“THEY’RE LIMITED BY THEIR CIRCUMSTANCES...MAYBE IT’S THE BEST THEY CAN DO”:

PUBLIC HEALTH NURSES’ UNDERSTANDING OF THEIR WORK WITH FAMILIES LIVING WITH SOCIAL AND MATERIAL DISADVANTAGES

by

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Abstract

Public health nurses (PHNs) have a long history of supporting the health of families living with social and material disadvantages. Professional nursing organizations, researchers and theorists emphasize that consideration of the social determinants of health and efforts to address health inequities are critical components of nursing’s mandate. Literature emphasizes that nurses’ practices are shaped by personal, organizational and ideological factors that influence their assumptions about, and understanding of their role with, vulnerable families. Literature also highlights the need for PHNs to engage in critical reflection about their personal assumptions regarding their clients in order to provide care that is socially just.

The purpose of this qualitative study is to explore the range of understandings and assumptions PHNs may hold about families living with social and material disadvantages, how PHNs understand their work with these families and the ways in which PHNs reflect on their assumptions and nursing practice. The specific research questions are: What is the range of assumptions that PHNs have in relation to families living with social and material disadvantages? How do PHNs understand their work with families living with disadvantages? How do PHNs describe engagement in self-reflection regarding their assumptions about clients living with disadvantages and how does this impact the PHNs’ nursing practice? What can be learned from the perspective of expert PHNs on the ways that nurses can work effectively with families living with social and material disadvantages? What recommendations can be generated to help support PHNs working with families living with social and material disadvantages?

A qualitative exploratory research design was used to address these research objectives. Six, experienced PHNs participated in interviews with the researcher. The findings are organized around five main themes: (i) understanding clients’ context and engaging with individuals and families, (ii) building trusting relationships, (iii) PHNs are one agent, among many, that may influence change, (iv) recognizing the significance of small increments of change, (v) PHNs’ practice has a primary focus on mothers and children. PHNs valued opportunities to engage in self-reflection, but identified barriers to this practice. Recommendations are suggested in domains of education, organizations, PHNs’ practice and research.
Preface

This study is a critical analysis of the literature related to PHNs’ work with families living with social and material disadvantages. Additional perspectives were obtained by in-depth, narrative interviews of experienced PHNs currently working with families living with disadvantages. This study was approved by the University of British Columbia’s Behavioral Research Ethics Board (UBC BREB) on February, 2015, under the title, PHN Assumptions and Self-Reflection. The certificate number is: H14-03114.
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Chapter 1: Introduction

There is abundant evidence that human health is closely related to the social and material context in which people live (Raphael, 2010). Research also shows that public health nurses (PHNs) have an important role in supporting the health and quality of life of families living with social and material disadvantages. PHNs engage, during the perinatal period, with many families and offer more intensive services to those identified as vulnerable to poor health outcomes. PHNs provide services to families living with disadvantages, often over the course of many months, and are therefore in a position to closely observe, and respond to, the context of their clients’ lives (Cohen & McKay, 2010). Professional nursing organizations, such as the Canadian Nurses Association, researchers and theorists continually point to the importance of considering the social determinants of health and efforts to address health inequities as critical components of nursing’s mandate. However, personal, organizational and ideological factors may influence nurses’ perceptions of clients living with disadvantages and the ways nurses understand their role with these families.

The literature highlights the need for PHNs to engage in self-reflection regarding their personal assumptions about families living with disadvantages, in order to work effectively with these families (Lynam, Loock, Scott & Khan, 2008). Anderson et al (2009) note that the views nurses hold toward their clients can contribute to socially just actions or reproduce social injustices. While researchers have described how nurses sometimes respond to patients in ways that reflect dominant social stereotypes and a lack of critical self-reflection, other research suggests that PHNs, in general, tend to scrutinize and reflect on their personal assumptions in order to create a non-judgmental approach with clients (Browne, Hartrick Doane, Reimer, MacLeod & McLellan, 2010; Cohen & McKay, 2010). Professional nursing documents, such as the CRNBC Professional Standards for Nurses and Nurse Practitioners (2012), also provide clear direction for nurse to engage in self-reflection. There is a need to understand the assumptions held by PHNs toward families living with social and material disadvantages, factors that influence these assumptions, how PHNs understand their work with these families, how/whether nurses consistently
reflect on their beliefs and perceptions and whether this reflection influences their nursing practice, in order to support nurses to provide the most effective care to families.

**Problem statement**

It is clear that human health is detrimentally affected by conditions of social and material disadvantages. PHNs are well positioned to make positive impacts on the health and quality of life of families living with disadvantages. The literature points to the important need for PHNs to consider both the social and material context of their clients’ lives, as well as their personal assumptions about families living with disadvantages in order to engage with families in a socially just manner. Some literature suggests that PHNs hold attitudes towards their clients that help mitigate the impacts of disadvantages, while other literature suggests that nurses may hold beliefs that contribute to health inequities. A number of factors may impact PHNs’ beliefs about their clients, as well as PHNs’ understandings of their work with families living with disadvantages. Despite the expectation of professional organizations that nurses use self-reflection to examine their personal assumptions about their clients, the literature does not clearly describe how nurses engage in this activity. PHNs with significant experience working with families living with disadvantages may provide insights gained from their years of engagement that will add to the consideration of effective nursing practice. The purpose of this critical analysis is to explore the range of understandings and assumptions PHNs may hold about families living with social and material disadvantages, how PHNs understand their work with these families and the ways in which PHNs reflect on their assumptions and nursing practice.

**Research questions**

What is the range of assumptions that PHNs have in relation to families living with social and material disadvantages? How do PHNs understand their work with families living with disadvantages? How do PHNs describe engagement in self-reflection regarding their assumptions about clients living with disadvantages and how does this impact the PHNs’ nursing practice? What can be learned from the
perspective of expert PHNs on the ways that nurses can work effectively with families living with social and material disadvantages? What recommendations can be generated to help support PHNs working with families living with social and material disadvantages?
Chapter 2: Review of the Literature

A review of the literature will establish the context for this critical analysis. Research clearly demonstrates the profound impact of social context on human health. PHNs play an important role in supporting the health and quality of life of families living with disadvantages. PHNs are encouraged to consider the social context of their clients’ lives and to engage in critical self-reflection about their own assumptions related to clients’ circumstances. This review will examine factors that may influence PHNs’ assumptions about, and response to, families living with social and material disadvantages.

The link between social determinants of health and health outcomes

There is a well-established body of literature that highlights the important connection between a variety of health indicators and the social and material context in which people live, (commonly referred to as the social determinants of health). Evidence demonstrates that health differences among Canadians result primarily from “experiences of qualitatively different living conditions associated with the social determinants of health” (Raphael, 2010, p. 150). Social determinants of health include: income and its equitable distribution, early childhood development, education, employment and working conditions, food security, health care services, housing, social safety nets, and social inclusion (Reutter & Kushner, 2010).

Raphael (2010) points out that income is particularly important as a marker of many other social determinants of health: quality of early life, education, employment and working conditions, food security, housing quality, and the experience of social exclusion. Further, a significant condition of Aboriginal life and the experience of women in Canada is the greater likelihood of living with conditions of low income. Raphael notes that income is strongly associated with morbidity and mortality from a variety of diseases. Persistently high levels of poverty in young children increases their lifetime risk of chronic disease, school failure and criminal involvement (First Call: BC Child and Youth Advocacy Coalition, 2013).
Populations that have been identified as being at risk for poorer health outcomes include: persons living in poverty, persons living with disabilities, ethno-cultural minorities, sexual minorities, indigenous peoples, persons living in rural and northern areas, women in precarious circumstances, immigrants and refugees, and persons with limited literacy. In Canada, the most significant health disparities are related to socioeconomic status, Aboriginal identity, gender and geographic location (Reutter & Kushner, 2010). However, rather than suggesting there is an intrinsic vulnerability associated with certain populations, it is important to recognize the social conditions that lead to poorer health in some groups. Health differences are termed ‘health inequities’ when they are unnecessary, unfair, preventable and result from social injustices (Falk-Rafael & Betker, 2012a).

