

**BEING THERE AND BEING WITH FAMILIES: FAMILY UNDERSTANDINGS OF
PUBLIC HEALTH NURSE-FAMILY RELATIONSHIPS**

by

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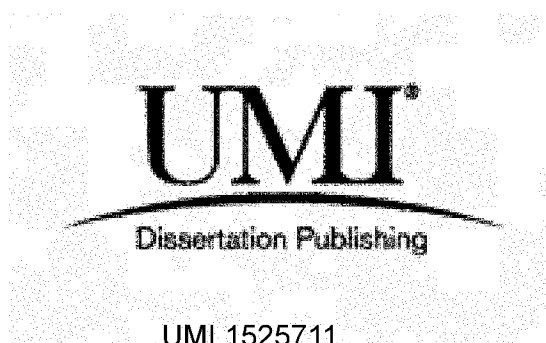
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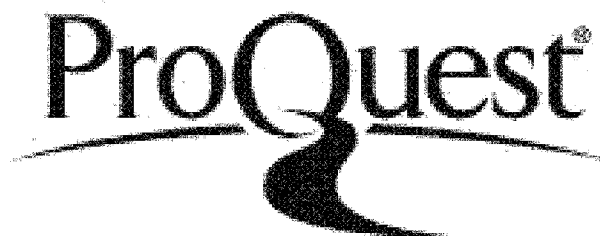


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Abstract

As a phenomenon in nursing, the experience of presence is thought to unfold through relationships between nurses and their clients. Although literature on nurse-client relationships emphasizes the importance of presence few studies explore the phenomenon from the perspective of families. In this thesis I explore families' experience of nursing presence in their relationships with public health nurses. The intent is to understand how families experience presence and how nursing presence contributes to the development of relationships. Eight family interview transcripts were analyzed using a hermeneutic phenomenological approach. Analysis and interpretation of the transcripts revealed that families experience nursing presence when they work with nurses whose perceptual abilities and relational skills enable them to intuit how to respond to and work with families in ways that are meaningful to the family. The study demonstrates the need for nurses to be responsive to families' needs as they shift and change over time.

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CHAPTER ONE

Contextualizing the Problem

“Do for, do with, and cheer on”

The words written above *Do for, do with, and cheer on*, in many ways form the impetus for this study. When I graduated with my undergraduate nursing degree, I entered the practice area of public health where I worked with a program entitled Families Count. The Families Count Program (FCP) provided intensive support for high priority families in the areas of family functioning and child growth and development for up to five years. When I first came to work with the program, I was confronted with the words *Do for, do with, and cheer on* cut out of construction paper and tacked to a large bulletin board outside the main door. I can distinctly remember my initial thoughts regarding what I assumed to be a slogan or general words of motivation and wondered about their relevance to practice. When I entered my office, which was shared with another Public Health Nurse (PHN), I asked her, “What’s the *Do for, do with, and cheer on* thing all about?” Her response was, “Oh that! That’s what we do here”.

Initially, my partner’s response confused me. I remember thinking “what do you mean it’s what we do here”? It was not until I began my practice with families and realized how important relationships were to the success of the work that I understood the depth and breadth of the words that initially I thought were really rather simplistic, and juvenile in their presentation. *Do for, do with, and cheer on* were words that formed a philosophy of practice that guided all of our work with families in the FCP. More importantly they acted to guide how we were *to be* in relationship with families. *Do for* informed what we did pragmatically

in the way of educating and sharing information and typically served to initiate relationships with families. *Do with and cheer on* represented practically and philosophically how we were to work with families in the middle and end stages of the relationship respectively. Once relationships were firmly established with families engaged in service provision, we were to begin a process of stepping back, allowing families to lead and learn on their own until the family felt confident to “go it on their own”. In essence *Do for, do with, and cheer on* called for an approach to practice that valued relationships built on reciprocity and mutuality. In order to establish relationships that worked, PHNs had to value the strength and resilience of families, have faith in families, and in turn act to invoke these feelings within the families themselves.

When I completed my orientation with the FCP and began practicing independently, I began wondering how I could operationalize the meanings embedded in the words *Do for, do with, and cheer on*. I looked to other nurses for guidance and became intrigued with how some had fully embraced the philosophy underlying the FCP, integrating it seamlessly through all of their practice with families. They appeared to easily and openly cultivate relationships with families, in particular families whose experiences and every day realities were far removed from their own.

The ability to connect with families, despite apparent differences, was significant because the FCP was primarily aimed at families whose experiences with varying degrees of vulnerability at times made developing relationships challenging. Some of these families had experienced untold hardships that made it difficult for them to be open and trust the nurses. As I watched the nurses work to forge relationships with families, it became clear

that something exceptional existed within the relational capacity of those who easily connected with families. But what was it? Was it something inherent in them; in their way of being? Or was it something in the process of relating, something unspoken yet pervasive that worked to engender a sense of trust and willingness on the part of the family such that they welcomed the opportunity for relationship?

These observations began a process of inquiry into the nature and character of nursing presence and its contribution to developing and maintaining working relationships with families. Nursing presence is considered to be a key feature of good working relationships with families, but it is a concept that is poorly studied and thus difficult to ascertain within the context of PHN practice (Benner, Tanner, & Chesla, 2009; Parse, 1997; Paterson & Zderad, 1988). Despite extensive theoretical exploration, there is little research examining how nursing presence is operationalized in practice. Furthermore, the few studies that do explore the concept within the context of PHN practice only do so from the perspective of nurses. Very few studies explore nursing presence from the perspective of families. When we consider that nursing presence exists at the core of good working relationships, it seemed prudent to obtain the perspectives of clients engaged in relationships. With the perspectives of clients, we are better poised to understand what comprises nursing presence and how its experience contributes to the development of relationships. Current research only provides a partial view of the role of nursing presence plays in developing relationships between nurses and families.

Statement of Purpose

This study is aimed at developing a clearer understanding of the nature and character of nursing presence, and how it contributes to the development of working relationships with high priority families. This study is particularly concerned with how families experience nursing presence; how nursing presence unfolds over the course of the relationship; how it makes families feel, and what they recognize as comprising nursing presence. Invoking an understanding of how families experience nursing presence will enhance our conceptualization regarding the nature and character of good working relationships and contribute to the seemingly scant body of literature exploring presence from the perspective of families.

Overview of the Study

Data for this study were produced as part of a larger qualitative project entitled, *The Nature and Character of Working Relationships Between High Priority Families and Public Health Nurses* [WRP] (MacLeod et al., 2005). In the study, which was conducted in northern British Columbia, public health nurses (PHNs) identified one of the most important, yet difficult areas of their practice to be working with high priority families (MacLeod et al., 2005). PHNs stated that “often they do not understand the experience of high priority families and that they are concerned with whether or not their services make a difference to the families” (p.12a). PHNs recognized the importance of developing good nurse-family relationships but also described inherent difficulties in doing so when family experiences appeared to be far removed from their own (MacLeod et al., 2005).

In response to PHNs, the WRP (2005) sought to articulate the nature and character of working relationships between PHNs and families. To this end, the WRP researchers interviewed both nurses and families with the aim of not only understanding and articulating processes involved in developing working relationships but as well, providing insight into how families and nurses inter-relate to develop responsive, supportive relationships. The original study employed three avenues of inquiry. The first was to conduct in-depth, open ended interviews with participants to elicit rich narrative data about families' and nurses' experience, and the contexts of that experience (MacLeod et al., 2005). The second involved participant observation of PHNs and lastly, a documentary analysis of relevant nursing policies and standards was conducted (MacLeod et al., 2005). The research study reported in this thesis utilizes interview data, both in audio form and transcripts, from eight families interviewed during the original WRP study. Four transcripts were chosen from families who described their relationship as challenging and four from families who considered their relationship to be easy. The decision to choose transcripts that described extreme variances in experience facilitated a better understanding of the complexities inherent in developing relationships and the role nursing presence plays in mitigating those complexities.

In this study, an interpretive approach is used to uncover the lived experience of nursing presence as it unfolds over the course of relationships with PHNs. Interpretive approaches allow researchers to explore phenomena to uncover a meaningful account that resonates with the experience of those involved in the study as well as those who read the study results (Moules, 2002). Interpretive approaches are not used to achieve a truth that is equated with frequency, reoccurrence, and control. In the original WRP study, MacLeod et

al. (2005) noted that an interpretive or hermeneutic phenomenological approach would be used in data analysis. This study follows the approach taken in the WRP study and draws on the philosophical hermeneutics of Hans Georg Gadamer (1989) and the methodological approach to interpretive research afforded by Max vanManen (1997).

CHAPTER TWO

Review of the Literature

The following literature review presents literature concerned with the development of relationships between PHNs and families. The first section provides background information concerning the nature of PHN work and the context in which it is carried out in order to explicate the role of relationships. The second part of this review explores theoretical literature specifically concerned with nursing presence. The third section looks at concept analyses exploring nursing presence in order to locate nursing presence within PHN-family relationships. The fourth section of this review explores qualitative research concerned with the nature and character of developing relationships between families and nurses. The fifth section focuses on literature concerned with the nature of PHN-family relationships with high priority families and includes a sixth section on the importance of responsiveness. Finally, the last section of the review highlights the practice of home visiting in PHN practice with families. All of the literature reviewed is used to explore what is thought to contribute to the development of good working relationships between nurses and individuals or families. What are missing from all three are the perspectives of individuals and families. With the exception of one qualitative research study, views into what comprises good working relationships are only offered from the perspective of nurses and as such, leave some speculation as to how nurses and families interrelate to develop good working relationships.

Public Health Nursing Practice and Context: Why Relationships Matter

Developing good working relationships with families is relevant to all nursing roles, but it is particularly relevant to the work of PHNs (Heaman, Chalmers, Woodgate, & Brown, 2006). The nature of PHN work and the context in which it is carried out emphasize relational skills that enable nurses to gain *entre*, develop *rapport*, and engage clients in the provision of service (Heaman et al., 2006; 2007; Luker & Chalmers, 1990). Despite the emphasis on relationships in PHN practice, PHN education does not emphasize the skills necessary to engage in good working relationships with families. Although therapeutic communication courses teach skills and techniques associated with good communication, they do so prescriptively, failing to emphasize the importance of connection and collaboration in PHN practice with families (Arnold & Boggs, 1999).

In other nursing roles, gaining *entre*, developing *rapport*, and engaging clients in service can be less challenging because explicitly stated health problems determine clearly the nurse's course of action (Briggs, 2007). PHN work however, focuses on what are often considered the invisible aspects of health: health promotion and disease prevention (Public Health Agency of Canada, 2007). Health promotion is defined as a mediating strategy between people and their environments, "a positive, dynamic, empowering and unifying concept that is based on the socio-environmental approach to health" (Community Health Nurses Association of Canada [CHNAC], 2003, p. 36). According to the Community Health Nurses Association of Canada Standards of Practice (2003), disease prevention involves a repertoire of activities designed to minimize the occurrence of diseases or injuries and their consequences to individuals, families, and communities.

The foci of health promotion and disease prevention on the prevention of illness are often what characterize the work of public health nurses as invisible. In Canada, the approach to health care delivery has largely been focused on curing illness instead of prevention. The largest consumers of health care spending in Canada have historically been hospitals, physician services, and pharmaceuticals (Canadian Institute for Health Information, [CIHI], 2011). Although trends in spending are beginning to shift with public health receiving more funding, public uptake of health promotion and disease prevention strategies continues to wane within some populations (CIHI, 2011). It is not uncommon for PHNs to feel as though they have to sell health promotion and disease prevention work to the general public.

Adding to the complexity of the work is the role of PHNs in addressing issues related to the non-medical or social determinants of health which focus on social and environmental issues thought to impact health status (CHNAC, 2003). Some of these determinants include issues related to income and social status, race, and gender that because of inequities related to the distribution of money and power, profoundly impact the lives and health status of families globally, nationally, and locally (Epp, 1986). Although the social determinants of health are now widely accepted and considered essential to approaching health status holistically, addressing these issues on an individual and a collective basis can prove challenging (Hogan, 2008). Many of the systemic issues identified as impacting the health status of a population require inordinate amounts of time, resources, and funding in order to be adequately dealt with (Hogan, 2008). Furthermore, many individuals and families who live with varying degrees of vulnerability already feel underserved and undermined which

can create barriers to overcoming issues related to the social determinants of health (MacLeod et al., 2005; Moules, MacLeod, Thirsk, & Hanlon, 2010).

Given the magnitude of issues related to the social determinants of health, the CHNAC (2003) directs PHN practice towards building individual and community capacity to increase the skills, knowledge, and willingness so community members can take action on their own in the future. One of the key aspects throughout this process is ensuring maximum involvement and participation of community members (CHNAC, 2003). This involves an element of outreach whereby PHNs seek out and meet with those who would likely benefit from their services. It also involves the capacity to form long and lasting relationships to ensure the success of programs and services (CHNAC, 2003). Mittlemark (2001) writes that building relationships with individuals, families, and communities helps promote social responsibility for health. Mittlemark (2001) argues that the best-intentioned national or international healthy public policy initiatives may fail to have the intended impact at local levels because of an ignorance of local contexts. PHNs working in communities are perfectly poised to translate and contextualize national policy in ways meaningful to the families and communities with whom they engage. PHNs do this through the development of relationships. Their position as nurses and community members provides them with a unique understanding of the community that can assist with the mobilization of resources and the maximization of public participation (Mittlemark, 2001).

