke, 1999). In keeping with this paradigmatic shift and the contention that relationships are foundational to nursing practice (Gastmans, 2002), best practice guidelines have been developed to promote and facilitate provider/family caregiver relationships for the purpose of enhancing nurses' knowledge and skills in order to meet the needs of families (Registered Nurses Association of Ontario, 2002).

The evidence to date, however, suggests that there remains a gap between theory and application. Often, provider/family caregiver interactions are non-existent (Fischer & Eustis, 1994) or are ambiguous and characterized by tension and power struggles (McWilliam, Ward-Griffin, Sweetland, Sutherland, & O'Halloran, 2001; Ward-Griffin, 2001; Ward-Griffin, Bol, Hay, & Dashnay, 2003; Ward-Griffin & McKeever, 2000). The successful implementation of partnering and relationship-centred approaches calls for a greater understanding of family caregivers' perceptions of their relationships with in-home providers. Much of the literature addressing relationships between family caregivers and health-care providers is conceptualized in terms of a division of labour between the

two roles (Duncan & Morgan, 1994). Few studies (Clark, Corcoran, & Gitlin, 1995; Scharer, 1999; Ward-Griffin et al., 2003) have explicitly examined relationship-building amongst health-care providers and family caregivers, and virtually nothing is known about how family caregivers perceive relationship-building with providers during the delivery of home care.

The purpose of this study was to explore family caregivers' perceptions of relationship-building with health-care providers, including the barriers to and facilitators of this experience. The research question was *How do family caregivers perceive relationship-building with providers in the context of in-home service delivery?* It was our belief that the findings would have the potential to inform relationship-centred approaches to health-care delivery for seniors and have significance for practice, education, and in-home service delivery.

Literature Review

Provider/Family Caregiver Relationships

Research suggests that family caregivers prefer having close, personal rather than distant, professional relationships with nurses (Smyer & Chang, 1999) and that the type of relationship has an influence on the delivery of health care to senior clients. For example, Duncan and Morgan (1994) found that the formation of relationships with health-care providers enabled family caregivers to communicate their knowledge about the needs of senior clients and the most effective care strategies. Additionally, family caregivers have reported that forming relationships with providers allowed them to gain information about their relative's care, improved care coordination, made care delivery easier for providers, and ensured that clients' needs were met (Gladstone & Wexler, 2002). Family caregivers who develop relationships with health-care providers feel more comfortable accepting respite care provided in-hospital (Gilmour, 2002). Also, the formation of provider/family caregiver relationships has been shown to be instrumental in the ability of family members to let providers do the caregiving (Smyer & Chang, 1999).

However, family caregivers and providers are not always successful in establishing a positive relationship. Ward-Griffin et al. (2003) found the provider/family caregiver relationship to be characterized by an imbalance of power and status, with providers taking "power over" and limiting the input of family caregivers. Similarly, McWilliam et al. (2001) found that provider/family caregiver relationships based on the expert medical model of service delivery undermine care partnerships and contribute to family caregivers' sense of empowerment. Research findings also suggest that conflicting roles and expectations strain provider/family caregiver

relationships and contribute to the exploitation of family caregivers (Ward-Griffin, 2001; Ward-Griffin & McKeever, 2000).

Facilitators of Provider/Family Caregiver Relationship-Building

Numerous facilitators of relationship-building among providers and family caregivers are described in the literature. For example, providers can build relationships with family caregivers by offering emotional and cognitive support, being friendly and caring, communicating effectively, and establishing trust (Clark et al., 1995). Research indicates that provider/family caregiver relationships may be facilitated by providers who are empathetic, supportive, encouraging (Laitinen & Isola, 1996), non-judgemental, positive in their expectations, and willing to spend time with and engage with family caregivers (Scharer, 1999). It has also been found that provider/family caregiver relationships are facilitated by providers who are concerned, appreciative, compassionate, and welcoming and who take family caregivers' opinions seriously and regularly provide feedback (Hertzberg & Ekman, 2000; Ward-Griffin et al., 2003). For their part, family caregivers' positive expectations as well as readiness and willingness to engage with providers also serve to promote relationship-building (Scharer, 1999).