A number of authors have described the social processes that create inequities, by depriving certain groups from opportunities for health. Lynam and Cowley (2007) point to evidence that material circumstances, in combination with social conditions, make the greatest contribution to health inequities. Their research demonstrates the ways marginalization (“the sense of being overlooked, categorized or misrepresented” p. 146) is a barrier to opportunities and creates social exclusion for individuals in particular social locations. Discourses of difference and categorization reinforce negative assumptions and impact relationships.

Link and Phelan (2006) note the close association between socioeconomic status and disease, “people with greater resources of knowledge, money, power, prestige and social connections are generally better able to avoid risks and adopt protective strategies” (p. 529). These authors also describe stigma as a social process where one group has the power to identify and label human differences and link these differences to undesirable characteristics, creating a rationale for exclusion. Stigma has a dramatic impact on life opportunities, resources and wellbeing. Pauly, McCall, Browne, Parker and Mollison (2015) point out that stigma in health care contributes to mistrust of the healthcare system by stigmatized individuals and groups. Aston et al (2014) describe the social discourses that negatively frame those with less education or economic stability and create barriers to opportunities for optimal health: “lower class, lower education and single mothers have been historically and socially constructed to be less than” (p. 15).
Yanicki, Kushner and Reutter (2015) explain social inclusion/exclusion as a social process involving just/unjust social relations and social structures, differentially applied to certain individuals or groups, that enable or constrain opportunities for participation and health. These authors describe three discourses within Canadian literature, each highlighting a different view of the injustices leading to social exclusion and the conditions supporting inclusion and social justice: (i) recognition – social inclusion involves recognizing, respecting and valuing unique identities and group differences, while social exclusion involves rejecting those who differ from dominant norms; (ii) capabilities – conditions that enable or constrain participation, freedom and opportunities of capability development; (iii) equality and citizenship – social inclusion involves opportunities for citizens to realize their rights and responsibilities, the presence of just social structures and freedom from aggression, while social exclusion results when citizens are constrained from participation in civil society, fair access to social goods, social/cultural expression and economic participation. These authors argue that all nurses have an ethical role to play in addressing both the relational and structural dimensions of social justice.

The current role of PHNs with families living with disadvantages

Public health nursing has a history of responding to the needs of disadvantaged individuals and populations. Early nursing leaders such as Lillian Wald, Lavinia Dock and Margaret Sanger recognized the destructive health effects of poverty, gender and ethnic inequalities, and worked to create more progressive health policies (Bekemeier & Butterfield, 2005). Wald helped establish the Federal Children’s Bureau to protect children from the harmful effects of child labour. Dock, a suffragist, pushed for reforms to improve the health of women and children. Sanger worked to distribute information about contraception and human reproduction (Drevdahl, Kneipp, Canales & Dorcy, 2001). Each of these nursing leaders recognized the need for political activism and broad system change as interventions to improve the health of whole populations (Reimer Kirkham & Browne, 2006).
Despite these early examples of activism addressing social justice issues, some authors note that the direction of nursing changed dramatically in the early 20th century (Drevdahl et al., 2001; Reimer Kirkham & Browne, 2006). As medicine adopted a focus on disease and the health of the individual, attention shifted away from the impact of social conditions on health. The evolution of nursing also led to an increasingly individualistic focus, reflecting a societal ideology that assumes health is an individual responsibility and the goal of healthcare is to support individuals to make healthier choices, rather than working to change social conditions that constrain opportunities for health (Reimer Kirkham & Browne, 2006). These authors also maintain that economic pressures in healthcare and the demands to produce concrete, measurable outcomes contributes to the difficulty for PHNs to engage in the kind of social activism seen in the past.

Although public health nursing may have moved away from its early roots in political activism, a large body of recent literature demonstrates the important role PHNs continue to play in their work with individuals and families living with material and social disadvantages. Positive outcomes include: improved maternal mental health (Izzo et al., 2005; Olds et al., 2004a), improvements in development and intellectual achievement of children (Heaman, Chalmers, Woodgate & Brown, 2006; Kitzman et al., 2010; Olds et al., 2004b), reduced maternal substance use (Izzo et al., 2005; Olds et al., 2010), increased breastfeeding duration (Kemp et al., 2011), improved maternal-infant attachment (Armstrong, Fraser, Dadds & Morris, 2000), gains in maternal experience of self-agency (DeSocio, Holland, Kitzman & Cole, 2013) increased community resource utilization among pregnant adolescents (Flynn, Budd & Modelski, 2008), and maternal feelings of greater confidence, empowerment, reduced stress and anxiety (Aston et al., 2014). PHNs and their managers also share a belief that their home visits to vulnerable families make a significant positive difference to the health of their clients (Aston et al., 2014). Clearly, PHNs make positive impacts on the health of clients living with disadvantages, although the literature continues to focus on work with individuals and families rather than strategies for addressing broader social determinants of health.
Directives guiding public health nurses’ work with clients living with material and social disadvantages

Recent literature has highlighted the importance of health care providers’ consideration of social determinants of health and active participation in efforts to improve health equity. Professional nursing documents emphasize the responsibility of nurses to consider, and respond to, the social context of health in the populations we serve.

The Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses (2008) states: nurses should endeavour as much as possible, individually and collectively, to work for and work toward eliminating social inequities by recognizing the significance of social determinants of health and advocating for policies and programs that address these determinants; recognizing that some people have limited choices because of social, economic, geographic or other factors that lead to inequities. In a 2013 position statement on social determinants of health, the CNA states that registered nurses must include the social determinants of health in their assessments and interventions with individuals, families and communities (CNA, 2013). Yanicki, Kushner and Reutter (2015) point out that the ‘weak’ language of the CNA Code of Ethics suggests that social action is “optional…and implies that reducing health inequities was not considered part of the everyday work of nurses” (p. 128). These authors maintain that nurses are not only called to recognize the significance of social determinants of health, but also to play a key role in changing the social, economic and political conditions that sustain health inequities.

Some of the responsibilities identified in the Canadian Community Health Nursing Standards of Practice (2008) include: community health nurses are keenly aware of the impact of the determinants of health on individuals, families, groups and populations; assess the impact of the determinants of health on the opportunity for health for individuals, families, communities and populations. The Core Competencies for Public Health in Canada, as described by the Public Health Agency of Canada (2013), identifies knowledge about inequities in health and recognition of social determinants of health as practice
requirements for public health providers. These statements describe the knowledge of social determinants of health required by nurses, but do not provide direction for action.

A Canadian Nurses Association social justice paper (2010) outlines specific responsible actions nurses and the nursing profession can take towards eliminating avoidable disparities, such as: pursue roles in advocacy and policy change; create enabling environments and reduce poverty; advocate for human rights; align with social responsiveness, gender equality, fairness and equity; conduct research to determine which changes in the provision of nursing care are most effective. Nursing researchers and theorists argue that nurses have an important role to play in addressing social determinants of health (Cohen & Reutter, 2007; Cohen & McKay, 2010; Reutter & Kushner, 2010; Falk-Rafael & Betker, 2012a). Falk-Rafael (2005a) maintains that contemporary public health nursing practice should be informed by an integration of caring and social justice. She argues that one of the core processes of a “carative” approach is the creation of supportive and sustainable physical, social, political and economic environments. She states that nurses have a moral and professional obligation to be involved in socio-political activities that address conditions that contribute to health inequities. Yanicki, Kushner and Reutter (2015) argue that PHNs are ideally positioned to address social justice issues in health. They propose an integrated social justice framework for nursing that offers interventions to address inequities at both the relational and structural dimensions.