The focus on relationships is further emphasized by the context in which PHNs work (Briggs, 2007; Doane, Browne, Reimer, MacLeod, & McLellan, 2009). According to the CHNAC (2003), the nature of PHN work requires that PHNs meet clients in increasingly

diverse settings, such as community health centers, schools, the street, and in family homes. In addition, PHN services are invited services (Hogan, 2008). They are not required nor are they mandatory but occur at the volition of individuals, families, and communities (Hogan, 2008). The emphasis on meeting clients where they *are* coupled with the voluntary acceptance of service places considerable emphasis on relational skills. PHNs are required to pay particular attention to processes involved in developing, maintaining, and ending relationships that are respectful and indicative of the nurses' full attention to the needs of individuals, families, and communities (Hogan, 2008).

Studies that have explored the relational processes involved in developing, maintaining, and ending relationships have found that underlying most good working relationships is a need for nurses to be highly attuned and in synchrony with families (Appleton, 1996; Briggs, 2006; Chalmers, 1992; de la Cuesta, 1994; DeMay, 2003; Moules et al. 2010; SmithBattle, 1997; 2009; SmithBattle, Lorenz, & Leander, 2012). MacLeod et al. (2005) liken the process to a "tip toe dance"; "a precarious interaction full of tentative advances and retreats" (p.32). During a tip toe dance there is an ever-present risk that toes might get stepped on. In the context of developing relationships, the toes to worry about are those of the clients with whom the PHN engages. By being attuned to the subtle cues and nuances of the family, PHNs poise themselves to ensure that their next step is the right step in serving the needs of the family.

The precariousness of relationships between PHNs and families is well documented in the literature (Byrd, 1995; MacLeod et al., 2005; Moules et al., 2010; SmithBattle, 1997; 2009; SmithBattle et al., 2012). Relationships are tenuous, particularly in the beginning

where there is “a careful testing of boundaries, rules, and conditions of the relationship” (Moules et al., 2009, p. 3). This is particularly significant for many high priority families who may be extremely reticent about inviting PHNs into their homes. Past experiences with authority and/or other service providers may have been experienced negatively, which in some cases clouds expectations for all future interactions with people in positions of authority (Byrd, 1995; Selwood, 2010).

Under the circumstances outlined above, developing relationships with families can be extremely challenging. Literature exploring the nature of relationships between PHNs and high priority families stresses the importance of highly developed perceptual and relational skills. Very few studies, however offer a view into how these unfold in practice. Many studies list, somewhat prescriptively, nurse characteristics thought to contribute to good working relationships but few provide any insight into the inter-relational experience that unfolds between families and PHNs. The following section of this review explores literature specifically concerned with nursing presence. Although presence is a difficult concept to define, literature focused on the phenomenon recognizes it as a key component of developing relationships. The sections that follow explore theoretical literature and concept analyses concerned with presence in order to gain a sense of what presence looks like, how it unfolds in practice, and what it contributes to the development of relationships.

What is Nursing Presence Theoretically?

Presence exists as a somewhat ineffable concept which makes it difficult to describe and define. Most dictionaries provide circuitous definitions owing to its numerous uses in describing particular qualities or conditions or states of existence. For example, presence is used to describe a way of being that denotes an individual's bearing, stature or carriage (Oxford English Dictionary, n.d.). It also describes a type of existence that is detectable either physically or spiritually, and it is also used to imply proximity to something or someone (Oxford English Dictionary, n.d.). Despite its multiple uses in the English language, the experience of presence always invokes a particular feeling that develops in relation to something or someone else. As a phenomenon in nursing, presence is thought to unfold, and thought to be experienced, through relationships. The emphasis on the word, thought, is deliberate. Without the perspectives of individuals and families, it is difficult to know for certain the extent of the phenomenon as it is experienced in relationships with nurses. The following body of literature however does contribute to the phenomenon as it is understood by nurses.

Theoretical nursing literature exploring nursing presence focuses on qualities associated with the concept that are thought to invoke a sense of unconditional regard for individuals and families and that have great capacity to heal physically, spiritually, and emotionally (Benner et al., 2009; Godkin, 2001; Parse, 1997; Paterson & Zderad, 1988). Parse (1997) locates presence within relationships between nurses and individuals and families by relating true presence with the intention and the will to be present with another. Nurses who are present are with people without expectation or preconceived ideas of what

the other is going through or experiencing (Parse, 1997). True presence, as Parse (1997) describes it, is a “subject-to-subject interrelationship that honours the ever-changing reality of the other” (p. 173).

Paterson and Zderad (1988) similarly understand presence to be a phenomenon that occurs in practice, with the giving of oneself in an inter-subjective reciprocal relationship. Presence evolves through dialogical experiences that occur between the nurse and client. Dialogue is understood in this context to include an ontological sphere: a form of lived dialogue that involves a particular way of inter-subjective relating (Lived Dialogue section para. 2). Paterson and Zderad (1988) described the dialogical experience as a way of “seeing” the other person as a distinct unique individual and openly entering into relation with them (Lived Dialogue section para. 6). In their openness to enter and engage fully in relationship, the available nurse reveals themselves as *present* (Lived Dialogue section para. 8).

Benner et al. (2009) also locate presence within relational practices that involve nurses, who through years of practice experience have developed a moral and ethical comportment that reflects “embodied, skilled know-how of relating to others in ways that are respectful, responsive, and supportive of their concerns” (p. 280). The experience of presence then occurs in relationship with nurses whose *comportment* reflects more than words, beliefs, and values; “it encompasses stance, orientation, touch – thoughts and feelings fused with physical presence and action” (p. 180).

How is Nursing Presence Defined Conceptually?

Concept analyses concerned with nursing presence follow the work of the theorists explored above by also locating presence within praxis. Praxis refers to the application of theory in practice. In contrast to the theoretical literature, concept analyses focus on defining attributes and antecedents associated with the concept of presence in an attempt to define the phenomenon. The concept analyses explore presence as it is practiced by nurses engaged in the development of relationship. In order to articulate presence in practice, the concept analyses focus on defining attributes and antecedents associated with the concept such that the practice of presence becomes visible and can be more easily operationalized in practice. Doona, Chase, and Haggerty (1999), Finfgeld-Connett (2006), and Hessel (2009), and Tavernier (2006) list several attributes such as openness, availability, willingness, and attentiveness that, in practice, invite individuals and families into therapeutic alliances or relationships with nurses. Antecedents listed include the client's need for presence, which is evidenced by physical and psychological distress. The individual in need must also be open to presence (Doona et al., 1999; Finfgeld-Connett, 2006; 2008). In other words, the presence of the nurse can be invited but enacting presence requires that the client accepts the nurse's invitation of presence (Finfgeld-Connett, 2006; 2008).

Osterman, Schwartz-Barcott, and Aselin (2010) explore nursing presence with a focus on the acute care setting. In their qualitative study, they detail many of the same attributes and antecedents associated with nursing presence that are outlined in the concept analyses discussed above. One striking difference however is the distinction made between four different types of presence observed in hospital based nursing. Osterman, et al., (1996;

2010) point to different ways of being there and being with clients. Firstly, “presence alone” is defined as being there in the context of another. Second, “partial presence” is defined as being there but focused on a particular task that is relevant to but not directly focused on the client. Third, “full presence” is distinguished as a way of being there in the context of another that involves physical presence and an “interactive presence which is evidenced by attentive listening and responding, and focused on the client” (p. 198). Lastly, Osterman, et al., (2010) describe “transcendent presence” which is broader in scope, more abstract and elusive. Transcendent presence focuses on the existential and is reminiscent of descriptions offered by Parse (1997). Here the focus is on the metaphysical, referring to an energy exchange between the client and nurse that is transforming and more spiritual in quality (Osterman & Schwartz-Barcott, 1996; Osterman, et al., 2010). Individuals involved in transcendental presence are physically there and centered as in a meditative state, “they feel spiritually connected, and energy emitted can be felt by others in the environment” (Osterman, et al., p. 199).

What Does the Research say about the Nature and Character of Nursing Presence?

In contrast to the theoretical literature and the concept analyses reviewed, qualitative research literature does not locate presence as a topic of inquiry within the context of developing relationships. Rather, this body of literature focuses on particular nurse characteristics thought to contribute to ways of being and working with families that invite them into relationship and keep families engaged until the completion of services. Presence is not overtly discussed but rather alluded to through various descriptions related to the nurse and her way of working with the family.

Studies exploring the nature and character of relationships between PHNs and families emphasize good working relationships with nurses whose particular ways of being and working with families engender a sense of trust, confidence, and empowerment with families. Relationships are defined as a meeting, whether deliberate or not, between a nurse and an individual for an expressed purpose that is usually defined by some kind of health concern (Peplau, 1997). Inherent in each relationship are *relations* that Peplau (1997) defines as “the connections, linkages, bonds or patterns that develop and are identifiable within the relationship” (p. 162). Relations, Peplau (1997) reasons, are developed, formed, and dependent on reciprocity. Their reciprocal nature, however is not equal nor is it balanced. According to Peplau (1997) the formation of relation within the context of nurse-family relationships rests squarely with the nurse. She writes:

Relations depend on participant observation; on the nurses unflinching self-scrutiny and total honesty in assessment of their behaviour in interactions with patients. By observing and analyzing their own behaviour, nurses become aware of the needs, intentions and messages they communicate to patients (p. 163).

Developing relationships therefore involves a capacity for self-reflection that results in a nurse’s heightened awareness of the words, voice tones, body language, and other gestural messages that they use and that are noticed by clients. By paying attention to these, nurses become aware of their own ways of communicating, and in turn learn to recognize what is useful and what is not useful to the families with whom they engage.

Peplau (1997) calls this process participant observation, which on first reading seems rather erroneous. Participant observation usually refers to processes carried out by the nurse

in their assessment of individuals and clients and rarely emphasizes self-assessment. However, in her definition, Peplau not only stresses the importance of a nursing self-assessment, but also emphasizes the family's assessment of the nurse. In other words, participant observation occurs on both sides of the relationship. By emphasizing the importance of self-assessment and including families in the process, Peplau accomplishes two things. First, she offers a view of the relationship from the perspectives of families. Although this view is not emphasized nor is it clearly articulated, its importance is certainly implied. Second, she asks that nurses be cognizant of their approach with families and that they consider how they might shift and change approaches to suit the needs of families. This process, reasons Peplau, involves an adjunct form of observation called *empathic linkages*.

Empathic linkages involve the ability to feel in oneself the emotions experienced by another in the same or similar situation (Peplau, 1997). When an individual or family is experiencing anxiety, nurses who similarly feel their anxiety form an empathic link. The nurse essentially connects with the family through the shared feelings associated with anxiety. More important to developing empathic links is how the nurse responds to these feelings (SmithBattle et al., 2012). If the nurse is attuned to their own ways of being and acting in relationship, and has taken the time to observe how the family responds, then theoretically her response should be congruent with the experience of the family. However, if the nurse understands one way and one way only in her way of relating with families, then quite possibly her response will fall short causing the relationship to falter.

Participant observation and observation that fosters empathic linkages are according to Peplau (1997), critical to moving *with* individuals and families through relationships to

ensure the success of interventions. Moving with families requires a different approach than what is normally applied in those situations that emphasize a *do to* approach with families. *Do to* relationships, reasons Peplau, should only occur in emergent situations where a client's life hangs in the balance. *Do with* should always be the goal of any therapeutic alliance or relationship with individuals and families because its focus is with the family and its goal is it to empower the family (Peplau).

Relationships in general evolve over three phases: an orientation phase, a working phase, and a termination phase (Peplau, 1997). Throughout the literature these phases are described differently, however all explanations represent a definitive beginning, middle, and end to relationships. In PHN-family relationships each phase of the relationship is distinguished from one another by the nature of the work and by subtle differences in the way PHNs respond to families from one phase to the next (Mulcahy & McCarthy, 2008; SmithBattle, 1997). Movement through the phases is largely determined by the family's response to the nurse (Heaman et al., 2006). For example, the orientation phase with a family who seems reticent to engage with PHN services may involve a nurse who approaches the family with warmth and openness in hopes of establishing trust. If the nurse's reading of the family is indeed on mark and they respond to her by choosing to engage with services, they effectively move to the next phase, the working phase. Movement into the working phase may bring with it a need for a different kind of interaction than that which characterized the first phase. The nurse who approached the family with cautious optimism in the orientation phase may find that the family in the next phase requires confidence and a sense of friendship. Peplau (1997) cautions against relationships that bear any resemblance to

friendship, however other authors offer different perspectives by insisting that the word *friend* be an integral part of professional relationships between nurses and families (SmithBattle, 2000; 2009; SmithBattle et al., 2012).

The most widely understood definition of friend is “a person with whom one has a bond of mutual affection, typically one exclusive of sexual or family relations” (Oxford English Dictionary, n.d.). Other definitions offer a different dimension to the meaning of the word that when considered in the context of nurse-family relationships make friendship important in the development of good working relationships. The most notable of these definitions are friend, defined as “a person attached to another by feelings of affection or personal regard” and friend as “a person who gives assistance; a patron or supporter” (Oxford English Dictionary, n.d.). When conceptualized this way, the word friend implies an inter-relatedness that evolves with PHNs whose relational skills support families based on who they *are*, rather than who the nurse presumes they should be. Conveying a sense of unconditional regard for families is particularly significant for many high priority families whose experiences with vulnerability often leave them consigned to the outer margins of society (SmithBattle, 2000).