Barriers to Provider/Family Caregiver Relationship-Building

Researchers have also examined the barriers to provider/family caregiver relationships. Such barriers include a disregard by providers for family caregivers' knowledge and expertise (Duncan & Morgan, 1994; Gilmour, 2002; Hertzberg & Ekman, 2000; Ward-Griffin et al., 2003), lack of contact with family caregivers (Hertzberg & Ekman, 2000), and strict adherence to a division of labour (Duncan & Morgan, 1994; Ward-Griffin et al., 2003). Relationship-building is also hindered by ineffective communication (Gilmour, 2002) and by providers' negative and incongruent expectations of family caregivers (Scharer, 1999). Other impediments are absence of family caregivers when health-care providers are present in the home and family caregivers' lack of respect for or unrealistic expectations of health-care providers.

In summary, evidence suggests that provider/family caregiver relationships are highly valued by family caregivers. While researchers have identified facilitators of and barriers to relationship-building, much of the research has been conducted in institutions and has focused on the actions and perspectives of health-care providers. Greater understanding of family caregivers' perceptions of relationship-building in a community context could serve to optimize positive provider/family caregiver relationships during the provision of in-home care to seniors.

Methodology

Interpretive phenomenology is a methodological approach for the study and interpretation of everyday life. Using this methodology, the researcher is able to examine the “present and living reality” of perception and the complexities of human relations (Merleau-Ponty, 1964, p. 25). Interpretive phenomenology lends itself well to interpreting family caregivers' perceptions of their relationships with providers, particularly the facilitators and barriers encountered in this human experience.

The study was conducted within one home care program for seniors in southwestern Ontario, Canada. The program provides in-home services delivered by a multiplicity of professional and paraprofessional providers (case managers, registered nurses, registered practical nurses, social workers, speech-language pathologists, occupational and physical therapists, home support workers, and, on occasion, physicians). Characteristic of in-home service delivery in general, family caregivers were exposed to whatever categories of provider the client's care required, through visits scheduled only as frequently and regularly as needed. For this reason, the more general term “provider” is used to refer to those individuals who delivered paid in-home services.

The study was approved by and implemented in accordance with the guidelines of the University of Western Ontario's Ethics Review Board. Case managers employed by the home care program served as key informants, identifying potential family caregivers for the study. To be eligible for recruitment, family caregivers had to have provided care to a person 65 years of age or older who was or had been receiving in-home services. From among those eligible, participants were purposively selected to achieve maximal variation (Patton, 2002) of sex (nine females; two males); age (range = 35–94 years; mean = 67.4 years); relationship to the client (one woman caring for her mother; six women caring for their husbands; two men caring for their wives; one woman functioning as a power of attorney for an unrelated senior; one woman whose ill husband had recently died but who still wished to be interviewed); duration of relationship with in-home provider (range = 1.5–6 years; mean = 2.78 years); type of in-home service received (home support; registered nursing; registered practical nursing; occupational therapy; physical therapy); type of living arrangement (nine lived with the client; two lived away from the client); and types of care provided (personal care; banking and finances; shopping; housekeeping; preparation of meals; transportation; wound care; physical, spiritual, and emotional support; household maintenance), thereby promoting a holistic interpretation of the diversity of perspectives that might be found amongst family caregivers of community-dwelling seniors. Recruitment and sampling ceased when the

researchers encountered theme saturation (Patton, 2002) — that is, when the data were sufficient to answer the research question. The final sample consisted of 11 family caregivers.

Data were collected using face-to-face semi-structured, in-depth interviews (range = 60–150 minutes; mean = 83 minutes). All interviews were audiotaped and transcribed verbatim. Field notes of observations made during interviews captured non-verbal nuances and subtleties.

The immersion and crystallization strategy for interpretive analysis (Spiegelberg, 1982) was used to elicit the findings. This reflective process entails reading and rereading interview transcripts while simultaneously listening to the audiotaped interviews with the aim of achieving sensitization to nuances in the text. As themes and their connections to patterns became apparent, they were crystallized into an integrated, holistic interpretive analysis that was subsequently subjected to member-checking and peer review (Kuzel & Like, 1991) to ensure authenticity and credibility.

Findings

Family Caregivers' Experience of Relationship-Building With In-Home Providers

Family caregivers perceived their relationship-building with in-home providers as a holistic, interconnected, and dynamic process consisting of three components. From their perspective, relationship-building with the in-home providers began with *reluctantly making essential connections*. These relationships developed through two other relational components: *getting to know each other* and *finding ways to work together*. There was movement from one component of the relationship-building process to another, with facilitators and barriers encountered at both contextual and individual levels, as described in the following sections.