Despite these calls for a response to health inequities, the evidence of positive impacts by public health nurses, on the lives of clients living with disadvantages continues to focus on individuals and families, rather than wider social advocacy. Researchers have found that PHNs clearly recognize the impacts of the social and material context of their clients’ lives (Browne, Doane, Reimer, MacLeod & McLellan, 2010; Cohen & McKay, 2010), but it is not clear that this leads to broader action to address inequities.
Factors that may impact public health nurses’ understandings of, assumptions about, and responses to clients living with material and social disadvantages

The literature suggests a number of factors that may influence the attitudes of PHNs towards families living with disadvantages and the ways PHNs may, or may not, respond to the social context of these families. Perspectives that arise from neoliberal ideology, organizational influences and personal characteristics of individual PHNs may all impact the ways PHNs understand their clients and how they respond to issues related to social and material disadvantages.

Ideological considerations

A number of nursing theorists have discussed the influence of the dominant political ideology of neoliberalism on the nursing response to social determinants of health. Central to this political philosophy is the belief that a free-market economy is the foundation for economic growth and human wellbeing (Coburn, 2010). Other key features of neoliberalism include: individualism, egalitarianism and freedom of choice (Browne, 2001). Capitalist economies place individual interests above those of the greater social community. Individualism conceptualizes humans as rational thinkers with independent choices and responsibilities, directing attention away from the social and structural context of people’s lives. Within this paradigm circumstances, such as poverty, are constructed as something located within the individual, rather than a result of economic and political structures (Drevdahl et al., 2001; Falk-Rafael & Betker, 2012a). Neoliberal ideology in western countries has resulted in increased privatization, cutbacks in social programs and a fundamental belief in individual self-reliance (Reutter & Kushner, 2010). Egalitarianism assumes that all persons have equal opportunity to achieve optimum health (Browne, 2001).

The individualistic perspectives within health care frequently leads providers to focus on the presumed impacts of individual behaviours on health, rather than attending to the social and material context of clients’ lives. Poverty and social exclusion are viewed as individual problems and responsibility for solutions is placed on families and communities (Yanicki, Kushner & Reutter, 2015). Many authors have acknowledged that the individualized approach to illness and health promotion
constrains effective action by PHNs on the social determinants of health (Falk-Rafael, 2005b; Raphael, 2003). Reutter and Kushner (2010) comment that the dominant ideology of individual responsibility shifts attention from social determinants of health to a position where individual behaviors and the health care systems are seen as the main determinants of health. Reimer Kirkham and Browne (2006) note that when health is seen as an individual responsibility, nursing activities focus on supporting individuals to cope with their circumstances or to help them make healthier choices. Bekemeier and Butterfield (2005), in a review of national nursing documents, noted that the nursing focus on the individual assumes health problems to be with the patient or community rather than a function of a deleterious social system. Hartrick Doane and Varcoe (2015) also describe how liberal individualism leads to the assumption that people are autonomous and independent of their relational, economic, historical and political contexts.

Hartrick Doane and Varcoe (2015) also explain the problems with the common nursing practices of categorizing and differentiating. Placing people in categories draws attention to certain features and not to others and we attach values differently to different categories. Nurses can influence how people are perceived by others “through the categories they apply and the differences they highlight” (p. 89). In western societies many forms of difference are seen primarily as individual choices.

**Organizational considerations:**

A number of organizational issues have been identified that impact PHNs’ responses to social determinants of health and clients living with disadvantages. PHNs report that an organizational commitment to make action on social determinants of health part of public health nursing work is a critical foundation for an effective nursing response (Cohen, 2006; Cohen & Reutter, 2007). PHNs state that an organizational commitment must include resources to enhance nursing knowledge and skills, and organizational structures that support PHNs in this work (Cohen & Reutter, 2007). However, despite recognition of broad determinants of health in some organizations, programs continue to focus public health nurse attention on health issues at the individual level and regard health as an individual responsibility (Cohen & McKay, 2010; Yanicki, Kushner & Reutter, 2015).
Browne et al (2010) note that public health nursing work with vulnerable families requires organizational support to ensure adequate staffing levels, mentoring of new nurses by experienced PHNs and flexibility in programmatic expectations. However, PHNs have reported a lack of human resources to adequately address issues of disadvantages, a lack of managerial support and little opportunity for PHNs to engage in program planning (Reutter & Kushner, 2010; Yanicki, Kushner & Reutter, 2015).

Cohen et al (2013) note that the public health sector in Canada continues to be preoccupied with behavior and lifestyle approaches to health improvement. These authors point out that some public health units in Canada have few staff with the skills required for community engagement and advocacy and limited capacity for community assessment and surveillance. Aston, Meagher-Stewart, Edwards and Young (2009) reported that PHNs identified many constraints to their efforts to foster citizen participation, including lack of funding for health promotion and prevention programs and misunderstanding of PHNs roles by politicians, the general public and managers. Without organizational support for PHNs to be engaged in wider advocacy efforts, PHNs may feel restricted to an individualistic focus in their work with clients living with disadvantages.

**PHNs’ perceptions of their role and personal agency:**

While the literature is clear that PHNs make positive impacts in their work with families living with disadvantages, there is also concern that PHNs are limited in their ability to advocate beyond the individual/family level. Cohen (2006) has reported that PHNs describe reluctance to engage in health promotion strategies beyond the level of the individual because of a lack of confidence and perceived lack of competence. Cohen and McKay (2010) note that while many PHNs are familiar with principles related to advocacy for healthy public policy, they do not feel they have the skills to apply this theoretical knowledge.

Aston et al (2015) draw our attention to socially constructed stereotypes about PHNs whereby their work is seen to be “friendly, simple and easy” (p.25). Complex assessments and practices are often invisible and unrecognized in the community. These authors argue that the work of PHNs has been
marginalized through social and institutional discourses that have led to negative understandings of their work; creating perceptions that PHNs’ work is seen as “softer” and “less professional,” compared to dominant constructions of what constitutes professional behaviour. (Aston, et al., 2014). Wide acceptance of these stereotypes devalues the contribution of PHNs in their work with individuals and populations. Further, if PHNs accept this construction of their work they may be less likely to believe in their own effectiveness as advocates for those living with disadvantages.

A number of authors have noted that PHNs do indeed consider the social and material context of their clients’ lives and understand the relationship between this context and health (Browne et al., 2010; Moules, MacLeod, Thirsk & Hanlon, 2010; ). However, if PHNs feel constrained in their ability to impact disadvantages, because of personal perceptions, organizational philosophy, or ideological influences, we may suggest that PHNs will maintain a more individualistic focus and pay less attention to social advocacy.

**Literature pertaining to PHNs’ assumptions about families living with social and material disadvantages**

While I am not aware of any literature that exclusively examined PHNs’ assumptions about families living with disadvantages there is research that provides some insights into nurses’ beliefs about their clients. Much of this research reveals how dominant societal attitudes are reflected in the perceptions of some nurses and other health care providers in ways that constrain socially just health care.

In research exploring nurse perceptions of First Nations patients, Browne (2006) described nurses’ attitudes that were a reflection of the discourses and beliefs of the dominant society, reinforced by media, institutional policies and everyday practices. Nurses in this study expressed social views of Aboriginal people prevalent in the larger society. Browne notes that relating to patients on the basis of assumptions and stereotypes can jeopardize equitable health services. As noted earlier, in the discussion of ideology, Browne argues that the dominant political ideology of neoliberalism profoundly affects nurses’ beliefs, deflecting attention from many forms of inequality.
Johnson et al (2004) explored the concept of “othering” practices of health care providers towards South Asian immigrant women. Othering refers to the practice of naming those who are thought to be different from oneself and a process of constructing a personal identity in reference to others. By describing individuals or groups as “other” one magnifies the apparent differences from oneself and reinforces positions of differential power. Experiences of othering were widespread in the discourses of health providers, suggesting that perspectives and assumptions are shaped by the dominant values of the health care system and a “lack of critical awareness of manifestations of discrimination, racism and the social context of women’s lives” (p. 266).