High Priority Families

The term high priority family or vulnerable family evolves from the language of PHNs interviewed during the WRP (2005) study. PHNs in northern communities use the term to describe families identified as having actual or potential parenting concerns that may impede optimal growth, development, or safety of their children (Moules et al. 2010). In the WRP study, PHNs reported that standard practice was to identify high priority families

through the use of the Parkyn infant risk screening tool that assesses families over physiological, developmental, and functional domains (Selwood, 2010). Families with a score of 9 or more on initial infant/child screening are flagged by the PHN who then follows up with the family in an effort to foster healthy infant and family development (Selwood, 2010).

In the literature, high priority families are typically referred to as vulnerable, high-risk or at-risk (Appleton, 1996; Jack, DiCenso, & Lohfield, 2002; Mulcahy, 2004; Plews, Bryar, & Closs, 2005). Identification of these families in public health or community health settings typically involves use of an assessment tool but is not limited to the Parkyn (Selwood, 2010). Moreover, many PHNs admit to using their own professional judgment when determining risk (Appleton, 1996). When PHNs define risk, they recognize it as both ambiguous and transient, noting that many families can move in and out of risk and its varying degrees (Appleton, 1996; Jack et al., 2002). Identification of risk however, always involves an expressed concern with the development of children (Appleton, 1996; Jack et al., 2002; Mulcahy, 2004). In extreme cases, it involves concerns for the physical safety of children and/or other family members (Appleton, 1996).

SmithBattle's (1997; 2000; 2009; SmithBattle et al., 2012) work focuses on developing nurse-family relationships with a segment of society that is often understood as being extremely high priority or high risk. Teenage childbearing is often believed to jeopardize the trajectory to adulthood by interrupting education and curbing access to the labour market, which ultimately leads to the persistent poverty associated with welfare assistance or low-skill jobs (SmithBattle, 2000). Perhaps more damning is the scrutiny faced

by many of these teens when dealing with people in positions of authority. Many nurses and clinicians treat teen pregnancy as a personal decision, laying blame with the mother for her inability to make good decisions (Knott, & Latter, 1999; SmithBattle, 2000). SmithBattle, (2000) argues that an over simplified understanding of teenage pregnancy disregards the distinct life-worlds of teens. Contrary to what is often presumed, many teen mothers relish in the dreams and accomplishments associated with teens that do not have children.

SmithBattle (2000) argues further that in the face of this kind of scrutiny, a *friend* as it is defined above, with its emphasis on providing support and engendering a sense of regard, is what many teen moms need. More importantly PHNs engaging in relationships with teen mothers that resemble *friendships* invite trust and forge connections considered critical to the work of relationships.

A recent qualitative study by Landry, Jack, Whoush, Sheehan, and MacMillan, (2012) exploring mother's experiences in the Nurse-Family Partnership Program (NFP) bolsters SmithBattle's (2012) findings. The NFP is an intensive home visiting program recently introduced in British Columbia that targets first-time mothers during pregnancy and follows their progress through the first two years of the child's life (Landry et al., 2012). The NFP program replaces the original Families First and Families Count programs in British Columbia that were also aimed at ensuring optimal growth and development of children and family functioning (Hackler, 2011). The Landry et al. (2012) study is the first to explore the perspectives of families, specifically mothers', engaged in the NFP program. Findings from interviews with mothers who had positive experiences with the NFP program indicated that most associated the success of the program with the relationships they had developed with

their nurses. Six themes describing positive relationships were identified. The first theme entitled, *the NFP Nurse is an Expert, but also like a Friend Providing Support*, echoes what is described by SmithBattle (2000). The second theme related to the nurse's personality, the third related to her respectfulness and trustworthiness. The fourth theme related to empowerment and advocacy. The fifth theme was titled, *The NFP Nurse is an Honest Expert* and the sixth related to how easy it was to access the NFP nurse when help was needed. While Landry et al. (2012) usefully describe what contributes to families positive experiences with the NFP program, there remains room to examine what underpins the nurses' contributions to the experience. For example, questions remain as to how nurses develop relationships that provide a sense of expertise while also creating a sense of friendship.

The Importance of Responsiveness

Much of the literature exploring relationships between nurses and high priority families emphasizes the importance of particular nurse characteristics that invite a sense of *friendship* that when coupled with expertise and a capacity to respond to the needs of families support the development of good working relationships (Plews et al., 2005; SmithBattle, 1997; 2000; SmithBattle et al., 2012). However, underlying descriptions of the characteristics and expertise required to develop relationships is a call for nurses to be above all else responsive; to open themselves to families such that they can intuit their needs and then act in such a way as to ensure needs are met (SmithBattle, 1997).

Responsive relationships are conceptualized in the nursing literature as founded on three essential elements: respect, trust, and mutuality (Tarlier, 2004). Tarlier (2004) reasons

that these three elements are grounded in ethical nursing knowledge; “a knowledge that integrates personal and public moral knowledge as the basis for nurse-family relationships” (p. 232). Discussions in the literature concerned with responsive relationships often do not include its moral underpinnings. Tarlier (2004) however, roots responsive relationships in the nurses’ public and personal moral knowledge. To illustrate, Tarlier (2004) presents two aspects of responsive relationships that reflect personal and public moral knowledge. These are appropriate engagement with the nurse-family relationships and the politics of power in nurse-patient relationships.

In the first aspect, Tarlier (2004) points to a need for nurses to approach families from the perspective of their own standpoint, as a “person and a professional, while simultaneously acknowledging and engaging from the standpoint of the family” (p. 239). In this regard, nurses acknowledge their own personal morals but as well, try to reconcile and understand those of the family through a stance that is largely empathetic. In the second aspect Tarlier (1994) emphasizes the need for nurses to be constantly aware of and be willing to negotiate issues related to “balancing paternalism/maternalism with advocacy, mediating personal and professional mandates and managing issues of power” (p. 239). Responsive nurse-family relationships imply collaboration, negotiation and sharing of knowledge and power and as such are “incompatible with abuse or misuse of power and authority” (p. 240).

SmithBattle (1997) conceptualizes responsive relationships in much the same way as Tarlier (2004) however SmithBattle (1997), does not discuss the moral underpinnings of responsive relationships. Instead she focuses her discussion around the importance of developing situated understandings that consider the lived realities of families as they are

influenced culturally, historically, traditionally, politically, and socially (SmithBattle, 1997). When considered in light of Tarlier's (1994) discussion, situated understandings imply a personal and public moral knowledge that values the uniqueness of families. Indeed, situated understandings evolve with nurses who, as Parse (1997) states, engage in relationships that exist as "subject-to-subject interrelationship[s] that honour the ever-changing realit[ies] of the other" (p. 173).

Public Health Nurses Presence and Home Visiting

Literature concerned with the PHN practice of home visiting puts a particular emphasis on the development of situated understandings (Benner, Tanner, & Chesla, 2009; SmithBattle, 1997). Although this body of literature does not specifically use the term situated understanding, it clearly points to the importance of embracing the lived realities of families such that they feel understood, respected, and valued. Home visiting offers nurses opportunities to engage with clients that are unparalleled in any other intervention. Meeting in the home provides nurses with an opportunity to experience more fully the realities of families as they are lived everyday. The practice of home visiting has been a part of the public health nursing landscape since the time of Florence Nightingale, who saw home nursing as an opportunity to access the sick and the poor in workhouses and workhouse infirmaries (Monteiro, 1985). To date home visiting continues to exist as one of the most effective ways to access and engage families, however it is also considered one of the most challenging aspects of PHN practice, particularly with high priority families.

Literature concerned with home visiting stresses the importance of being open and friendly, communicating effectively, and therapeutic use of self (DeMay, 2003; Heaman et

al., 2006; 2007; Jack et al., 2002). In addition, having a keen sense of timing, being sensitive to the needs of the family, and being willing to suspend agendas to meet the family where they're at, work to develop trusting relationships between the home visitor and the family (Briggs, 2007). However, these can be difficult to achieve, particularly for novice PHNs whose practices are often indicative of inexperience. Novice PHNs can be tied to policies, protocols and guidelines that make relating to the family a challenge (Benner, et al., 2009; SmithBattle, 2004). Furthermore, the lack of practical experience associated with novice PHNs can cause anxiety and nervousness as they grapple with the unfamiliar when faced with a myriad of families and family concerns (SmithBattle, 2004).

SmithBattle (2004) recognizes the difficulty inherent in developing a situated understanding and responsive relationships, particularly for novice PHNs but she concludes by offering advice to new PHNs wanting to develop the skills necessary for both. I will end this literature review with a view into some of what SmithBattle (1997) and Tarlier (2004) suggest with respect to personal and professional development to create responsive relationships. SmithBattle (1997; 2000) starts by asking that nurses reflect on their own preconceived notions of what comprises high priority families and reflect on these notions with an open mind. Tarlier (2004) offers a similar suggestion by highlighting the need to "negotiate intersecting paradigms" as an important facet to appropriate engagement with families. Negotiating intersecting paradigms involves the creation of a common space in which to engage with the patient despite differing world views (Tarlier, 2004). This practice, remarks Tarlier (2004) creates common ground and fosters a sense of willingness on the part of the family to enter and engage in relationships.

Summary

In summary, this review explored several bodies of literature aimed at articulating processes involved in developing good working relationships. The intent was to examine closely the nature and character of good working relationships as they are presented in the literature. A key component in this aim was to explore how nursing presence contributes to the development of good working relationships. The theoretical literature focused on presence provided a view into the phenomenon as it unfolds in relationships. The concept analyses provided a similar view but focused more on antecedents and attributes associated with nursing presence. The qualitative literature did not directly include nursing presence as a topic of inquiry. It did however provide insight into how specific nurse characteristics contribute to the development of relationships. Many of the characteristics outlined in the qualitative research echoed those described in the concept analyses.

CHAPTER THREE

Methodology and Method

The Qualitative Paradigm

Qualitative research supports a process of understanding that is in a continual development. Coming to understand something requires shifts and changes as new experiences emerge. Equally important is the idea that the researcher and participant are part of a unique interaction that shapes and informs understanding, which involves the practice of interpretation. In contrast to quantitative approaches that flow from a highly objective, de-contextualized epistemological position, qualitative methods, particularly interpretive approaches, emphasize the existence of multiple truths, realities and understandings of the world and the inherent value of individual experience (Vis, 2008).

Research undertaken within the qualitative paradigm is well suited to questions that are concerned with the nature of experience as it is lived daily by the participants under study. Van Manen (1997) notes that “from a phenomenological point of view, to do research is always to question the way we experience the world, to want to know the world in which we live as human beings” (p. 5). In this regard, qualitative research assumes that reality is socially constructed by every unique individual, from within their own unique contextual understanding (Vis, 2008).

Hermeneutic Phenomenology

Hermeneutic phenomenology has been described as the practice and theory of interpretation and understanding in human contexts (Moules, 2002). Its central premise is that human beings are attuned to meaning and that meaning is derived through our being-in-

the-world (Fleming, Gaidys, & Robb, 2003; Thistleton, 2009). Through the practice of interpretation, researchers seek to reveal meaning, meaning that is often taken for granted with the goal to understand more fully (Moules, 2002). As an approach to inquiry, it is considered a reflective inquiry that is concerned with “our entire understanding of the world and thus...all the various forms in which this understanding manifests itself” (Gadamer, 1989, p. 17).

Research undertaken with an interpretative or hermeneutic approach in many ways defies method. Hermeneutics is a substantive philosophy rather than a strategic method (Moules, 2002). There is no didactic play book that directs the researcher through a series of steps to arrive at a foregone conclusion. Rather, there is philosophical guidance that asks the researcher to stay true to certain underlying principles as they explore the topic under study (Moules, 2002). The philosophical principles that served to guide this project were those laid out by Hans Georg Gadamer (1989) and Max van Manen (1997). Gadamer (1989) asks that we pay particular attention to language and its uses and that we keep our pre-conceptions or pre-judgments constantly in view. Pre-judgments reasoned Gadamer (1989) are always with us and shape who we are as beings-in-the-world and are shaped by our being-in-the-world (Binding & Tapp, 2008; Fleming et al., 2003). They form as we experience the world and are thus rooted in our histories, cultures, and traditions (Gadamer, 1989). Because our pre-judgments exist as an inherent part of who we are, we cannot, as some would suggest, bracket them out in our attempts to discover the true meaning of things. Instead, Gadamer (1989) asks that we embrace our pre-judgments, keep them close so that we can understand

how they shape and influence our perceptions and understandings of what we believe to be true.