The Context of Care

Participants identified two contextual barriers and facilitators arising from the home care context. They perceived the barriers and facilitators of *not having/making time* and *not having/having continuity of provider* as vital to the relationship-building process as a whole.

Not having/making time. The participants perceived that their ability to build relationships was contextually impeded or facilitated by time. Family caregivers perceived that the time limitations of in-home providers undermined their relationship-building efforts:

[The provider] is so busy and has so little time when she's here, we often don't get the chance to talk much.

They also perceived that their own ongoing caregiving responsibilities put severe limits on the amount of time they were able to spend with in-home providers. The arrival of in-home providers afforded family caregivers the opportunity to obtain necessary respite or to attend to the necessities of daily living. One participant reported:

[The in-home provider] is here for 45 minutes. While she's with [the client] I have to do the grocery shopping and things like that. . . . It's not much time. I can't leave her [the client] any other time, you know. I'm afraid she'll fall again. . . . [The in-home provider] comes, I go.

Conversely, family caregivers perceived that their opportunity to build relationships with in-home providers was facilitated when they made the time to relate to one another:

The first day that she came, she was here quite a while . . . and we talked. That helped [build the relationship].

Not having/having continuity of provider. The family caregivers perceived that relationship-building with in-home providers was contextually impeded or facilitated by the assignment of in-home providers. They desired contact with the same in-home provider over time. They saw lack of continuity as a barrier to relationship-building and were frustrated by it:

I didn't get the same ones. Every time, someone different comes. I didn't really get to have a real relationship with any of them. They [provider agencies] switched to a new batch of people and I wasn't quite as pleased with that. . . . I find I have to show them where everything is and that kind of thing. It's frustrating. I find I keep repeating the same things over and over.

When participants were afforded continuity of in-home provider over the course of the client's care, they perceived that their ability to build relationships was improved:

I've had the same [in-home provider] for the last 3 years. That's made it much easier to have a relationship, I'd say.

Thus, family caregivers believed that the relationship-building process was facilitated by having time and by continuity of assignment of in-home provider. Not having time or continuity of provider often undermined their relationship-building efforts.

Reluctantly Making Essential Connections

Participants struggled with having to enter into a relationship with an in-home provider. For some, difficulties initiating such a relationship

stemmed from a perceived societal stigma against requesting outside assistance for an ill family member:

You have your pride. In our generation you didn't ask for help. Both of us came through the Depression, and in those days only those who really needed it got help, and you didn't dare take anything. Asking for help was a stigma in our minds. I guess it still is.

However, when the care demands of the ill senior became too great to be met by friends and family members, family caregivers had to confront the reality that outside assistance was required if institutionalization of the ill senior was to be avoided:

I'd like to keep doing it [providing care] myself if I could, but I can't. . . . It's either this [having in-home provider assistance with care] or [placing the client in] a home. I certainly don't want that.

Resenting/appreciating each other. Commencement of in-home health care presented an opportunity for family caregivers and in-home providers to form a relationship. However, some family caregivers resented having to accept outside assistance:

I'm sure they can sense that I'm not thrilled with having them here. . . . I'm short with them.

Others, however, saw the arrival of in-home providers in a positive light and expressed their appreciation:

I'll thank them and say, "Oh, gee, that made him [the client] feel so good" and "It's nice that you take time with him." Well, I think that it makes them [in-home providers] happy if they know that you're happy. It gets things off on the right foot.

Family caregivers also wanted in-home providers to appreciate them and their struggle to care for the senior:

I think the main thing is [for in-home providers to] just let people [family caregivers] know that they're going through a hard time and that you have feelings for them, not just the patient but also the caregiver.

Perceiving no need/need to connect. In addition to mutual expressions of appreciation, family caregivers perceived that relationship-building was facilitated by connections between in-home providers and themselves. However, even though in-home providers were in the home on a regular basis, some family caregivers saw no need to connect with them and were absent during their visits. According to one participant, there simply was no reason to be present while a provider was in the home:

There's no reason for me to be there when the providers are in the house.

Some family caregivers also believed that care relationships should exist primarily between in-home providers and the senior client and therefore chose not to attempt to make a connection. One participant elaborated:

She [the in-home provider] asked me at first or early on [to be involved], but I said, "Oh, no, this is between you and [the client]. . . ." After all, they were looking after him, not looking after me . . . we never talked.

Relationship-building was facilitated when in-home providers and family caregivers perceived a need to connect with each other. For instance, some family caregivers expressed a desire to connect with in-home providers by requesting inclusion:

I have a relationship with them [in-home providers] because I've asked for inclusion.