Van Ryn and Fu (2003) note that the perceptions of public health providers are unconsciously influenced by social categories. Observers assign different meanings to the same behaviour depending on the race, class or other demographic characteristics of the individual involved. These authors state that providers may communicate lower expectations for clients in disadvantaged social positions than for their more advantaged counterparts.

Research examining nurse perceptions of patients who used illicit drugs found that some nurses perceived patient behaviour through the lens of dominant societal attitudes. Illicit substance use by some nurses was seen as an individual problem/choice, a criminal activity and as a disease. Each of these perspectives failed to acknowledge the life circumstances that may have shaped the lives of their patients. Other nurses in the same study, however, expressed attitudes aligned with a social justice approach, recognizing the context of their patients’ lives and its impact on their health (Pauly, McCall, Browne & Mollison, 2015).

Individuals living with disadvantages have described the negative perceptions held by the wider society about them. People living in poverty overwhelmingly thought that other members of society viewed them as a burden (Reutter et al., 2009). They believed their social identities resulted primarily from individualistic attributions for their impoverished circumstances. Families living in poverty reported facing negative assumptions and pre-judgment from others and these assumptions create barriers to access social and health services (Lynam, et al., 2010; Lynam, Scott, Loock & Wong, 2011; Aston et al., 2014).
Turning our attention to literature that focuses directly on PHNs’ work with families living with disadvantages, there is evidence that some PHNs may hold attitudes that reflect dominant societal beliefs, while other PHNs may challenge these perceptions. Cohen and Reutter (2007) argue that the public health nurse response to family poverty requires that nurses place a high value on social justice and have a positive attitude towards those living with poverty. However, they note that there is evidence that health practitioners may perceive financial and material problems as issues of personal inadequacy, rather than considering structural explanations. PHNs suggested to Cohen and McKay (2010) that some PHNs may hold negative attitudes towards people living with poverty (for example, viewing poverty as a product of laziness or some other individual deficit).

Aston et al (2014) described the experiences of PHNs working with mothers and infants who were screened as ‘high risk.’ PHNs were very aware that the mothers had experienced stigmatization based on their social and/or economic circumstances and that the mothers anticipated negative judgments by the PHNs. As a result, PHNs described the attention they gave to developing trusting relationships. While PHNs carefully considered the context of their clients’ lives, their attention was focused on individual clients. There was no mention of efforts to address underlying causes of disadvantages.

Aston et al (2015) described the dominant medical discourse in western society that often situates health care professionals as experts with specialized knowledge, creating a hierarchical relationship and power differential. PHNs in their study were aware of this dominant perception and actively challenged this discourse in their work with mothers in the postpartum period, encouraging the mothers to identify their own concerns and stressors.

Literature that examined PHNs’ practice with families living with disadvantages clearly demonstrates that PHNs understand the impacts of the social and material context of their clients’ lives (Browne et al., 2010; Aston et al., 2014). PHNs were conscious of the social stigma and exclusion experienced by mothers and families living with disadvantages. PHNs described an understanding of clients’ strengths and capacities, despite social circumstances that placed families at risk of poor health outcomes. In my own research, additional insights were sought from PHNs about their perceptions of
clients living with disadvantages and how these beliefs may impact their work with these individuals and families.

**Importance of self-reflection on assumptions about people living with social and material disadvantages**

In addition to considering the contextual nature of their clients’ lives, nurses are also encouraged to engage in self-reflection about their personal assumptions regarding families living with social and material disadvantages. The underlying belief for this recommendation is that particular attitudes or biases may impact the nurse’s response to client needs. As noted by Anderson et al (2009), the views nurses hold toward their clients can contribute to socially just actions or reproduce social injustices.

A number of Canadian professional nursing documents speak of the importance of self-reflection by nurses in their practice. The CNA Code of Ethics (2008) states that nurse self-reflection is an essential component of ethical nursing practice. The Canadian Community Health Nursing Standards of Practice (2008) note that one criterion for the demonstration of professional responsibility and accountability for community health nurses is the use of “reflective practice to continually assess and improve personal community health nursing practice” (p. 15). The College of Registered Nurses of British Columbia Standards (2012) requires that nurses “identify the effect of own values, beliefs and experiences in carrying out clinical activities; recognizes potential conflicts and takes action to prevent or resolve” (p. 14). These documents do not provide clear direction about how to engage in reflective practice, how to respond to personal assumptions that may contribute to health inequities or whether self-reflection should motivate nurses to engage in advocacy.

Beam, O’Brien and Neal (2010) describe reflective practice as a cyclical process, “triggered by a sense of discomfort within the self that is attached to an experience…the individual attends to his/her positive and negative feelings about the event, and ultimately re-examines the experience in an effort to understand and plan how he or she would act in the future in a similar situation” (p. 133). Asselin and Fain (2013) describe self-reflection as a process of “deliberately and critically thinking through a clinical
situation which subsequently leads to insights and changes in one’s approach to practice” (p. 111). Other authors describe public health nurse self-reflection as a practice of critically examining personal beliefs (Doane et al., 2009; Poor, 2005). Browne et al (2010) describes public health nursing work with vulnerable families in northern British Columbia. Creating effective working relationships with these families, based on acceptance and trust, required a consistent practice of critical self-reflection by nurses. This self-reflection involved a critical examination of personal assumptions and biases nurses may have held towards particular families and “purposefully enlisted assumptions/beliefs that would open possibilities for change” (p.33). Falk-Rafael and Betker (2012b) also describe self-reflection in public health nursing relationship development as a process of examining biases and one’s personal belief system, in order to achieve an open, non-judgmental approach with clients. Lynam, Loock, Scott and Khan (2008) also highlight the need for health care providers to engage in continual reflection on the assumptions they bring to their relationships with clients, to challenge the validity of these assumptions and to consider how these assumptions may shape their nursing encounters.

Hartrick Doane and Varcoe (2007) argue that nurses determine their ethical obligations to patients in particular moments of relationship and this involves an examination of personal biases, nursing values and ideologies. These authors advocate for a relational inquiry lens; a reflexive process that assumes people are contextual beings, with each person (nurse and patient) living within a unique personal, socio-historical location that shapes the person’s identity, experience and interpretations. They comment that meeting nursing’s ethical obligations is difficult without attention to the particularities of client and nurse context and critical consideration of one’s own and others’ interpretations.

Anderson et al (2009) argue that ethical health care requires self-reflection through the lens of critical social justice. This theoretical perspective calls on health providers to examine the knowledge that guides practice and the assumptions that underpin that knowledge. This self-reflection encompasses a personal awareness of nurses in relation to others and their historical context, which often places nurses in a position of privilege relative to their clients. Hartrick Doane and Varcoe (2015) also discuss the importance, in client encounters, of constant inquiry into the values and power dynamics operating in each
situation. They note that personal experience shapes our values and these in turn shape how we perceive and relate to others.