Max van Manen (1989) offers six research principles or activities thought to guide phenomenological research. He writes: “How can human science research be pursued? Reduced to its elemental methodical structure, hermeneutic phenomenological research may be seen as a dynamic interplay among six research activities” (p. 30). This chapter outlines four of these activities as they are described by van Manen. The first of these activities; *turning to a phenomenon which seriously interests us and commits us to the world* which Gadamer (1989) aptly called “the experience of address” is described in Chapter One of this thesis. The second principle or step in van Manen’s (1997) approach involves *investigating experience as it is lived rather than as we conceptualize it* (p. 30). This activity is outlined with a description of the participants involved in the research and data collection processes. Step three, *reflecting on the essential themes which characterize the phenomenon* and step four, *describing the phenomenon through the art of writing and rewriting* are described in the discussion and conclusion sections.

van Manen’s fifth research activity *maintaining a strong and oriented relation to the phenomenon* relates to my overall research approach. van Manen insists that qualitative phenomenological researchers must maintain a strong orientation to the phenomenon in question in order to avoid getting “side-tracked or to wander aimlessly and indulge in wishy-washy speculations, to settle for preconceived opinions and conceptions” (p.33). In this study I attempted to maintain a strong orientation to the phenomenon by constantly reflecting on my own understanding of nursing presence and on the experience as I sought to interpret,

explain, and deeply understand the nature and character of nursing presence from the perspective of families. Lastly, van Manen's sixth research activity refers to a continuous process of *balancing the research context by considering parts and whole*. Carrying through the sixth research activity involved consciously moving in and out of all five of the previous outlined research activities. To engage in phenomenological research, one must be willing to live in the tensions that phenomenological research presents (p. 131). Throughout this study, I continuously had to balance my intense, personal involvement with the experience of nursing presence while simultaneously providing a thoughtful interpretation of what families had described throughout their experience.

Description of Participants

Participants in this study included eight families from northern British Columbia whose last recorded contact with PHN services was no less than three months prior, and no longer than one year to being interviewed for the original WRP (2005) study (MacLeod et al., 2005). All families lived in northern British Columbia communities whose populations range from 10,000 to 76,000 (Statistics Canada, 2011). The closest metropolitan center of 100,000 residents or more is located over 500 km away from each respective community. The main industries within these communities are forestry, mining, oil and gas, lumber and pulp mills, and fishing (MacLeod et al., 2005).

All of the families selected for this study had children and reported having been involved with PHN services through the practice of intensive home visiting. Although family units were not explicitly described or defined by the families themselves, most interviews occurred with the mother of the family. In one instance, both the mother and the

father participated in the interview. Until recently, home visits in northern British Columbia were offered through the Family's First Program (FFP), a program that offered universal home visiting to all primiparous women following the birth of their child (Reiter, 2005). If following the initial home visit, families were found to require more in the way of service, PHNs would arrange for more intensive visiting with families (Reiter, 2005).

The FFP program was carried out differently in the various communities represented. For the seven families living in some of the smaller communities, the FFP was incorporated into the general practice of PHNs (MacLeod et al., 2005). The one family living in the largest community was offered intensive home visiting services through the Families Count Program (FCP). In this program, teams including PHNs and home visitors provide intensive support to families for upwards of five years through an ascribed program delivered weekly through home visits by lay visitors who would report to PHNs acting as case managers (Reiter, 2005).

Data Collection

Data for this research project were collected as part of a larger qualitative research project entitled, *The Working Relationships of Public Health Nurses and High Priority Families in Northern Communities (WRP)*. Participants for this study included twenty-five families, thirty-two PHNs and three lay visitors in the Northern Health Authority. The original study employed three avenues of inquiry. The first was to conduct in-depth, open ended interviews with participants to elicit rich narrative data about families' and nurses' experience and the contexts of that experience (MacLeod et al., 2005). The second involved participant observation of PHNs and lastly, a documentary analysis of relevant nursing

policies and standards was conducted (MacLeod et al., 2005). This research study utilized interview data, both in audio form and interview transcripts from eight families interviewed for the narrative component of the original WRP (2005) project.

Participant Selection, Recruitment, and Interview Process

Participants for the WRP (2005) study were selected from fourteen communities in northern British Columbia that represented eight different types of community contexts. The community contexts were described by PHN collaborative partners in the study who reported these contexts as profoundly impacting their work with high priority families (MacLeod et al., 2005). The contexts were community size, the proximity of the community to First Nations reserves, the numbers of public health nurses in the community, and the availability of community resources (MacLeod et al., 2005). Data were obtained through twenty-three in-depth individual interviews and one focus group with families, eighteen individual interviews and three focus groups with PHNs, one focus group with PHN interviewers and one focus group with lay family visitors. Prior to interviews and focus groups, written informed consent was obtained from participants. All interviews with families were conducted in person by PHNs trained by one of the researchers in family interviewing (Moules et al., 2005). Anonymity of participants was maintained by having PHNs interview families outside their region of practice (Moules et al., 2005). Senior researchers conducted all PHN interviews and focus groups, with one exception: one PHN focus group was conducted by the research coordinator (MacLeod et al., 2005).

Of the eight interviews with families selected for this study, four described their relationship as challenging and four considered their relationship to be easy. Interviews were

selected based on the depth and richness of family descriptions of their relationships with PHNs. During my initial review of the family transcripts it became apparent that some families described their experiences in more depth than others. They talked about the process of developing relationships and in doing so revealed inherent complexities that seemed to play a part in determining the outcome of the relationship. Choosing from a selection of varied experiences facilitated a better understanding of how complexities were negotiated over the course of the relationship.

The purposeful sample was also selected for logistical reasons related to data management and analysis within interpretive approaches. The goal of hermeneutic inquiry is to uncover a meaningful account that reflects and resonates with the experience of those in the study (MacLeod et al., 2005). It is not an approach “validated by numbers but by the completeness of examining the topic under study and the fullness and depth to which the interpretation extends understanding” (Smith, 1991). An adequate sample size is one that permits a deep analysis, which results in a new and richly textured understanding of experience. As such, eight transcripts for a study of this nature were enough for the creation of substantial themes.

This inquiry was guided by the following research questions:

- What is nursing presence?
- What is the experience of nursing presence for families engaged in relationships with PHNs?
- How does nursing presence influence PHN-family relationships?”

Data Analysis

Data analysis initially involved reading and re-reading all twenty-five transcripts from interviews with families for the original WRP (2005) project. From these, I was able to identify eight transcripts that provided rich and detailed descriptions of what comprised easy relationships and challenging relationships for families engaged with PHN services. In order to garner a complete sense of the relevance of these family experiences to the research questions, I also obtained audiotapes for the eight transcripts. The audiotapes proved invaluable to gaining a holistic understanding of family experiences. Listening to the spoken words of families invited a view into their experience as it unfolded in memory and as it was re-lived with the PHN interviewer. The audiotapes provided an opportunity to hear subtle inflections and changes in tone of voice over the course of the conversation. Listening to family conversations with the PHN interviewer provided an opportunity to hear not only the words but as well moments of thought and reflection that added to the detail and richness of the written transcripts.

Both the audiotapes and transcripts proved essential in determining themes thought to contribute to the meaning of the phenomenon. As I listened to the audiotapes and read the transcripts, I wrote down bits of data that comprised words, sentences, phrases and anecdotes into a journal and cross referenced these with the transcript number so that transcribed material could be easily found. I also used the journal as a way to reflect on other literature I had read that resonated with what I was seeing and hearing in the audiotapes and transcripts. This included research literature, philosophical literature, and even novels that felt as though they had some resemblance to the topic under study. The journal also allowed me to record

my personal reactions to the data. I was able to write down how I felt, or what I believed was being suggested, in order to examine the impact that my pre-judgments had on my interpretations. This encouraged me to further question what I was reading, hearing, and what I was feeling to again ensure that what I was seeing was indeed reflective of what was being stated by families.

Following this, I reviewed all transcribed material in my journal with a deliberate aim to find similarities and differences among what families had described. Over the course of several weeks, essential themes were revealed. Essential themes are defined by van Manen (1997) as those that cannot be removed from the phenomenon lest the phenomenon loses its fundamental meaning (p. 107). Once I was confident about what I understood to comprise the essential themes, they were coupled with thoughtful selections of text and copied verbatim from the transcripts to illuminate their meaning.

The analysis of these excerpts involved careful reflection, writing, and rewriting in order to enliven the thematic aspects of the participants' words. In hermeneutic traditions this involves "bringing the topic to life in language" (Moules, 2002, p. 32). This does not imply that hermeneutics reports on meaning but rather, "creates it, not by translating one's subjectivity out of the interpretation but by applying oneself to it with a sense of responsibility to deepen understanding" (p. 32). This proved most difficult for me as a neophyte hermeneutic phenomenological researcher. I was forever enmeshed in how to articulate meaning without sounding overly didactic or prescriptive. At the same time, I found it difficult to fully immerse myself in the circularity of language that often defines many hermeneutic studies. I wanted to create an account that resonates but as well, that was

equally accessible to those less familiar with hermeneutic processes. A helpful process in this regard was to engage with the data by constantly questioning what I was seeing and hearing. Equally important was writing down my thoughts to provide an account of my interpretations that remained true to the whole of what was being said but as well, remained true to the voice of families who described their experiences in simple yet resonant terms.

Methodological Rigor

Rigor in qualitative research is equated with notions of credibility, transferability, and dependability (Koch, 1994). Credibility and transferability in hermeneutic studies are obtained when interpretations provide faithful, recognizable, and true descriptions of experience, in that they ring true to those who read them (Moules, 2002; Lavery, 2003). Gadamer (1989) suggested that there are many interpretations, and though none are finite there are some which offer a better account and ring more true. This applies not only to study participants but as well to others in similar situations. Findings can “fit into contexts outside the study situations and [are] viewed by audiences as meaningful and applicable in terms of their own experiences” (Moules, 2002, p. 33).

The method I used to determine if interpretations were indeed faithful, recognizable, and true involved reviewing the findings of this study with colleagues and other nurses, particularly those working in acute care settings. I was particularly interested in whether or not the account offered would resonate with nurses working outside of public health. Unfortunately, it was not possible to re-establish contact with the families interviewed in the original WRP (2005) study, however connecting with nursing colleagues in both public health, acute care, and those who currently teach was accomplished. These nurses indicated

that the findings of the study resonated with their own experience and they expressed general agreement that indeed, relationships in general could be challenging; particularly those with high priority families. Two of the nurses appreciated the insights afforded through the discussion regarding responsive relationships, adding that the connection between responsive relationships, self-reflection, and self-awareness was what resonated most.

Dependability lies in the exact documentation of the process of inquiry and interpretations must be supported by the selection of transcripts (Moules, 2002). The researcher must not be led astray by tendencies to interpret the speaker beyond what is being said. At times this proved difficult as I found myself empathizing with the experiences of families as a public health nurse as opposed to a researcher. In my practice as a public health nurse, I had witnessed and personally experienced many nurse- family relationships that were similar to those described by the families. It was difficult at times not to presume to know what the right or proper approach with families should be. My hope is that, throughout this project, I have indeed remained true to the words of participants and presented interpretations that would ring true to them and other families engaging with PHNs in relationships.

Ethical Considerations

Participants in the WRP (2005) study were informed of the voluntary nature of their participation in this study and their right to withdraw at any time. Confidentiality of interview participants was maintained by ensuring access to audiotapes and/or transcriptions by research personnel only. Anonymity was maintained through coding of all names and places. Ethics approval for the WRP (2005) study was obtained in 2004 from the University

of Northern British Columbia. Ethical approval was obtained for this study in May 2012 from the University of Northern British Columbia.

Confidentiality of participants for this study has been maintained as per the requirements of the original WRP (2005) study. Transcripts and audiotapes made available to myself were coded. Anonymity was insured through letter coding of all identifying names, people, and places. In addition, this study makes no reference to participants or places throughout. Data have been securely stored under lock and key and will remain stored for an indefinite amount of time.

CHAPTER FOUR

Findings

Meeting at the Beginning, the Middle, and the End

Studies have shown that the success of PHN work with families depends on the development of relationships. The nature of PHN work and the context in which it is carried out require that PHNs negotiate, collaborate, and work toward goals with families that are mutually derived. In addition, PHN service is an invited service. It is not required or mandatory but occurs at the volition of the family. The voluntary acceptance of the service, its emphasis on collaboration and the context in which the work is carried out all have a resounding influence upon family understandings with respect to the nature of PHN work and its relationship to the comportment of the nurse. Comportment in this context is defined as the way or manner in which one conducts oneself (Oxford English Dictionary). As I read through the transcripts chosen for this study, it became clear that families have definite expectations with respect to how PHNs should *be* as home visitors, *be* as purveyors of knowledge, and *be* as sources of support.

The research questions guiding this study focus on family experiences with nursing presence. Presence in this context refers to the nurse's way of being; a manner or air that acts to engage families in the development of relationships. In this study, nursing presence is understood as being inherently connected to the comportment of the nurse. Although nursing presence exists as a sentiment that at times seems almost palpable, it remains a difficult concept to define. By attending closely to family descriptions of the nurse's

comportment we are better poised to understand how the nurse's way of being; her air, and her manner influences family experiences of nursing presence. When families talked about their relationship with the nurse, they described behaviours, mannerisms, and actions that either supported the development of the relationship, or caused it to falter.

One of the most interesting and perhaps significant insights offered through family descriptions of the nurse's comportment is the idea that in order for relationships to work, the nurse had to consistently demonstrate her presence in terms of her responsiveness and willingness to be there for the family. Families described subtle yet very important changes in how the nurse supported the family, shared information, and visited in the home as the relationship evolved. Families also stressed how important it was that these changes or shifts in how the nurse presented herself occur at the right time and in response to the families' needs. Analysis of the family transcripts has revealed that broadly speaking, these shifts and changes in how the nurse responded to families occur over three phases of the relationship. The discussion that follows explores family experiences of the nurse-family relationship when both meet for the first time, meet in the middle of the relationship, and at the end of the relationship.