Several in-home providers also perceived a need to connect with family caregivers and expressed a desire to form relationships by inviting family caregivers to become involved. One participant explained:

She [the in-home provider] offered me [the opportunity] to come in [and be involved] . . . so I did.

Distancing/spending time. Although family caregivers and in-home providers were often in the home together during home care visits, some chose to distance themselves from each other, thus impeding relationship-building:

I really don't like having to have them here. . . . It's a bit of an intrusion. I don't get involved with the nurse.

Others, in contrast, perceived in-home providers as creating distance during the provision of care:

She [the provider] really didn't talk to me. She came in, did her thing, and then left.

Conversely, family caregivers and in-home providers facilitated relationship-building by spending time with one another. One participant reported:

I have a relationship with them because I've made a point of spending more time and talking with them when they're here with him [the client].

Family caregivers perceived that in-home providers made similar efforts to spend time with them:

They're here to help [the client], you know, but on their way to the bedroom or if they're preparing a bath they . . . come out here just to chat [with me].

On occasion, however, the nature of in-home service provision made it problematic for family caregivers and in-home providers to spend time together. As illustrated by the comments of one participant, in such instances providers arranged to meet with family caregivers outside the home:

You have to remember that when you're dealing with a husband and wife there are times when you won't say things in front of your spouse for fear of hurting them. . . . She [the provider] said, "Well, I'm working a lot up near [your area], so I'll give you a call some day and we'll have coffee." And that's how it [the relationship] started.

In summary, relationship-building within *reluctantly making essential connections* was impeded by those family caregivers who resented the involvement of in-home providers or by members of both groups who saw no need to connect. Additionally, when family caregivers and/or in-home providers maintained a distance, relationship-building was undermined. Conversely, family caregivers and in-home providers who expressed appreciation for each other, perceived a need to connect, and spent time together facilitated the building of what they viewed as an essential relationship.

Getting to Know Each Other

Participants described a "feeling out" process that involved mutual self-disclosure:

Well, I mean, when somebody comes in [to the home] they're a complete stranger. You sort of feel them out a little bit, to know whether you're comfortable with them. . . . You share things about yourself, and they do the same. You have to make the effort, I think. It's like that with anything . . . it makes it easier [to build the relationship] when you know a bit about them.

Conveying no interest/taking an interest. Family caregivers perceived that in-home providers' apparent lack of interest in getting to know them was a barrier to relationship-building. One participant regretted that her in-home provider did not show more interest in her:

She didn't seem too interested in getting to know me while she was here. I would have liked that.

On the other hand, in-home providers' interest in family caregivers as individuals facilitated relationship-building:

She would say, "What did you do? Did you start out with a cow and a couple horses and did it take you a long time to pay for that farm?" She was interested in us.

Keeping to oneself/disclosing one's life context. While family caregivers perceived that sharing their lives with in-home providers facilitated relationship-building, one participant indicated that such sharing did not always transpire:

There was one [in-home provider], we didn't get to know her very well at all. Most times you hear about their kids and things like that. . . . Not this one. She kept to herself, you know. She wasn't talkative. It's nice when you can find out about people.

At times, not having the opportunity to share life contexts contributed to feelings of apprehension and mistrust on the part of family caregivers:

I'm still very cautious having them coming in. I still don't know them very well. . . . I keep an eye on them. I'm always watching what they're doing.

Relationship-building was facilitated by the sharing of life histories, with family caregivers often asking questions on various topics:

I'd ask them about their kids or how their day was going. We talked, and it wasn't all about his [the client's] care and nursing. It was about, you know, her parents and animals and whatever.

Family caregivers would share details about themselves in return. One woman described how her in-home provider got to know her over time:

Oh, she knows all about me and [the client]. We usually get a chance to talk before she's off to the next person. . . . I've told her about our grandkids and our farm. I think they should know [details about my life].

In-home providers made similar efforts to share their life context with family caregivers:

The first time she was here she talked a lot. She got me to open up by asking us questions and telling us about her. She was terrific.

In summary, family caregivers placed high priority on getting to know their in-home providers and to being known in return. While relationship-building was impeded by perceived lack of interest and lack of self-disclosure, it was facilitated by efforts to express an interest in each other and to share life contexts.