Cultural safety is a concept that aims to “counter tendencies in health care that create cultural risk – those situations that arise when people from one ethno-cultural group believe they are demeaned, diminished or disempowered by the actions and the delivery systems of people from another culture” (Browne et al., 2009, p. 169). These authors were interested in a broader use of the term “cultural safety,” to encourage the consideration of historical and material context of people’s lives, and racializing discourses in Canadian society. A key component of cultural safety is critical self-reflection by health care providers on their assumptions about the social context of individual clients and the prevailing discourses about different social and cultural groups in the wider society. Pauly et al (2015) add that cultural safety directs health care providers to examine their own privilege and power in relation to patients and how one’s perspectives can “impact the development of trusting and therapeutic relationships” (p.132). These authors emphasize that nurses must reflect on the ways social stereotypes operate in health care and nursing practice and how stereotypes impact relationships with patients. The purpose of my research is to examine the beliefs held by PHNs about vulnerable clients and to understand whether/how PHNs consider the impact of their assumptions on their nursing relationships.

Asselin and Fain (2013) state that it cannot be assumed that nurses know how to reflect. They point to research that suggests nurses may not recognize the effect reflection has on their development and organizational barriers may inhibit engagement in reflection. They contend that education on reflection should be an essential component of nurse training. This thesis provides an opportunity to explore some of these issues within PHNs’ practice with families experiencing social and economic challenges.

The self-reflection discourse highlights the need for nurses to consistently examine the origins and impacts of their personal assumptions about individual client encounters. The literature suggests that some nursing attitudes may reflect wider organizational and societal ideologies and may contribute to further health inequities if left unchallenged. Other research, specifically focused on PHNs’ practice, describes PHNs engaging in self-reflection about their personal biases and beliefs. Much of the evidence
about PHNs’ self-reflection describes particular biases that may be examined within a specific working relationship. It is not clear how PHNs’ self-reflection leads to consideration of a response to the root causes of social and material disadvantages. My research examines additional perspectives from experienced PHNs about families living with disadvantages, factors that may intersect with their understandings of their work, the process of nurse self-reflection about their personal assumptions and the impact of this self-reflection on their nursing practice.
Chapter 3: Research Methods

In this chapter I will describe the methods used to conduct my research. I will describe the theoretical perspective of critical social justice that forms the lens for consideration of the research questions. I will also discuss the qualitative research approach of interpretive description that guided my methodology. I then discuss the sampling procedures, data collection, analysis and ethical considerations. Finally, I outline limitations of my research.

Theoretical perspective

My research is guided by a critical social justice perspective, from a postcolonial feminist tradition, as described by Reimer Kirkham and Browne (2006). Analyses arising from this framework “broaden nursing’s concentration beyond individualism and healthcare access to examination of the embeddedness of health disparities in social, historical, economic and political contexts that relate directly to the dimensions of distribution, recognition and participation” (p.337). This understanding of social justice encourages nurses to expand their viewpoint beyond the individualistic perspective to consider “how certain groups are more likely to bare the burden of illness and suffering, and the social conditions that contribute to these disparities” (p. 337). These authors argue that without a critical social justice perspective nurses will continue to focus on individuals and offer interventions that do not address root causes of inequities. The lens of critical social justice, from a postcolonial feminist perspective, directs us to expose differential power relations between groups who have been socially constructed as ‘other’ and inferior, by those with more privileged histories (Anderson et al., 2009). This framework argues that contextual knowledge of nursing clients and the recognition of ‘others’ as persons of equal worth are central to socially just actions. Fundamental to this approach is critical self-reflection, by health practitioners, on the knowledge that informs our practice, the underlying assumptions of that knowledge and an awareness of our historical social positioning.
A critical social justice perspective is an appropriate lens for my research objectives of understanding PHNs’ assumptions about families living with social and material disadvantages. This perspective guides me to consider whether PHNs attend to the contextual elements of their clients’ lives, how health disparities are embedded in this context and how PHNs respond to this consideration. It also directs me to consider whether PHNs engage in critical self-reflection about their personal assumptions and whether this activity motivates them to address root causes of disparities.

Research approach

My research explores the range of assumptions of PHNs may hold about families living with social and material disadvantages, how PHNs understand their work with these families and how PHNs reflect on their assumptions and nursing practice. I will present a critical analysis that will explicate issues raised in the literature with additional perspectives of key PHNs. My research aligns with the qualitative methodology of interpretive description. This method evolved in response to a recognized need to generate qualitative knowledge specific to the domain of nursing and applicable to human health and illness problems (Thorne, Reimer Kirkham & O’Flynn-Magee, 2004). The fundamental purpose of interpretive description is a “qualitative investigation of a clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding” (Thorne, Reimer Kirkham & O’Flynn-Magee, 2004, p. 5). Interpretive description is borne from the need for new knowledge pertaining to the subjective, experiential and contextual aspect of human health experience, to guide clinical decisions (Thorne, 2016). Interpretive description challenges clinicians and researchers to consider new perspectives about phenomena, within their applied discipline, beyond that which may appear self-evident. Thorne argues that there is value in systematic, contextual examination of a phenomenon and in bringing the resulting analysis back to the practice field, potentially shifting the “angle of vision with which one customarily considers it” (Thorne, 2016, p. 57). I am interested in the experiences of PHNs in their work with families living with disadvantages, particularly the assumptions
made by PHNs about these families. Interpretive description allows me to examine perspectives, capture common patterns and generate findings that may yield application to PHNs’ practice.

**Sampling and recruitment**

I invited PHNs currently working in the field to voluntarily participate. The intention was to interview nurses who were experienced and who had at least 5 years of clinical public health nursing experience, with the objective of identifying PHNs who would provide rich, thoughtful narratives and new perspectives regarding my research questions. I purposively approached PHNs among my colleagues who had the required experience and who I felt would be thoughtful and articulate participants. I described my research objectives, the voluntary nature of the study, and invited their participation.

I also asked PHNs in my professional practice network in British Columbia to consider their public health nursing colleagues and ask those with appropriate experience to contact me if they were interested in learning more about my project. I contacted any who expressed interest in my research, explained the study and invited their involvement.

Considering limitations of time and travel distances, I restricted the geographic distance of potential participants to locations less that a five hour drive from my home in southern British Columbia. I also excluded PHNs who are involved in the Nurse-Family Partnership Program, as this program limits client inclusion according to very specific criteria and I do not have involvement with this program.

**Study sample**

Often, when interpretive description is used, participant samples tend to be small to enable the researcher to embark on an in-depth exploration of the subjective experience of a phenomenon (Thorne, 2016). My study sample included six PHNs with clinical experience in public health nursing ranging from 3-18 years. While I had initially planned to include only PHNs with a minimum of five years of experience, I was contacted by one public health nurse who had 3 years of experience. She worked in a different geographic area of British Columbia and provided nursing services to a different client
population than the remaining PHNs. On reflection, I thought she may offer perspectives unique to her work circumstances, so I included her in my participant group. All the PHNs were female. Five PHNs were of Euro-Canadian ancestry and one self-identified as having Asian ancestry. Four PHNs worked in urban settings and two worked in rural communities. All work in southern areas of British Columbia.

Data collection

Participants engaged in individual, in-depth, face-to-face interviews with the researcher in private locations of the PHNs’ choosing. All interviews were recorded. The semi-structured interview questions were open-ended (see Appendix 2), inviting PHNs to describe their work with families living with disadvantages, using examples of particular experiences with clients. The researcher listened for implicit assumptions imbedded in the narratives. PHNs were also asked to share their understanding of self-reflection, how/whether they incorporate it into their practice and what impacts result from self-reflection.

I listened to the audio-recordings after each interview was completed and noted emerging insights, as well as questions for clarification or elaboration in subsequent interviews. Once I had developed some preliminary themes from the data produced by the first set of interviews, I returned to two participants for second interviews, to further clarify my understanding and to verify my findings.