Meeting for the First Time

Meeting for the first time is critical to the development of trust between nurses and families. Trust is considered the cornerstone to developing relationships. Without it, relationships can falter or never figuratively get off the ground. When families described meeting for the first time, they talked at length about how important it was that the nurse convey trusting behaviours. They were equally concerned however, with their own ways of

being and how those would be perceived by the nurse causing feelings of nervousness and anxiety at the outset of the first visit:

And again that might just be my personality...like afraid of what she might tell you or maybe you're doing something wrong and she's there to tell you you're doing it wrong, I don't know! Or is my house clean enough or...do I...does everything look good? You know...you want to make a good first impression

Making a good first impression speaks to an overall sentiment families expressed at the prospect of having this complete stranger in their home for the first time. Although families understand the role of PHNs to be largely supportive and appreciate the convenience of home visiting, many felt the initial entry into the home to be an extremely personal thing that at the outset left them feeling a little exposed, "you're inviting them into your life, at home they get to see more of you".

Feeling exposed was often tied to the perceived authority of the nurse, which is understood as having two dimensions. The first relates to the knowledge of the nurse. Families expected PHNs to be authorities in their field and share information that was both current and practical. However, they also admitted to being intimidated by the knowledge of the nurse. If PHNs entered the home asserting more of their authority as an expert than was perceived necessary by the family, the family felt they were too professional, overly focused on their role as an expert nurse with not enough emphasis on the personal nature of the visit:

Well, the reason why I didn't like her very much is because she was too... and then I thought it was in my head, right, I'm thinking okay, well maybe I'm just

imagining this cause you don't know yourself any more, right when you're going through that. So I asked my husband. And he sat through a visit and...what I thought...now I understand that she's a public health nurse, I understand that's her job and that kind of thing, but...when you're coming over to somebody's home and...let's face it, it is very personal. Your baby is involved, you're going...and if you are going through postpartum that's a biggie and it would be nice...she was too...I would say she was too job-like. This is my job and this is what I do and this is black and white and these are the rules and...she wasn't personal at all.

The second way authority was understood relates to the role PHNs play in surveillance of the family (Selwood, 2010). In cases where PHNs witness behaviours or lifestyle choices that might put children at risk, they are bound by law to report to the appropriate authorities (Selwood, 2010). Although this is far from the central mandate of public health nursing, it does determine a certain level of authority over the family that although rarely asserted, shapes some of the work and as such, some of what families understand about the role:

I didn't want to talk about everything, because some days were really bad. And so I...I know your rules! I know your rules!

The personal nature of home visiting coupled with the understated yet very real authority of the PHN was particularly pronounced for families who had negative experiences with other support agencies and/or PHNs. These families expressed hesitancy at the prospect of having public health enter the home because past experiences with authority had overshadowed the

supportive function of the nurse. Indeed, one family refused home visits outright opting instead to meet with the PHN at the health unit:

I didn't want them in my home...I didn't want to go through that again so...so

I took him to the office to have his shots...that's where I met her first.

For this mom, meeting at the health unit, instead of at the home acted as an initial safeguard against what she understood to be a potential threat. In cases where families had children removed from the home, or lived with the threat of removal, home visiting was indeed a danger. As indicated here, some families choose the safety of the office for their initial visit because it is understood as neutral territory, a place where the family can acquire needed service without feeling scrutinized, judged, or misunderstood. Meeting at the health unit also gave families an opportunity to assess and evaluate the PHN before inviting them into their home. For families who felt intimidated by the meeting in the home, meeting at the health unit gave them an opportunity to discern, without prejudice whether or not they could trust the nurse. During a brief office visit, families described how they could tell, almost immediately, whether or not things were going to work out:

Well, for a period of time I went to see different nurses for their shots. And I

Didn't like any of them...well, it's not I didn't like them, I didn't feel comfortable with them. They seemed to be mean with giving needles and not really...caring about how the mother feels...whereas with S...she was always gentle...she gave helpful advice. She...you can see that she cares about the child...or she cares about the mother

The importance of the first few moments. Families determine in moments, whether or not they are going to be able to work with the PHN through a process called “thin-slicing”. In his book *Blink* (2005), Malcolm Gladwell underscores the importance of the first few seconds of any encounter and uses research about rapid cognition to show that the human brain has an amazing ability to “thin-slice” and form impressions of others in a glance. Before families have had the first encounter, they ask questions of themselves and of the nurse. Is the PHN trustworthy, competent, and effective? Will she like me? What will she think of our home and our family? Answers to these questions are arrived at within seconds by attending to subtleties and nuances observed in the PHN’s comportment. Our capacity to thin slice implies that the first few moments of conversation may predict the success of the entire nurse-family relationship. Although families did not say so directly, they allude to the importance of being self-aware; of being conscious of what is said, and not said through body language:

The other nurse was judgmental. She was like...she had attitude the minute she just walked in and looked at me. And I seen that and I didn’t like that at all so I gave her an attitude right back

In the beginning of relationships, families stressed how much they appreciated a nurse who entered the home as a guest and who shared stories. Those who entered conveying a sense of respect for the family and a willingness to accept the family on their terms, were viewed as welcome guests. For some these gestures may seem trite, but for families experiencing hardship or who have felt scrutinized by other support agencies, entering the home as a welcome guest is vital.

For many Northern British Columbia families, having a PHN who entered the home as a welcome guest was particularly significant. In Northern British Columbia, there are a number of families living in poverty who are of Aboriginal descent (Macdonald, 2011). Aboriginal people across Canada have faced systemic hardship as a result of government policies that continue to assert their effect today. Past assimilationist policies that saw the forced removal of many aboriginal children from their homes have created a persistent mistrust of outside agencies (Macdonald, 2011). PHNs have reported difficulty with accessing and engaging Aboriginal families. When PHNs are invited into the home, engendering a sense of trust, acceptance, and respect is pivotal to developing and maintaining a relationship.

Teaching and learning in the beginning. One of the most powerful ways PHNs engender a sense of trust with families was to share particular details of their lives through stories. Sharing stories is among one of the oldest methods of communication (Hunter, 2008). Stories serve to educate others, record historical facts, teach cultural values, and share common experiences (Hunter, 2008). For nurses, telling and listening to stories related to health and illness provide a vital means through which human experiences can be honored (Hunter, 2008). Stories give families an opportunity to voice, in their own words, what their experience is like and how it has impacted the family. When nurses shared their stories, families realized that their situation, although unique to them, is in many ways similar to the experiences of the nurse. In the process of sharing, the family's sense of being alone in the experience can dissipate, restoring a sense of calm and control:

That worked for me, yeah. Actually it was good. I mean I was...I'm a new

mom so...and I don't have any family around here so I don't have...my mom here or any sisters or anything. So it was nice to have another... another person. And it turns out she's a mom so that's helpful...because...you know, she has personal experience with it you know. It's just like being a teacher, you know. : When...you know, I've worked with kids for almost ten years now so...but even now that I'm a mom, I'm starting to look at things differently. And I mean it's just...I mean...you know, you see a different point of view. One that you maybe wouldn't have considered before. Not to say that...not to say, of course that I was callous or...you know, didn't think of it in that way. But I think it gives you a little more insight.

Families also remarked that when the nurse shared stories, they listened and learned more:

She told us about what worked for her...different positions for feeding...breastfeeding her baby and that was really helpful.

Sharing stories as a way to communicate knowledge is important to consider for the first home visit. When PHNs visit families with new babies in the home, they deliberately do so around 4-5 days post partum because this is when issues with breastfeeding or post partum depression typically become apparent (Reiter, 2005). It is also a time when post partum women in general need extra support. They are often exhausted, feel overwhelmed, and need encouragement. When mothers are in this state, it is difficult to make sense of a day let alone

reams of information. Sharing stories can be a valuable way to educate moms who in their postpartum state may not feel terribly open to didactic teaching.

Sharing stories also had a disarming effect for families who initially felt intimidated by the nurse's authority. Some families expressed feelings of intimidation with the nurse's level of education. They had experienced being talked down to in the past, and had felt that their knowledge hadn't been valued, and that they had been doing things the wrong way:

I've spoken to nurses before, you know, in the health unit who they're like oh, well, you need to do this and you need to do that with your baby 'cause they're just full of information and they just tell you how to do it.

When families felt intimidated by the knowledge of the nurse, stories helped to contextualize new information in terms more familiar to the family. Stories had the effect of making new information more practical and accessible. In addition, when PHNs shared stories, families were able to see that although the PHN perhaps had more education and a different lifestyle, both had been shaped by the shared experience of parenting. Families in effect felt more connected to the nurse and less intimidated by her education and knowledge.

Families who experienced visits with nurses who were willing to share their stories felt as though the nurse had given something of themselves. Stories had the shared effect of personalizing the first home visit and of engendering a sense of trust for the family. Through stories families and PHNs came to know one another and together, could co-create a sense of safety and comfort.

Summary. Relationships at the beginning are tentative, even precarious because of a power imbalance related to professional practice. This is in part because families understand the initial meeting or invitation into the home as representing more than a mere opportunity to share information. It is an invitation into their lives. Families are keenly aware of what home visiting offers the nurse in the way of assessment and they are equally aware that relationships with PHNs are neither equal nor balanced. If relationships were going to figuratively “get off the ground”, families insisted that nurses be carefully attuned to how they walk in the door and share information. It is clear from the transcripts that if nurses asserted too much authority, were in any way insensitive to the needs of the family, or implied judgment, the relationship would falter.

Meeting in the Middle

Although meeting for the first time plays a pivotal role in the outcome of relationships, relationships also require maintenance over time. In order for relationships to hold together and grow, families required above all else that nurses be attuned to their needs and be willing to meet them where they are at. “Meeting me where I’m at” was a phrase used by families to describe how important it was that nurses move with the family, that they be attuned to the needs of the family, and more importantly, tailor their responses to meet those needs.

A central component to being able to meet families where they are is the need for caregiver continuity. Being responsive to the needs of families at specific points in time requires a heightened sensitivity to the ways of the family and the context in which they live.

When we consider that the beginning of relationships are marked with tentativeness requiring time and effort to come to a place of mutual comfort, we can see how important it is that the same nurse visit with the family whenever possible. Families equally stressed the importance of continuity. Indeed, when continuity was amiss, they were very forthcoming in their frustration:

They sent the two women over to the house...and I thought it was kind of odd because they came to the house to see how things were going and then I...actually I quite like them, right, and when I phoned or they phoned...I was talking to somebody and they told me that they wouldn't be coming back. So...what is the point of trying to...you know, you're going to be getting something going with this particular person and then it's like...so I thought that was kind of strange.

Equally important to caregiver continuity was fulfilling the expectation that PHNs be flexible. Flexibility was referred to in terms of time and as a necessary component of service delivery. For some families being flexible meant working around their schedules, allowing families to choose times for appointments and home visits as opposed to strictly adhering to the PHNs schedule:

She was very flexible. I got to make a time and talk to her about his growth, his development, his risks, his...what was happening, the plans for and all that. So that was really good.

Flexibility was also an important consideration in delivery of services. Families chosen for this study, who required PHN services beyond the first maternity home visit were enrolled in

the Families First Program (FFP). FFP was a PHN initiative designed to foster healthy infant and family development among vulnerable families. The program has since been replaced by the Nurse Family Partnership program that has similar goals but a different delivery structure.

Families enrolled in the FFP were provided with continued support in the areas of growth and development of an infant or child, parenting and child safety, and nutrition education (Healthy Child Manitoba, 2010). Support was provided within a general framework that focused on helping families to identify their own needs and set goals accordingly (Healthy Child Manitoba, 2010). The PHN acted to provide support and education in obtaining those goals. For some families, the structure and flow of the FFP proved challenging. Like many programs the FFP had a limited enrolment time and was structured so that certain requirements were met at certain times (BC Ministry of Health, 2005). The focus on time proved difficult for families who simply were not in a place to meet the requirements of a program:

This particular program, there was...definitive things that needed to be done that was...making personal goals and...and achieving them and doing the journal and stuff like that. Like there were certain things that I really had a hard time doing just because of my...well, first off, I was working full time, even...at two months and one month and stuff like that. So doing extras was really challenging. And setting goals...well, I could hardly see five o'clock let alone what I'm supposed to do in two months and three months.

In these situations, families felt supported by PHNs who negotiated the program for them and tailored its delivery to suit their needs:

She helped me try to find goals. Because I had a really hard time with it. So...but then taking what I wanted to do and...and what my idea about goals is, cause I have a different idea of goals than everyone else, for some reason.

When PHNs were flexible with time and provision of service, they made families feel valued. Families felt valued as individuals and appreciated when the PHN recognized that they have lives beyond their work with PHNs. When PHNs were flexible, families also felt that their ideas and opinions were valued. Flexibility with the provision of service provided families with an opportunity to discern for themselves what was most useful given their situation and context. It allowed their own insights to take shape and inform goals that they felt they could achieve.