Finding Ways to Work Together

Family caregivers perceived their ability to find mutually acceptable ways to work with providers as important for relationship-building:

They have to know the family. They have to know them well enough to know what they'll accept, what they won't accept, who they can work with and who they can't, and what the rules of the game are and [to ensure] that everybody understands them [the rules]. We have to know them too. Then you're in business and you can come to some reasonable solutions. I think you have to meet each other halfway.

Withholding/expressing needs. However, family caregivers were not always willing to share their perceptions with providers. In particular, they often admitted to being fearful of how their views would be received:

You have to stand up for your rights, and I found that difficult to do. . . . You worry that if you say something, then they will take it the wrong way.

One participant believed that any voiced criticism would result in a loss of in-home services:

Oh, some people have that mindset that if you . . . tell me off or if I don't do it the way you want, then get somebody else.

Another shared her perception that expressing her concerns would result in the mistreatment of the senior client by in-home care providers:

You'll pay for asking them to do it another way. . . . That's the same as your kids in school, isn't it? If you complain too much, then the teacher might take it out on them.

However, some family caregivers were able to express their needs and expectations:

Why would you just put up with something if you're not comfortable? I don't believe in that. If you're not comfortable, speak up — have something done about it.

Directing care as the expert/working things out together. Some participants had attempted to contribute their caregiving knowledge to the provider/family caregiver relationship but perceived it as unwelcome:

I've been caring for him for years, and sometimes he can be a little difficult, you know. I offered to sit with him while she was giving care, to help keep him calm. She said that it wouldn't be necessary as she has had many difficult patients. . . . He ended up falling. It didn't have to happen.

In contrast, family caregivers believed that having their experiential knowledge elicited and valued by in-home providers was beneficial for relationship-building:

I've been caring for [the client] for years now. I think that's worth something. She [the care provider] has been great. They ask for my opinions . . . I appreciate that. I think you have to meet each other halfway. They're here for a few hours and I'm here for the rest.

Similarly, they valued the contributions of in-home providers and often solicited their knowledge and expertise in determining how best to care for their ill relative:

I think it's far easier to sit down and say, Gee, I don't know how to do this, or What do you think I should do about such and such? I don't think I know everything. I'm willing to learn from her experience instead of pretending that I know it all.

In summary, relationship-building was impeded by both family caregivers' unwillingness to express their needs and expectations and in-home providers' tendency to direct care as the expert. Conversely, relationship-building was facilitated by family caregivers' and providers' willingness to share and use each other's knowledge and expertise in care delivery.

Discussion

The personal and individualistic nature of interpretive research precludes generalizability. Nevertheless, the findings of this study afford several insights that may be applicable in other health-care contexts, particularly those involving in-home or other community-based health services wishing to promote relationship-building with family caregivers. The participants in this study were reluctant to be dependent on and to form relationships with in-home providers. Evidence that family caregivers tend to consider caring a private matter, deem provider assistance as intrusive (Kellet & Mannion, 1999), and resist the use of in-home services even in the face of overwhelming care demands (Kramer, 2005) may explain the reluctance observed in this study.

Many of the family caregivers were confronted with the "ideology of familism" (Ward-Griffin, 2001), perceiving themselves as duty-bound and obligated to independently meet their ill relatives' care needs within the home. Some authors suggest that, in order for family caregivers to be more receptive to having relationships with providers, independence must be understood not as the ability to perform activities for oneself without assistance but as the ability to exert control over whatever help

is needed to achieve goals and objectives (Morris, 1993). This view of independence may be an underlying factor in the family caregivers' perceived importance of their having control over type and delivery of in-home care. Some participants did appear, ultimately, to transcend the independence/dependence dichotomy in a way that accommodated a realization of the importance of forming relationships with their in-home providers. Indeed, some authors view the human condition as one of *interdependence* (Shakespeare, 2000). Kittay (1999) argues that interdependency is not an alternative to or a negation of dependency but, rather, is based on a recognition of "nested dependencies" that link those who need support with those who can provide it. The present findings also reveal that providers' use of empathy to convey recognition and understanding of family caregivers' transition to interdependence facilitates relationship-building. This insight may inform the advancement of relationship-building with family caregivers and is particularly relevant to refining practice in the context of the home, where both individual independence and family autonomy are social norms.

The findings from this study suggest that relationship-building requires that family caregivers and in-home providers perceive a need to connect with one another and make an effort to do so. While the participants had many opportunities to interact with in-home providers, the findings reveal that family caregivers and in-home providers often chose either to relate to each other or to keep a distance. Consistent with the results of previous research (Gladstone & Wexler, 2000), some family caregivers employed strategies such as being present and requesting involvement as a means to connect and build relationships with providers, while others adopted the stance that providers should build relationships with clients only and did not see a need for relationships between themselves as caregivers and the providers of client care.