Data analysis

The recorded interviews were transcribed verbatim by a professional transcriptionist and reviewed for accuracy once I received the written copies. I read each of the transcripts in their entirety at least four times. As I read, I kept in mind the research purpose and questions guiding this study, focusing on understanding the assumptions PHNs hold about their clients living with disadvantages, how PHNs understand their work with these families and how PHNs reflect on their assumptions and nursing practice. I made notes in the transcript margins about the possible PHNs’ beliefs underlying their narrative descriptions of clients and client encounters. I noted potential relationships between PHNs’
assumptions and the ways PHNs described their work with their clients, as well as similarities and differences between the narratives of the different PHNs.

Thorne (2016) cautions against the use of rigid codes that may limit the capacity to consider alternative interpretations of the data. This is particularly important when the investigator is taking a critical stance in the data analysis. Thorne suggests using “language references” to consider similar data elements and to compare them with other elements. By engaging in the data repeatedly (listening to the recordings and reading the transcripts) one can develop a sense of each individual’s experience, as well as possible connections among the whole collective, while also attending to contrasting accounts and identifying taken for granted assumptions. I organized the data into a number of themes, which I refined further and discussed with my committee. Although my research intention was to discover assumptions of PHNs about families living with disadvantages, it became clear that these beliefs were embedded in the PHNs’ narratives that described their understandings of their practices. Following discussion with my supervisor the analysis was modified to encompass both the PHNs’ assumptions about their client families, but also the PHNs’ understandings of their work with these clients.

Credibility

Interpretive description attempts to capture themes and patterns within subjective perspectives that contribute to the understanding of a clinical experience (Thorne, Reimer Kirkham, O-Flynn-Magee, 2004). With its reliance on interpretation, it is understood that this method of inquiry cannot claim to reveal ‘facts,’ but rather ‘constructed truths.’ The degree to which the findings provide new understanding depends on the researcher’s ability to “transform the raw data into a structure that makes aspects of the phenomenon meaningful in some new and useful way” (Thorne, Reimer Kirkham, O-Flynn-Magee, 2004, p. 13). However, there is an expectation that qualitative research follows an analytic logic that makes visible the decision-making and processes that occurred throughout the study (Thorne, 2016). Throughout the process of data analysis, I maintained at ‘audit trail’ that demonstrates the path of reasoning that led to my interpretation of the material.
Thorne, Reimer Kirkham and O-Flynn-Magee maintain that the best interpretive descriptions will pass what has been referred to as the “thoughtful clinician test,” in which those who have expert knowledge of the phenomenon find the claims plausible and confirmatory of “clinical hunches” at the same time as they illuminate new relationships and understandings. Once the six initial interviews were completed, I received feedback from my committee members about my preliminary themes. I then returned to two of the most experienced PHNs in my sample to consider my interpretation of the findings, verify my understanding and add any additional insights or modifications.

Limitations

The findings of this study must be considered within the context of several limitations. While it is common that interpretive description research includes small participant samples, I included only six PHNs in my study. These PHNs provided thoughtful consideration of the research questions, but there are likely to be additional perspectives that could be gained from interviews with PHNs working in other geographic areas of British Columbia and with different client populations. This study included a sample of PHNs with significant clinical experience. While this provided opportunities for these PHNs to reflect on the evolution of their practice over time, it is also possible that PHNs who have more recently completed their nursing training would bring different understandings of their role working with families living with disadvantages. Future research could contribute new insights by including PHNs with more varied characteristics.

My initial intention in this research was to focus entirely on the assumptions held by PHNs towards families living with social and material disadvantages. However, during the interviews it became apparent that this focus was too narrow and the nurses gravitated towards a wider discussion of their understanding of their work with these families, which encompassed their working relationships with clients, their nursing practice and their assumptions about the families. The PHNs provided a rich narrative of nursing practice with families living with disadvantages. While the PHNs described many examples of ways they work with families, in retrospect, I would have gained an even more
comprehensive understanding of PHNs’ work if I had included specific inquiry about what interventions the PHNs provided to families.

As a PHN working in the clinical area examined in this research, I was able to bring my own observations and experiences to frame the study. Throughout the interviews and data analysis I tried to critically reflect on the impact of my own perceptions, but my biases may have focused my attention on particular issues and prevented consideration of others.

**Ethical considerations**

Ethical approval was obtained through the University of British Columbia’s Behavioral Research Ethics Board (Certificate # H14-03114). Confidentiality of the data was maintained throughout the research. Participants were assigned a coding number corresponding to the interview. The data was stored in password-protected computer files and flashdrives. Audiotapes, flashdrives and hard copies were all stored in a locked cabinet in the researcher’s office.

An informed consent for participation was obtained prior to each interview. Participants were told they could decline to answer any questions and may discontinue the interview at any time. Each participant signed a written consent (Appendix A). Participants in this study were PHNs who volunteered to be interviewed. It was not anticipated that participants would experience any greater distress, in discussing the study subject, than they might experience in their day-to-day nursing work. There was no anticipated power differential between the participants (all are currently practicing PHNs, as is the researcher). There was also no risk of loss of status or reputation or financial risk to the participants.
Chapter 4: Findings

This chapter will describe the themes that emerged from the analysis of the PHNs’ interviews.

Overview

The goal of the interviews with the six PHNs was to gather additional perspectives regarding their assumptions about families living with social and material disadvantages and how these impact nursing care. Particular attention was paid to the ways the PHNs’ assumptions may contribute to, or mitigate, social and health inequities. The interview data revealed some of the beliefs PHNs hold about their clients, but also provided many insights into their understanding of their work with families living with disadvantages. PHNs were also asked to consider the process of self-reflection and how it may modify their understanding and response to their clients. The PHNs engaged in narrative descriptions of many client encounters resulting in a rich picture of their work and an emerging understanding of their beliefs about their clients.

The analysis of the interviews revealed five major themes relating to their work with families: (i) understanding clients’ context and engaging with individuals and families, (ii) building trusting relationships, (iii) PHNs are one agent, among many, that may influence change, (iv) recognizing the significance of small increments of change, (v) PHNs’ practice holds a primary focus on mothers and children. Some themes are presented along with sub-themes to illustrate some of the nuances reflected in the PHNs’ interviews. It is important to note that the PHNs’ narratives reflect that these themes are woven throughout the PHNs’ practices and are not distinct categories of practice or understanding. The findings also include an analysis of the perspectives of the PHNs about the process of self-reflection and its impact on their nursing practice. All the PHNs placed value on self-reflection and there was a range of views about how to incorporate it into nursing practice.
Understanding clients’ context and engaging with individuals and families

The PHNs interviewed in this study demonstrated a robust understanding of the complex social context of their clients’ lives and the impacts of social and material disadvantages on the health of individuals and families. PHNs described how the realities of their work-lives primarily directed their nursing care towards individuals and families, rather than allowing engagement in wider advocacy to address the root causes of inequities. PHNs identified a number of barriers to wider advocacy and at times they experienced tension between their awareness of contextual causes of disadvantages and perceived barriers to addressing the sources of inequities.

Awareness of social context and the impact on clients’ lives: “It’s so difficult (for clients living with disadvantages), even if you have your wits about you.”

All the PHNs in this study provided detailed descriptions of the social and economic disadvantages faced by families with whom they work. The following quote is representative of the nurses’ narratives that provided examples of client families and the factors that create challenges for them:

When I got them on my caseload mom had just delivered a little girl. She was, mom was Caucasian, just eighteen years old; dad was Aboriginal, and he was about 22 years old. They had just moved a couple of months prior from Montreal; they’d come out on the train with their three dogs. Finances were definitely an issue for them; neither of them had employment. They both had a history of living on the street, homelessness, addiction and she also had a history of depression so there was lots going on with this couple. She had been in and out of twenty different foster homes and had run away at the age of thirteen. And he had lived at home with his fathers and brothers, but in a very abusive relationship. And his mother was alcoholic and had left him when he was young, so very little positive parenting background. (PHN3)
The PHNs recognized the many ways social and material disadvantages can impact their clients. The nurses emphasized economic poverty as a common experience of families, in every interview, and the following quotes are typical of the comments of PHNs regarding the challenges facing those who live with low income:

Poverty is, just becomes more amplified as you have more mouths to feed, as you need more shelter, you need more expensive shelter…you just have so many more responsibilities so that poverty, you know, feeding everybody is so, so difficult even if you have all your wits about you. (PHN2)

I realized how limited and how much of a struggle low income housing and the shortage of low-income housing is ridiculous. And the amount that these families are paying for rent and the conditions of the homes that they’re living in, it is awful. (PHN3)

Not only did the PHNs recognize the material deprivation that is experienced by those with limited income, they also described the psychological impacts of living with poverty. PHN2 made the following observation: “they go with their hand out to many different organizations, you know, they go to social services needing money, needing hardship funds, needing something for their kids, they’re always begging…that just must be so undermining.”