Teaching and learning in the middle. Creating a space for families to learn and try things for themselves assisted PHNs in maintaining relationships. In the beginning, families new to programs and service needed PHNs to present them with information regarding the best ways possible to care for their children. Information was offered by PHNs and taken up by families in a way reminiscent of how teachers offer knowledge to pupils. As the relationship progressed, families expected the PHN to shift from a role as teacher to one of guide. Rather than expect the nurses to assume the role of leader in their approach to knowledge sharing, families insisted that the PHN allow the family to lead and be there only to support and guide when necessary:

I think it started off more...at first it was like...her showing us a little...showing us things to do and we were looking more as like a...a guide or a teacher, to what we were doing. But the more we...the more we started to learn about taking care of H, the more we realized how unique his situation was [...] I mean, at the beginning we really paid heed to everything she told us, and then after a while it sort of like...we sort of put it through our little strainers and decided what to pay attention to and what to just ...ignore

When the family felt as though the PHN was not letting them lead, families effectively dismissed what the PHN had to say. Instead of actively taking up what the PHN was trying to teach, families ignored what they were being told:

We felt more like kids with a teacher coming to teach us, you know, like a piano teacher or something. Like it didn't ever seem like an equal sharing of...like it didn't feel like that to me. It felt like she was there to show and teach and we were just to listen and follow.

Families were quick to state that although they appreciated the knowledge of the PHN, when the PHN demonstrated a persistent need to assert her authority as an expert her actions effectively countered their learning.

In situations where families felt the nurse was overly authoritative, families went as far as to qualify the knowledge provided as “book knowledge” clearly distinguishing it from practical knowledge. Book knowledge was described as being impersonal, overly didactic, and in many ways cold in its presentation. By contrast, practical knowledge was often

presented through stories, was personal in nature, and forged a sense of connection for families. Practical knowledge resonated with families in its capacity to relate to their own personal experience and its usefulness. This is not to suggest that book knowledge was not valued. On the contrary, it was not the content of the teaching but rather how it was presented that influenced family understandings. When formal knowledge was translated and communicated in a way that complimented the context of the family's life, it became practical. Families were able to connect what was being said to their personal experience and use it to inform their own processes.

Sharing stories of being a mom too. Families described their connection to practical, useful information by indicating a strong connection to information when it was being communicated by nurses who were moms too. "Being a mom" too is a phrase that in many ways describes the essence of what families considered practical, useful information that they could relate to. When nurses shared their experience of being a mom, families perceived their knowledge as being grounded in real experience. Families were able to hear and see that book knowledge really works. Sharing information through experience helped to ground book knowledge in reality:

And that's what...when you're a new mom you...want to know what really works. You know, 'cause a book can say you can put the baby in the bed and give him a bottle and he'll go to sleep by himself, but...is that really going to happen?

It is important to note that although sharing in the experience of parenting had the effect of instilling faith in what was being taught, the experience of parenting should not be considered a pre-requisite to developing good relationships. The effectiveness of the PHN resides with the process of sharing. When information was shared contextually, by paying attention to the family's everyday reality, knowledge was perceived as useful and practical. Sharing the experience of being a mother resonated with the realities of many families in this study however, there were situations where families required PHNs to find different ways of relating their knowledge. This is evidenced in two of the transcripts chosen for this study. In one, the family describes a challenging relationship with a nurse who, despite sharing her experience as a parent who had suffered post partum depression, failed to connect with the everyday reality of the mom by not visiting when the mom needed it most:

When you get it. But don't not come out and see me because I live in the toolies. If anything, definitely come out and see me 'cause I've got postpartum for God's sake, right? I need connection. And it...it...in a way it bothered me because she told me that she went through postpartum and it's like okay...you tell me that you've gone through postpartum, you know how bad it is in the beginning, you know how much you need to talk to people and where the hell are you?

In contrast to the above, another family described how diligently a brand new PHN worked to gather and relay information with which she had no practical experience:

She just...I don't know if it was anything that she said, but she was like...she was very...like doing research and helping and...would bring me a plethora of

information on...It was helpful, you know, because...she is quite young and...it was...I was one of her first clients, like at home clients. She was new to the area. She's now having her first baby!

At the outset, it seems as though this nurse's youth and inexperience might have served as a barrier to the relationship, however, her willingness to share the only information she had to support family rendered her lack of experience insignificant.

Summary. In summary, meeting in the middle marked a point in the relationship that focused on maintaining the trust developed in the beginning but as well, empowering families to "go it on their own". Families characterized this process by describing subtle changes in how the nurse shared information and supported the family. Nurses who were willing to shift their stance from a position of teacher, as one who does for; to act more as a guide, or one who does with, signaled confidence in the family. Families in turn felt assured; took up what they had learned and made it their own.

Families indicated that information shared is more easily 'taken up' when it was communicated through the shared experiences of being a parent. Sharing parenting experiences had the effect of personalizing information. It made the work of parenting more practical and easily understandable. More importantly, sharing parenting experiences created a place where the nurse and family could connect. Differences in life experiences were set aside in order to shift the focus toward what was shared and valued by both.

Meeting at the End

Meeting at the end is described in many nursing theories as the termination phase of the nurse-family relationship (Peplau, 1997). It marks the point where the relationship in its entirety is evaluated in terms of the success of interventions and the attainment of goals (Peplau, 1997). This section's findings focus on the experience of three families who described an overall easy relationship with nurses. The decision to focus on these families relates to the provision of care by one nurse and the completion of her services. The experience of care continuity places these families in a better position to recount and evaluate the relationship at its end stage. In contrast, families who described challenging relationships may have experienced an end but the end was not conducive to providing a comprehensive evaluation of the relationship. Indeed, families who had experienced challenging relationships focused more on how and why the relationship had faltered. This section is aimed at exploring how it felt for families who had experienced good working relationships to end the relationship. The discussion focuses on two nursing actions aimed at moving families along during this time of transition, keeping doors open and transitioning. Families who had experienced nurses that in response to their needs, moved them along in the relationship and at the end indicated that doors would always be open, expressed a sense of ease and empowerment when the relationship ended.

One of the most interesting findings with respect to the end of the relationship were expressions of anxiousness and even fear on the part of the three families chosen for this section. Initially, it was presumed that relationships which fostered a sense of trust and empowerment insulated families from any sense of loss or anxiety associated with

terminating the relationship. Indeed, the assumption was that the three families, all of whom experienced good working relationships, would indicate that they were ready, even willing to end services with the PHN however, some expressed deep concerns with ending the relationship:

I think I would probably...It would have been nice to have more frequent visits and maybe have it go on a little longer, rather than even just a short six months kind of thing.” Although I knew at the end it was okay and I was okay. Saying six months really scared me. It was like oh my gosh, that’s it, that’s all you can give me? And then you’re done and you throw me away? It was like really scary because I felt there was a huge amount of help that I needed.

Although the sense of anxiousness expressed by this mother is indicative of what some experienced, when at the beginning of the relationship they were told how much time they were allotted for service, it also served as an expression of what some families felt when the end was near.

When families are just beginning in programs, having a PHN establish time boundaries is an important component in developing relationships (Reiter, 2005). However, responding to the health-related goals and needs of the family at times requires flexibility with timelines. Nurses reconciled the need to abide by timelines whilst honouring the needs and goals of the family by indicating that despite programs ending at a pre-determined time, doors would always remain open:

And she just said well, you know, if you really need me we could keep on...or, you could keep coming to me for the immunizations. Even knowing that I could still someday see her again was really helpful.

The effect of keeping doors open for families was twofold. In one sense, it demonstrated the nurse's willingness to be flexible and work with the family until health-related goals were achieved. In another sense, keeping doors open gave families confidence and a sense of comfort in knowing that they could remain connected with PHN services after programs had ended. For families feeling anxious at the prospect of ending relationships, knowing doors would remain open left them feeling re-assured that indeed, PHNs were always available when needed.

In addition to keeping doors open, families also experienced nurses who made a point of ensuring that, in the event families required more than the allotted time that they would be the nurse who would continue providing service where possible. In situations where this was not possible, the PHN made a point of personally informing the family that they may have to see someone else:

She phoned, maybe not all public health nurses do that, but when there was this switch and she couldn't come out any more, she phoned me...you know, and made the...that step in saying sorry I can't be there any more, somebody is going to be taking care of this aspect...She even expressed...she said oh, I won't be able to see A anymore and I hope everything goes well. So I don't know, I don't think...that's not part of the job...it's something extra that she just wanted to do.

In this particular case, contacting the family personally to inform them that they would be seeing someone else is immediately recognized as going beyond the call of duty. In situations where the nurse was perceived as doing “something extra” for the family, the effect on their sense of significance was profound. Doing something extra suggests that families are cared about differently; as people and active members of a community rather than clients on a caseload:

It's the nurses...so it's...you know, it's who you deal with. And I've dealt with many and remember them. And even today I can go downtown, you know and see them, you know the ones that were always there for you and you remember that.

Transitioning. Transitioning in the context of the nurse client relationship refers to a way of starting to slowly move families from the beginning of the relationship toward its inevitable end. Although transitioning looks different from family to family and from nurse to nurse, it consistently involved making families aware of boundaries and timelines and steadily increasing awareness as the relationship progressed. Initially, transitioning seemed counterintuitive to the purpose of good working relationships. When we consider the importance of relationships to the work of PHNs, telling clients that the relationship will eventually end before it has even begun seemed wholly at odds with its intended purpose. However, as I read through the transcripts it became clear that transitioning is indeed a key component to ensuring good working relationships. In addition to moving families along in

the relationship, transitioning acted to help families evaluate their successes over the course of the relationship and helped to maintain professional boundaries.

Families who experienced nurses that gently reminded them of the purpose, intention, and time limitations of the relationship appreciated knowing up front what was expected of them, what was involved, and how much time they had. Contrary to what was originally assumed, families found that knowing that the relationships would end helped them develop and focus on personal goals:

I think 'cause I was getting weaned off, or that I didn't have a choice! {laughs}

It just seemed like okay, I...I can feel that my feet are on the ground, I can feel that there's walls around me and I can feel that I can actually pay bills...you know?

This family speaks directly to how knowing that the relationship was going to end pushed them to realize their successes. Although we sense the family's struggles in the beginning, it is clear that knowing that the work of the relationship was purposeful and deliberate helped the family overcome their difficulties. As the end neared, the family felt almost compelled to recognize what they've accomplished.

Moving families along in the program through transitioning also serves to maintain professional boundaries. When families understand that relationships are purposeful and intentional with definitive time lines, it helps distinguish the nurse-family relationship from a friendship. Although it is important that the nurse maintain a stance of warmth, openness and friendliness in order to engage with families, their role is to support the family as a

professional. This places considerable emphasis on the nature of transitioning as a relational process dependent on sensitivity and responsiveness to the needs of the family. Although it is critical to define the relationship in terms of its intended purpose and to indicate that it is timely, to do so effectively requires nurses to be attuned to the family and carefully assess their readiness. Families who experienced good working relationships alluded to having worked with nurses who had transitioned them, almost seamlessly through the relationship. Despite knowing expectations and timelines, they did not feel rushed. They felt supported and confident in their capacity to set and meet desired goals. As one family stated, "she didn't rush us, we didn't feel rushed...you know we felt easy with her".

Summary. All of the families chosen for this section talked in varying degrees about the end of the relationship but, as was previously mentioned, none felt like it was really the end. This is due in part to the PHNs timing and sensitivity with respect to transitioning. Families, who worked with nurses that were responsive to their needs, found transitioning helpful. When conversations about time were coupled with sensitivity and a sense of confidence in the abilities of the family, families found it easier to develop and focus on goals. In a similar way, transitioning was met favourably when families felt that despite programs ending, doors were always open. When they were told that they could "drop by any time", ending relationships seemed less daunting.

CHAPTER FIVE

Discussion

This study began as an exploration into the nature of nursing presence. The questions that guided this inquiry were concerned with how nursing presence is experienced by families engaged in relationships with PHNs and how presence contributes to the development of those relationships. Although families do not discuss nursing presence overtly, they do offer a glimpse into its nature when they describe the comportment of the nurse; her behaviours, actions and mannerisms and how these contribute to developing relationships. By attending closely to what families described, we learn how important it is that nurses act and be in ways that convey a sense of openness and willingness such that families feel safe, confident, and secure about entering into relationships as well as comfortable with how services are provided. We are also enlightened to the importance of timing and of being sensitive to situation and context. Findings show that the actions, behaviours, and mannerisms of the nurse were understood as meaningful only when they were carried out at the right time, in the right place, and with particular attention to context. In essence, families experienced nursing presence when they worked with nurses whose perceptual abilities and relational skills enabled them to intuit how to *be* over the course of the relationship and deliver services in response to the family's needs.

Overall, families equated good working relationships with relationships that were responsive in nature. In this study, developing responsive relationships was crucial to developing partnerships between PHNs and families. This is, in part, because all of the families highlighted in this study were high priority families whose experiences with

vulnerability often have left them consigned to the outer status of society, judged inferior and sometimes blamed for the social issues that insinuate their lives. Some had experienced issues related to poverty, substance misuse, and poor family functioning that left them feeling scrutinized, judged, and misunderstood. Families who lived with constant scrutiny found it difficult to trust PHNs. They were often reticent to enter into relationships with nurses because of previous experiences that had left them feeling undervalued.