Some family caregivers reported that in-home providers ignored them and focused exclusively on the client, thereby precluding the formation of a relationship. This finding highlights the importance of moving beyond a narrow, client-centred orientation, to a more relationship-centred (Nolan, Davies, Brown, Keady, & Nolan, 2004) or partnering approach (Adams & Clarke, 1999) that considers all those involved in the client's care management. This position is supported by Fine and Glendinning (2005), who contend that it may be increasingly inappropriate to focus exclusively on senior clients and ignore the needs of family caregivers.

The findings also demonstrate how providers' devaluing of relational aspects of care can undermine relationship-building. Evidence suggests that providers tend to focus on biomedical, task-oriented aspects rather than on relational aspects of care delivery (McCabe, 2003) that entail

largely invisible emotional labour (Hochschild, 1983). Devaluing of relationship-building may stem from the current focus on the acquisition of technical skills in health-care curricula (Chant, Jenkinson, Randle, & Russell, 2002), which tend not to include guidance on working positively with seniors (Wadensten & Carlsson, 2003). Given the insights into the value of relationship-building arising from this study, curricula for health professionals might be enhanced by greater focus on important aspects of human relationships such as empathy, presence, self-disclosure, and empowerment and by a clinical orientation on developing the skills that health professionals need in order to build relationships with family caregivers.

Nichols (1995) argues that the need to communicate what it is like to live in our individual, separate worlds of experience is a powerful aspect of human relationships. While the benefits of mutual knowing amongst providers and family caregivers are well documented (Gladstone & Wexler, 2002; Scharer, 1999), the findings from this study highlight the necessity of mutual self-disclosure for the purpose of relationship-building. The findings also suggest that relationship-building is facilitated when family caregivers are able to assert their own needs and when in-home providers welcome and elicit family caregivers' contributions, thereby possibly mitigating any reluctance on the part of family caregivers to express their viewpoints for fear of repercussions from in-home providers (Hertzberg & Ekman, 2000; May, Ellis-Hill, & Payne, 2001).

Lastly, this study has identified two important contextual factors that influence relationship-building, namely time for relationship-building and continuity in the assignment of service providers. Research has shown that while continuity of provider assignment facilitates relationship-building (Gladstone & Wexler, 2002; Scharer, 1999), discontinuity in provider assignment contributes to feelings of exhaustion for some family caregivers, who then lack the energy to restart the relationship-building process (Hertzberg & Ekman, 2000). If family caregivers and in-home providers are not given sufficient time and continuity, their ability to effectively build relationships may be impeded.

In-home service providers are well positioned to reshape their relationships with family caregivers. As all individuals are unique human beings, family caregivers will not have identical needs, motives, and expectations for relationships with providers of care to an ill senior. However, in-home providers need to elicit and discuss family caregivers' perceptions of their desired partnering scenario (Scharer, 1999). This may enable in-home providers and family caregivers to connect on a personal level, thereby affording an opportunity for the co-creation of care-delivery strategies that not only are more mutually acceptable but also optimize family members' caregiving potential. While relationship-building

may take time, researchers (Duncan & Morgan, 1994; Gilmour, 2002; Gladstone & Wexler, 2000; McWilliam et al., 1999; Smyer & Chang, 1999) have found that the effort positively influences the provision of services.

Conclusion

While further research is required, the findings of this study extend our knowledge in a number of ways. For relationship-building to occur, family caregivers and providers must connect with each other. The mere presence of both family caregivers and providers in the home at the same time does not always lead to the formation of relationships, while the absence of family caregivers removes even the possibility of relationship-building. The findings demonstrate family caregivers' desire and need to share life contexts and the lack of trust caused by providers' failure to self-disclose. Lastly, the findings indicate that lack of time and frequent changes in provider assignment have the potential to undermine the ability of providers and family caregivers to form relationships. If quality in-home service is to be optimized, administrators and decision-makers will have to consider the possibility that the costs incurred in affording more staffing time for the development of provider/family caregiver relationships may be offset by more timely and personalized care delivery to seniors. Most importantly, the findings illuminate the role of family caregivers as invaluable partners in care and invite providers to attend to relationship-building efforts with family caregivers in the pursuit of this aim.

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