Each of the PHNs described being aware of the social stigma experienced by clients living with disadvantages. PHN2 described the social challenges faced by one client:

She had a great feeling of being judged…and I think sometimes it’s, you know, around the clothing people have to wear or the access they have to a washing machine, because our society says that you must have a shower every day and you must put on a whole new set of clean clothes…and for many people those are absolutely impossible.

PHN3 described how social stigma creates barriers to community resource opportunities, “he felt very hesitant with regards to employment support through Aboriginal connections because he felt stigmatized in some way.” PHN3 also described how the impact of stigmatization sometimes led to the family experience of negative social judgments from staff working at the various community services that her clients were trying to access, “she was feeling quite judged, so very introverted, which a lot of people would perceive her
as not being attached (to her baby), which it wasn’t.” PHN6 described a similar example of the judgmental language used by community outreach staff, when making a client referral, “the language I got was that she was kind of working the system and knew the system well.”

The PHNs frequently acknowledged how social and material disadvantages early in life can lead to challenges in adulthood. In the following quote, PHN3 described the difficult relationship between two parents and their own experiences of childhood abuse: “and it really related to issues that she had to deal with from a history of abuse; so just helping them deal with issues of their past and how to safely communicate with each other.” Another PHN described her conversation about infant feeding, with a mother, and recognized how the mother’s negative early life experiences influenced her decisions with her own child, “we talked about how she was feeding the baby and she just said, you know, I’m never going to deny my child any food because I was always denied food when I was growing up and I had a very terrible upbringing. And I will not deny my child anything that they want” (PHN6). PHN3 observed the connection between early childhood abuse and adult mental health, “because of her previous abuse she’d never received any counseling for any of it, she was chronically depressed.” PHN5 recognized that the lack of opportunity for early learning experiences and social support can result in unhealthy experiences in adult life, “it has to take a supportive network…in some cases they’ve just never had anybody along the way to teach them those things.”

PHN4 recognized how the social isolation that can be part of the experience of families living with disadvantages contributes to challenges. She described the struggles of an intellectually impaired mother, with limited social support, “I really feel like she doesn’t have anyone to talk to about this stuff because like feeding a baby is a complicated thing…and I don’t think she has anyone to vent to; I don’t think she has anyone to run ideas by.”

One PHN, who works with new immigrant families, offering prenatal support, provided a rich description of the impacts of the social and material context faced by many families new to Canada:

They do have language barriers, a lot of the times they’re very well educated in their own country but when they come here because of their status they’re just deemed as, you know, not really able to
contribute to society or lesser because, their education sometimes doesn’t always equate to our level of education so that’s also a barrier for them as well. Psychologically there are barriers because a lot of the times if you’re working with refugee families then they’re escaping some sort of trauma, so you’re dealing with that as well. Financially, of course, if you don’t have a good job, then financially you have barriers as well (PHN5).

While the interviews demonstrated a rich awareness of the social context of clients’ lives, there was acknowledgement that additional understanding of some contextual elements is needed. PHN1 offered a unique observation about the context of popular culture, its impact on young women and the PHNs’ difficulty understanding this aspect of the social world:

I see the music videos, I’m aware of a little bit of the popular culture where they’re coming from or what takes their time and attention. And I’m struck by its increasingly; some of it is just downright people-hating; it’s harsh and I know, I know for a lot of them this is their world. But you know, you just think these young women are in a tough, tough world and their popular culture…they are increasingly hard on them and they’re finding money for make-up and they’re finding money for all this stuff….that’s not brand new, but I just have a feeling that it seems like it’s intensifying…they’re caught between the intersection of a lot of worlds and I just have a feeling that they’ve got a lot of roles that they have to play out. And we don’t necessarily get a lot of information about that now. I guess it’s sort of a sociological side of things about their context and how they communicate, with the language they use…I’ve seen or sometimes got a sense that there’s a lot of what I would call vulgar language, that I don’t understand. Some of it seems like they will use these vulgar words to refer to each other. I don’t understand that; they’re not using them to be vulgar, but it’s how they refer to each other. And yet they seem to be laughing, they seem to be accepting of it. I feel those are contexts I don’t understand.

There is considerable evidence in these interviews that the PHNs recognize that their clients’ circumstances emerge from their social context, rather than primarily attributing outcomes to individual
choices and behaviors. The PHNs acknowledge that families living with social and material disadvantages have fewer options available to them. PHN2 observed, “if your education is interrupted, maybe the choices you make are not always the ones that someone who has a broader background might make.” Later, PHN2 added, “sometimes in whatever situation they’re in…it’s not what they would choose, but it’s kind of the way it ends up.” In the following example, PHN1 expressed her concern that children born into families living with disadvantages may continue to experience challenges throughout their lives, despite the best intentions of their parents:

The most challenging (about working with disadvantaged families) is the feeling of what life might be ahead for the children; knowing that this is so important; knowing that people have very high, good intentions in the beginning and really good intentions and you want to support them and knowing that in many cases the children that they’re bringing into the world may very well be headed down the same path and just hoping that something they’re connected with now is going to make a difference.

The pull toward individual-level interventions: “We are constrained from that bigger picture work”

The nursing work described by the PHNs in this study focuses on individuals and families, offering a range of services, depending on the identified needs. PHNs describe the following nursing activities with their clients living with disadvantages: support and guidance regarding healthy behaviors for children and adults, supporting behaviors that nurture the parent-child relationship, assistance with access to community services, and a wide range of referrals to community and health agencies for support with housing, mental health, employment, parenting, immigrant services and food access. The PHNs also described a number of ways that they modify their care in response to the client context: offering private appointments with a particular public health nurse, extending appointment length, meeting with clients in flexible locations (as PHN2 described, “on their turf”), accompanying clients to appointments or community groups, and a willingness to reschedule encounters after ‘no shows.’
Despite their understanding of the many negative health impacts of social and material disadvantages, the PHNs acknowledged that their work primarily targets individual clients and does not involve wider advocacy efforts to address fundamental causes of health inequities. Their nursing interventions target individual client needs and they described how they rarely participated in efforts to address root causes of disadvantages.

The PHNs described a number of barriers to engagement in advocacy initiatives. Some PHNs described an organizational shift in recent years that has restricted the role of PHNs in advocacy work. PHN2 observed organizational changes she has observed over many years:

I think those skills from perhaps public health nursing that was going on say 25 years ago and those nurses were looked upon as being community engaged…now I see I’m able to do less than I was at first…like I was asked to write articles for the newspaper around health things…or sitting on committees…that seems to have really diminished. We don’t necessarily have the ear of the mayor or council. I just think there’s not the face of public health nursing out there. We are constrained from the nurses sitting on committees and doing that sort of advocacy…that bigger picture work.

PHN4 agreed that there is an organizational expectation that restricts PHNs from engaging in community advocacy, “I’ve been told that I can’t attend meetings like this (a multi-disciplinary community committee to advocate for children)…nurses have been told they can’t do community work.”