PHNs who worked to develop responsive relationships were able to engage some of the most reticent of families by being open, willing, and available. When PHNs were open and genuine, families felt understood and accepted. They were more likely to engage in open and frank conversation with the PHN and enter programs and services with fortitude and determination. SmithBattle, (2009) and SmithBattle et al. (2012) recognized nurses who openly engaged with families as nurses who were able to develop situated understandings of families. Situated understandings are contextual understandings that consider the lived experiences of families as they are influenced culturally, historically, politically, and socially. Rather than approach families from an oversimplified understanding based on purely objective norms, PHNs who formed situated understanding of families were able to comprehend the complexities inherent in the lives of family's. In addition developing situated understandings provided the PHN with an opportunity to see and understand the family more fully, accept their differences, and work with the family in meaningful ways.

In this study, nurse-family relationships that were responsive in nature evolved with nurses whose ability to fully understand and appreciate the family enabled them to practice in a truly family centered way. Family centered care is a care philosophy that builds on the

strengths of families and fosters partnerships to collaboratively identify and address the family's needs and concerns (Blaycock, 2002). Family centered care is cited in the literature as the crux of PHN practice with families. As this study demonstrates, there are PHNs who instead of following the tenets of family centered care, practice from their own narrow vantage point and focus on 'fixing' what they perceive as parenting deficits (Blaycock, 2002; SmithBattle, 2009; SmithBattle et al., 2012). Rather than let families lead and guide their practice, some PHNs tend to apply health promotion theory and patient education in naïve ways with the intent of correcting risky practices and unhealthy lifestyles.

For most families in this study, relationships did not work well with PHNs whose approach to practice was overly didactic, formal, and focused on fixing problems. Rather than experience the strength and empowerment that is supposed to permeate relationships with PHNs, these families became disengaged with the services provided, and in extreme cases, disenfranchised from exercising their own expertise. When PHNs approached families bearing too much authority, as though they had all the answers, they inadvertently de-valued the knowledge of the family. Conversely, nurses who invited the family's participation and recognized their personal experiences as valuable sources of information, empowered families and supported their personal growth.

Families described many behaviours of the nurse that encouraged the development of relationships that were responsive in nature; that exemplified a family centered approach to care and that focused on empowerment. Two themes that represent a summary gestalt of all that families said with respect to the nurse's way of being are a responsive use of self and the responsive delivery of services. In the following sections, these two themes are discussed

separately however in practice both are inextricably bound as they reveal themselves within the context of developing relationships with families. As this discussion will highlight, families who experienced nurses who engaged in a responsive use of self also experienced nurses who were responsive to their needs by being flexible with the provision of service.

A Responsive Use of Self

A responsive use of self is described in the literature as the action of a nurse who above all else is present with the family; is *there* and *with* the family openly, willingly, and attentively and who listens deeply and intentionally to what the family says and does not say in order to disclose the relevant details of their life (SmithBattle, 1997; 2009). Once the family's frame of is grasped and better understood then the nurse can respond to the specifics of the family's situation and context. SmithBattle (2009), drawing on the work of Heidegger, equates a responsive use of self as an act of liberating solicitude that "leaps ahead...not to take away 'care' but rather to give it back" (Heidegger as cited in SmithBattle, 2009, p. 194). Leaping ahead occurs when the nurse in her stance of openness and willingness grasps the family's frame of reference. In her understanding, she positions herself to develop rapport and a trusting relationship so that the family feels safe to disclose their concerns, priorities, setbacks, and struggles.

In this study, families described acts of liberating solicitude with nurses who shared particular aspects of their life and experience to develop common ground and teach in meaningful ways. Findings show that relationships between PHNs and families can over emphasize disparities in knowledge, authority, and power. Rather than foster relationships that focused on respect and mutuality, some PHNs asserted power and authority over the

family leaving them feeling de-valued and mistrustful. Families spoke quite candidly about their concerns with the power of the PHN in surveillance of the family and with the PHNs authority that comes with a specialized body of knowledge.

When families were apprehensive about entering relationships it was extremely important that PHNs create a sense of common ground between themselves and the family. One of the most effective ways to create common ground was to share personal experiences with parenting or some other aspect of the PHNs life relevant to the family's situation and context. The effect of sharing on the development of the relationship was profound. When families experienced PHNs who were willing to share a part of themselves, the family's reticence to enter into relationship seemed to melt away. Families willingly engaged with PHNs, and perhaps more importantly, felt safe sharing parts of their personal life.

For families who felt particularly intimidated by the knowledge of the nurse, sharing was also a valued way to render information less daunting. Indeed, nurses whose approach to teaching overemphasized their expertise were frequently "tuned out". Rather than take up the knowledge they had to share, families disregarded what the nurse had to say and dismissed her expertise as self-importance. Conversely, families expressed a deeper more heartfelt understanding with what they had learned when PHNs shared information by teaching through example and with reference to real life situations.

When the PHN responded to the reticence of the family and their concerns with authority through the act of sharing they brought to light similarities in the everyday realities of both that are all too often enshrouded beneath ascribed roles that emphasize difference. This is particularly significant for high priority families whose experiences with vulnerability

emphasize difference daily. In a society that places high regard on individual success and achievement, vulnerable families are consigned to outsider status and often experience judgment and prejudice based on prevailing assumptions that understand vulnerability as a *life choice*. Given the vulnerability and social distance of these families from the PHN and her services, sharing to create common ground is crucial to inviting families in, developing rapport, and trust so that relationships flourish.

The Responsive Delivery of Services

As stated earlier, a responsive delivery of services was found to unfold with nurses who, over the course of the relationship related to families through a responsive use of self. Findings show that families who experienced relationships that evolved through sharing to develop common ground, similarly experienced nurses who responded to their needs by being flexible with time and the provision of service. Nurses who approached relationships failing to grasp the complexities inherent in the lives of families and who failed to embrace their uniqueness, offered services in a pre-determined, nurse-directed way that emphasized programmatic policies and protocols. Conversely, it would seem that nurses who invited families into relationships by offering up part of themselves in a more personal and connected way worked to ensure that services were delivered and taken up by families meaningfully.

In order to illustrate the differences inherent in both ways of being and working with families, I will draw on the work of Aristotle. Aristotle referred to a practice that relies on fully spelled out rules and guidelines to achieve outcomes as *episteme* (Parry, 2008, Aristotle section, para 2.). *Epistêmê* in the context of this study refers to those nurses who rather than

share information meaningfully, through personal experience and real life examples, approached the family overemphasizing the theoretical embedded in their knowledge. Instead of working with the family to develop the best way to convey information, some PHNs rigidly adhered to guidelines, policies, and book knowledge in their teaching. In some cases an overly didactic approach to teaching effectively diminished the experiential knowledge of the family. Rather than feel as though the PHN was there to work with the family, some families felt as though the PHN was simply there because it was her job. By contrast, nurses who communicated information in useful and meaningful ways were able to grasp and understand the family's frame of reference, embrace the family's lived experiences and value the family's knowledge. Nurses who worked *with* families engaged in what Aristotle calls *phronesis*; a term for the mode of reasoning associated with praxis (Cohen, 2012, Categories section, para 22). Phronesis involves "the character development, skill and judgment to act in accord with the demands of a situation and the larger goods of the [nursing] discipline" (SmithBattle, 2009, p. 115). It is concerned with practical judgment and ethical know-how that is suited "to the right person, [with] the right amount, at the right time, for the right purpose, and in the right manner" (Cohen, 2012, Categories section, para. 10).

Phronesis as it is described here is indicated throughout the findings with specific reference to nurses who were responsive; whose highly developed perception allowed them to "leap ahead" to ensure families felt comfortable and safe throughout the process of relating. In addition to teaching approaches that valued the knowledge of the family, these nurses were also flexible with time and the provision of services. High priority families can experience great difficulty with everyday tasks that others take for granted and even consider

mundane (MacLeod et al. 2005; Moules et al. 2009). It is not uncommon for families to experience challenges related to socioeconomic status that make availability and access to services difficult. I am reminded of one family who candidly described the difficulty she had packing up four children in the middle of winter to attend an immunization appointment for her two month old. She did not have a car and lived on social assistance. The nurse, in acknowledging her challenges, arranged to administer the next set of immunizations at the mother's convenience, outside of regularly scheduled immunization clinic hours.

This kind of practice, a practice that reflects an incisive ability to tailor interventions to the client's world is recognized in the literature as exemplary but is thought to arise only with nurses who have had extensive experience in practice.

Benner et al. (2009), SmithBattle (2009) and SmithBattle et al. (2012) suggest that the perceptual abilities and relational skills required to respond appropriately to clients' needs only develop with increased practice experience that exposes nurses to different clinical situations. As nurses work through different clinical experiences, they learn to discern what stands out as most important for families. Novice or new nurses, according to Benner (1984), SmithBattle (1997; 2009), and SmithBattle et al. (2012), are unable to hone in on the subtleties and nuances that shape the experiences of families because they are overly reliant on theory, process, and procedure to guide their practice.

Findings from this study suggest that although practice experience may help to develop the skills necessary to foster responsive relationships, it is not a pre-requisite nor does experience pre-determine a capacity to engage fully with families. It is clear from the findings that families continue to encounter nurses who, regardless of years in practice,

approach families from a highly objective, de-contextualized place that understands only one way in their work with families. In contrast, findings also highlight one instance where a novice nurse in her first year of practice, was able to openly and easily respond to the needs of a family despite her lack of experience. Indeed, her status as a novice nurse paled in comparison to her experience as a mature student whose experiences in life led her to care for the family in a way conducive to their needs. This raises questions about the nature of experience. What kind of experience and how much experience is required to practice responsively? These questions are clearly beyond the scope of this project however, based on the findings of this study I would surmise that the kind of experiences that shape our capacity to develop responsive relationships are those that emphasize the importance of humanity, experiences that invite kindness and compassion and ask that we be open to difference. Equally important is how we embrace these experiences, that we are fully engaged and allow their newness and difference to shape who we are and how we understand the world.

Summary

Overall in this study, families stress the importance of being understood; an understanding that was made clear through the development of responsive relationships. Many PHNs focus on the differences that seem to permeate the lives of high priority families. Developing and understanding that embraces these differences can be challenging when faced with lived realities that counter our own. So how do we foster understanding in the face of what appears alien? What is required of us and how can we encourage understanding in others? Gadamer (1989) offers us a way into understanding that unfolds through the process of relating. Gadamer (1989) reasoned that all understanding is

historically, traditionally, and culturally rooted. When we come to new and different experiences, we arrive with preconceptions that, like understanding, are also historically, traditionally, and culturally rooted. These preconceptions form what Gadamer (1989) calls our horizon. Our view of the world as it is informed through our experiences within the world. New understandings emerge when our openness allows us to discover to the horizon of another. When we move beyond our own preconceptions to confirm, amend, or abandon our earlier assumptions based on what we have learned from the other we experience what Gadamer (1989) called a fusion of horizons. Our initial assumptions no longer appear as natural or true but instead reflect the possibility and limits of the life-world we inhabit (Gadamer, 1989, p. 277). When considered in the context of developing relationships with families, Gadamer (1989) insists that we must first be open and interested with the horizon of another and perhaps more importantly, be willing to legitimize their lifeworlds by listening, attending, and responding in kind. More importantly, Gadamer (1989) would insist that we allow what we come to understand through our interactions to transform us; to expand our own horizons so that we can understand and affirm the family's strengths, resilience and support them in a way meaningful to their lives as they are lived our daily.

In summary, findings from this study enlighten us to what families feel is most important as they engage with PHN services. Contrary to what some believe, it is neither knowledge nor is it programs and services but rather how both are presented and offered to families. As findings show, knowledge is only useful when it is shared and communicated in a way that is meaningful. Similarly, services are only fully realized when families are afforded some control; some power over their content and how it is delivered. In this study

this was exemplified by PHNs whose capacity to be present with families, be there and be with families allowed them to truly center their practice around the needs of the family.

PHNs who were present and willing to be with families characteristically demonstrated highly developed perceptual abilities, experience, and compassion that fostered a deep and resonant understanding of the family, their situation and their context.

CHAPTER SIX

Conclusions and Implications

Summary of the Study

Relationships between PHNs and families is an area of study that has received much attention in the literature however very few studies have explored how nursing presence contributes to the development of these relationships. Moreover, there is little exploring the perspectives of families and their experience with nursing presence as it unfolds over relationships with PHNs. The purpose of this study was to elicit an understanding of how families experience nursing presence and understand its role in the development of relationships. The research questions that guided this study were: “what is nursing presence?” “What is the experience of nursing presence for families engaged in relationships with PHNs?” and “how does nursing presence influence PHN-family relationships?” This study utilized interview data from eight families interviewed for the narrative component of the WRP (2005) project. In order to draw out family experiences with nursing presence, this study utilized an interpretive approach to data analysis that was informed by the philosophical hermeneutics of Hans Georg Gadamer (1989) and the methodological approach offered by Max vanManen (1997). Findings from this study show that families experienced presence with nurses whose ways of being and working fostered responsive relationships; relationships that reflected the uniqueness of families; their situation and context, and that centered around their needs.

Conclusions

Working with families is a vastly complex skill that requires much more than what is afforded in books, policies and protocols. As this study demonstrates, it requires highly developed relational skills that enable nurses to be with families and be there for families so that the work of relationships truly centers around their experiences and everyday realities. The literature offers some insight into what is involved in fostering these kinds of relationships by focusing on nurse characteristics that are thought to engender trust, openness, and willingness such that families feel safe and comfortable with entering relationships. However few provide any insight into how nurses convey openness, willingness, and trustworthiness. Nor do they provide any evidence as to whether or not these characteristics indeed help to foster good working relationships that are responsive in nature.

SmithBattle (1997; 2009) and SmithBattle et al. (2012) provides considerable insight into what is involved in centering families at the heart of practice. In her work she highlights the practice of expert nurses whose perceptual and relational skills guide their practice with some of the most vulnerable families. However, like many others concerned with the nature of practice with families, she only offers a view from the nurse's side of the relationship. Although her work echoes much of what families say in this study about the importance of developing common ground and tailoring services to meet the needs of families, without the perspective of families we can only presume that her findings indeed support the development of responsive relationships.

By exploring the voice of families, this study invites a view into the relationship that informs us of our approach with families. For nurses whose work with families exemplifies willingness and an openness to understand and embrace the family based on who they are, these findings reinforce their practice. For those whose practices are ruled by programmatic policy and guidelines and focused on fixing deficits as opposed to promoting strengths, this study's findings provide insight into the importance of coming to know the family; of understanding and accepting the complexity that is inherent in their lives so that the work of programs can be achieved with success.

Interpretations offered also provide insight into how PHNs can begin to understand family's in truly situated ways. For example, findings stress the importance of being willing, willing to engage with families openly and genuinely with a sense of curiosity about who they are as people, rather than who they are as clients on a caseload. Findings also suggest that nurses find ways to honour families, honour their knowledge and expertise that have developed over years of practical experience. Lastly, findings stress a need for PHNs to walk with families and allow them to lead in practice. One of the key insights offered by families in this study was the need for PHNs to work with them in different ways over the course of the relationships. Families who experienced PHNs who delivered services in response to their needs and who allowed families to lead the PHN in her practice felt empowered and confident to move ahead in life on their own.

In addition to offering insights into how PHNs can foster responsive relationships, interpretations also add to the body of knowledge about family perspectives of the nurse family relationship and the role that nursing presence plays in the development of those

relationships. To date most of the literature concerned with nursing presence has looked to define the concept by identifying its attributes and antecedents. Several concept analyses outline presence as a phenomenon that occurs in relationship but few point to how it is experienced in relationship. Exploring the perspectives of families from the hermeneutic phenomenological approach outlined by Max van Manen (1997) enabled a view into the nature and character of nursing presence, what comprises nursing presence and how nursing presence contributes to the development of relationships.

Although families in this study do not use the word presence, they described behaviours and approaches of the nurse; her way of being that were understood to represent the essence of nursing presence. Some of these were described as particular attributes or characteristics of the nurse whereas others were indicative of a particular feeling or sense that the family experienced while working with the nurse. Although families described nurse qualities differently, all families emphasized a need for the nurse to convey a sense of unconditional regard and respect for the family's everyday reality. The effect of nursing presence on the development of relationships in this study was to ensure their success. In situations where families experienced nursing presence as a phenomenon that engendered feelings of understanding, value and respect relationships flourished. Conversely when families felt undermined, or undervalued, the relationship faltered. This finding is consistent with much of the literature exploring nursing presence in the context of nurse-family relationships. Respecting and valuing the uniqueness of families and their lives as they are lived daily is stressed throughout this body of literature. What this study adds are family understandings regarding the nature and character of nursing presence and its contribution to

the development of relationships. To date there are very few research studies exploring nurse-family relationships from the perspective of families.

The two themes highlighted in this study that exemplified the presence of the nurse were a responsive use of self and the responsive delivery of services. Families experienced a responsive use of self when they worked with nurses who personalized their practice by sharing aspects of their lives. Families experienced a responsive delivery of services with PHNs who were flexible with their time and how they delivered service. What resonates most from the study findings is the profound impact responsiveness had on developing relationships with families. When PHNs responded to families through the acts of sharing and being flexible, they were able to gain trust, develop rapport, and complete the required work of home visiting. Moreover, families felt valued and respected based on who they were. When nurses personalized their relationships with families, any concerns the family had with how the nurse may perceive them were quickly put to rest.

On the surface, nursing acts such as sharing and being flexible seem simple however there is considerable background work involved in being open, willing, and understanding so that indeed, sharing and being flexible occur in response to the needs of families. Being open, willing, and understanding can require considerable effort, but it is an effort that can be embedded in nurses everyday practice. Nursing, above all else, is a caring profession that by nature insists on character development that fosters the relational skills necessary to be and work with families in ways that are responsive to their needs. Ultimately when we resist cultivating the skills necessary to respond to all types of people, regardless of their situation

or their lifestyles, we neglect a fundamental part of nursing practice, developing relationships.

Implications for PHN Practice and Education with Families

Interpretations offered in this study hold significant implications for PHN practice with families. One asks that PHNs carefully consider what families feel is important in developing relationships to ensure that the work of relationships is carried out meaningfully and intentionally with the needs of families at the fore. The second concerns the practices and actions of nurses. In keeping with much of the literature, families describe the presence of the nurse by focusing on specific nurse characteristics however they also describe specific actions and behaviours that contribute to developing relationships. In doing so families offer practicing nurses and student nurses a glimpse into *how* nurses can be and act in ways that contribute to the development of good working relationships. Interpretations offered in this study add a new and different dimension to what it means to be present with families by providing a *how* for PHNs in practice.

In addition to providing insight into how nurses can *be* in practice to develop good working relationships, the study illuminates tangible and effective ways to educate families. Families throughout this study benefitted from personal stories and real life situations to grasp the meaning embedded in theory. When nurses provided examples or shared stories to support what they were teaching, families were more apt to take up the information in meaningful ways. Moreover, families felt a strong connection with nurses who were willing and able to share stories that rendered information more meaningful. This finding calls into question what we currently teach students about developing and maintaining therapeutic

relationships. Currently, the practice of many educators is to teach the professional and practice standards laid out by the College of Registered Nurses of British Columbia (CRNBC). In the area of therapeutic communication, it is common to stress the importance of the CRNBC standard entitled *Boundaries in the nurse client relationships*. Although the importance of this practice standard cannot be overstated, findings from this study suggest that perhaps some of the practice principles underlying the standard be taught with more flexibility and openness. Currently the standard cautions against sharing personal experiences and precludes ideas of friendship in developing therapeutic relationships with families. If sharing and friendship were considered, as they are described by families in this study, perhaps they could be included in the CRNBC practice standard as valuable components to developing therapeutic relationships. In addition, educators would feel free to teach the value of sharing and friendship when both are genuinely and professionally included in developing therapeutic relationships with families.

Further to the development of therapeutic relationships with families, sharing stories may also have implications for educating nursing students. The practice of nursing is steeped in theory that can be difficult for students to grasp and therefore, extremely difficult to integrate into practice (Dieklemann, 2000). Pedagogical approaches that utilize stories or real life experiences may be utilized to render information more meaningful and thereby easier to recognize and incorporate into practice. In addition, understanding the value of stories as a student may help educate newly graduated nurses in how best to foster connection and collaboration with families. If students are exposed to educators who are

willing to share personal experiences this may encourage willingness on the part of students to share stories with their clients.

Lastly, developing responsive relationships emphasizes the importance of personal development both as an individual and a nurse. Nursing practice and education stresses reflection on practice and suggests that nurses spend time reflecting on the self (Arnold & Boggs, 2011; Benner, 1984). Many pedagogical approaches in nursing however do not offer deep and thoughtful explanations regarding the nature of reflection and its intended purpose. Although reflective practice is introduced at an undergraduate level, the introduction merely skims the surface of what it means to engage in reflective practice. In addition, undergraduate education does not offer students thoughtful ways in which to engage in reflection. Journaling does exist as part of clinical practice education, but void of a complete and thorough understanding regarding the nature of reflection, journal submissions often fall short of their intended purpose. Educators might think of ways to invite deeper reflection that could include feedback from individuals and families with whom nursing students interact. Although feedback can at times be difficult to receive, its usefulness as a vehicle for reflection cannot be understated provided the intent and process of reflection is fully understood.

Another educational vehicle to invite reflective practice is simulation technology. Many nursing programs have integrated simulation technology as a way to enhance student skills in clinical practice. Perhaps simulation could additionally be used to encourage reflective practice, and enhance personal and communication skills required to practice expertly.

Implications for Future Research

Other areas of inquiry reside within the two prevailing themes; a responsive use of self and a responsive delivery of services. Of particular interest is the question of experience and how it relates to the relational skills required to practice responsively. As stated previously, findings from other studies place considerable emphasis on the need for extensive practice experience whereas this study demonstrates that indeed, novice nurses can practice in a way that responds to the needs of families. This calls into question the nature of experience and what kind of experience is required in PHN work with families.

Another area that requires considerable exploration rests with the relational skills necessary to develop responsive relationships. The literature cites the importance of being understanding. Gadamer (1989) offers us a view into how understanding unfolds through the process of relating, but what it means to truly understand remains a mystery. Moreover, how do we open ourselves to understanding when much of who we are and how we experience the world is pre-determined? How do we merge that which we hold to be true and right with what might appear as fundamentally wrong to arrive at new and different understandings? In other words, how do we temper our tendency to polarize when faced with difference? All of the questions here are based within the development of relationships and how PHNs can work to ensure that relationships are developed and sustained with the needs of families at the fore. PHN work with families depends on relationship however, not all PHNs develop relationships that are conducive to the needs of families.

Re-visiting Do for, do with, and cheer on

I would like to end this thesis by returning to the beginning; by re-visiting the Families Count practice philosophy, *Do for, do with, and cheer on*. At the outset of this project I described how utterly confused I was with the words above and their meaning as it related to practice with families. Over the course of this project I have given considerable thought and reflection with respect to my own experience as a PHN and as a Masters student of nursing. By reflecting on both experiences I have come to realize that the words, *Do for, do with and cheer on* can be interpreted many different ways but underlying all interpretations is the importance of supporting families in ways meaningful to the families we serve. In this regard my practice will be forever changed. I have always been drawn to the power of relationships in nursing, in particular how simple genuine gestures and interactions can make a world of difference. Having conducted this study, I now realize that indeed, it is the simple things we do that make the most profound difference. In this regard, my practice will be forever changed. In order to illustrate my deep and profound feelings with respect to what I have learned and what I have experienced as a PHN, I will draw on a personal practice experience in order to illustrate my understanding with respect to the meaning embedded in the Families Count Practice philosophy.

Early in my practice I met a family who initially appeared to require a great deal in the way of help. I distinctly remember being focused on issues with substance misuse and child growth and development that I neglected to recognize the incredible support system this family had developed for themselves. When the mother was unwell, the grandmother and aunt willingly stepped in to support the children and provide for them in the best way

they could. Initially I remember thinking that their actions simply enabled the mothers drinking and crack cocaine binges. I remember discussing my feelings with a colleague describing the disdain I initially felt for the mother of this family. My colleague listened intently. When I had finished my rant, she asked me one question, “Have you thought about why the mother has addictions issues”? At the time I thought to myself “No”, “What does it matter”?

As I continued my work with the family, I reflected on my colleagues question until I finally thought to explore why the mother felt she had issues with addictions. The story the mother told about her life as a child and as a parent was astounding. She revealed a reality so far removed from my own, I was shocked and then almost instantly honoured that she felt she could trust me with her story. By opening myself up to the possibility that perhaps my initial assumptions regarding addictions were wrong, I discovered, that addiction issues are often far more complex than what I initially presumed to be a lifestyle choice. With this realization, I came to see the mother in an entirely different light. I was able to understand the source of her pain and the reason for her addiction. I was also able to see that beyond the initial dysfunction was an incredible love for all three of her children and a strong desire to parent the children in the best way possible. In essence I came to realize that the family was not the problem, it was the misuse of substance that was the problem. Focusing my frustration and anger on the mother no longer made any sense. Instead, I found solace with the family and with the love they shared for the children and each other. I was then able to advocate for the family based on that love. When my work with the family came to an end,

the children were living full time with their aunt and grandmother, a decision that the family came to with my support. The mother was seeking treatment for her addiction issues.

When I reflect on the anecdote above, I am grateful for the question posed by my colleague when I disdainfully described the situation to her. More importantly, I was grateful for how my colleague posed the question. My colleague's stance at the time was open and receptive. She listened attentively, did not judge my opinion, nor did she overtly judge me. In retrospect she appeared thoughtful, and considerate. Moreover, she responded in a way that forced me, unknowingly, to reflect upon my initial thoughts and eventually on my overall opinion of the family. In essence, my colleague's openness, willingness, and respect; coupled with her poignant question compelled me to learn more. She subtly pushed me to develop a different, more situated understanding of the family. To this day I approach families openly, inquisitively, and with the utmost respect, regardless of the family's situation and context. I have learned to ask questions and be open to the answers as opposed to making judgments based on my own erroneous assumptions.

Finally, when I consider the anecdote above in light of everything I have learned over the course of this study, I realize similarities between what my colleague offered me and what families ask of PHNs. Throughout this study families asked that PHNs be open and receptive to their ways of being. They asked that PHNs listen attentively to what they have to say and accept what they have to offer. Ultimately, families ask PHNs to be present with them, to be there and with them as they learn new and meaningful ways of being as a family.

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