Other PHNs were also clear that programmatic expectations direct nurses to work exclusively with individuals and families and that wider advocacy is not part of the PHNs’ role. PHN6 commented, “we know about the social determinants of health, but we know about them and that’s about it. It’s never really seen as our role to be taking it to the town council, taking it to the government. That’s always somebody else’s job.”

PHN5 described her work entirely within the context of individual client-nurse interactions and saw advocacy as an extra demand that would only happen outside of her day-to-day working life: “because of how much energy it takes to individualize your care for a family I’m exhausted at the end of the day and if there was a rally of some sort I don’t think I would go because I find at the individual level I am helping them as much as I can.”
PHN6 felt that she lacked the personal knowledge and skills needed to address social determinants of health. PHN6 commented, “it’s never been an expectation of a nurse to be looking at how the social determinants of health can be addressed to effect your single client…we’ve never taken any training in terms of how to…we don’t have the skills.” PHN6 graduated from nursing more than 25 years, so we might consider that more recent graduates might have a perspective that brings their attention to wider advocacy efforts. However, those PHNs who finished their education more recently, including one who graduated only three years ago, also described a nursing focus on the individual and family.

Workload was also recognized as a barrier to wider advocacy work. PHN2 observed, “we are filled up with immunization clinics and other bits and bats that take time and perhaps part of it is we don’t have the time to gather together to make a combined force of PHNs to discuss these kind of issues; to see where we might put a little pressure on certain places or advance certain goals.”

Clearly, there was a sense of powerlessness expressed in some of the PHNs’ remarks. In her description of clients living with poverty, PHN4 said, “there’s not a whole lot that I can do to help with that…these are situations where I feel like my hands are absolutely tied.” However, PHN5 expressed satisfaction working with individuals and was not concerned about a lack of involvement in wider advocacy, “I always say if I could impact one person’s life in a day then I’ve done good…I don’t feel distraught about their situation because I know that I’m helping them.”

PHN1 considered the limitations of the health care system as a whole in responding to the needs of families living with disadvantages: “And then you realize whether you are working with the families that need understanding I’m also working in a system that need understanding and after a while it’s amazing how it blends together…people and a system that intends well, a system that means well, a system that wants to do more and can’t.”
Building trusting relationships

While nurses in any healthcare setting may suggest that trusting relationships with clients are fundamental to quality nursing care, the PHNs in this study made particular note of their understanding that relationships with marginalized families requires a distinct nursing perspective that attends to the client experiences of living with disadvantages. Throughout every interview, PHNs described the efforts they made to develop trusting relationships with their client families. For families living with disadvantages, experiences of stigmatization and social exclusion may have resulted in mistrust of health care providers and expectations of negative judgment by those in positions of power. The relationships with PHNs may develop over the course of many weeks or months, requiring a significant investment of time, flexibility, creativity and relational skill. The PHNs shared may beliefs about their clients that created a foundation for their working relationships: (i) recognition of client strengths and capacity for positive change, (ii) understanding their clients as voluntary partners in their relationship with the PHN, (iii) the need to ‘tread carefully’ and offer respect in order to build and preserve the PHN-client relationship, (iv) clients will benefit from a relationship with a public health nurse. The PHNs’ understanding of their clients is further enriched by the contextual awareness described in the first theme and contributes to the basis for trusting relationships.

Recognizing clients’ strengths and capacity for change

There were many examples in the interviews where the PHNs spontaneously described their clients from a strength-based perspective, reflecting optimism for the clients’ future and potential avenues of connection with the PHNs and local services. PHN2 described her positive observations of a young mother living with multiple social and material challenges:

She was somebody that I always thought had quite a few strengths; she was always proud of her kids, of their accomplishments. She could see herself down the road eventually finishing off the few courses she needed to complete high school. And moving forward with a bit more education so that
she could have a job that would look after them. She was open to suggestions for groups that she could go to; she always had this little plan, she could see herself in the future.

Recognizing a client’s pride in his aboriginal heritage allowed PHN3 to offer a connection with local Aboriginal supports: “he spoke with a lot of pride about his band that he was part of, so I tried to connect them with aboriginal supports.” PHN6 described a mother who was facing a number of social disadvantages, but highlighted the mother’s pride in her nine-year-old son, “she was very proud of him. He was doing well in school and he had a little acting career on the side…she was doing a good job taking care of him.”

PHN5 described the strengths she observed and acknowledged in a teen mother, who used multiple illicit substances before she became pregnant and how the public health nurse recognized and reinforced positive health changes. It is clear from PHN5’s comments that she experienced satisfaction from observing positive changes in her client:

I think that brings a big smile to my face is knowing that she was able to go from one spectrum a hundred and eighty degrees and completely change and I bring that up every time I see her I say look at how much, how well you’re doing. I just saw her the other day for her six weeks and I said you’re still breastfeeding really well like you’re making tons of milk; he’s growing really well, I think you’re really bonding with him and reading his cues properly so I kind of talked to her, you know.

Understanding clients as voluntary partners in their relationship with the PHNs

The PHNs recognized that their clients have the power to choose whether or not to enter into a working relationship with a public health nurse and will ultimately make their own choices about change. However, for some PHNs there was an expression of frustration when clients, who accepted PHNs’ service, did not demonstrate healthy change. In these instances, PHNs described persistent, creative efforts to improve engagement, frequently questioning their own nursing skills, rather than making negative assumptions about a client’s motivations.

PHN4 summarized the common understanding of a client’s decision whether or not to accept PHNs’ service: “I’m okay with that really; it’s up to them very much.” PHN1 also described her practice of allowing
clients to direct their level of engagement, “I will just be patient and just enjoy my time with them in whatever way they let me into their life when they come into the office; whenever I see them as I’ve just got to be very respectful of that and just leave it at that.”

Despite acknowledgement that PHNs’ services are voluntary, when clients were accepting of a working relationship, the PHNs worked very hard to try to support the families in addressing their challenges. PHN3 described a lengthy relationship with a family living with multiple challenges, (domestic abuse, intellectual impairment, poverty, alcoholism, unemployment), and a wide array of attempted nursing initiatives: “they were very open to public health being involved.” This public health nurse provided a lengthy narrative account of the many ways she attempted to facilitate services for this family and the lack of ‘follow through’ with most of the interventions, “this family desperately needed some social support to access services, but just barrier after barrier after barrier…we just really tried to work around these barriers, but still no follow through.” The public health nurse went on to describe her personal distress with this client relationship: “this was one I took home with me. I just felt like what am I doing wrong with this family because I just seemed to go above and beyond.” The public health nurse eventually drew some conclusions about this family’s challenges and continued to frame them in a positive light:

The biggest barrier was (intellectual) capacity. I really feel capacity was part of the issue with this…and her fear because of previous MCFD involvement. This was a family that I really saw hope, they were trying to do as much as they could but it wasn’t good enough I felt. Not that I felt like their kids needed to be removed by no means but they needed to be supported.

PHN4 also described a lengthy working relationship with a mother who had an intellectual impairment, limited social support and who also welcomed PHN involvement. This nurse had multiple encounters with this mother, over the course of many months, trying to offer support with infant feeding and child development. The public health nurse expressed her frustration with her early attempts to assist this mother:
It was one of the most frustrating experiences because we would create this plan what we're going to do for a couple of days…and it was like, you know, you might not have said anything at all because they just couldn’t follow the plan…I’ve felt so much frustration trying to figure out how to help her.

After continuing to try different approaches, over a long period of time, the public health nurse came to the realization that she needed to provide concrete demonstration of her recommendations, rather than continuing to provide verbal direction: “I’ve got to stop telling her, I’ve got to show her…I did that and thank god I did that because it’s like that’s just what I need to do with her.”

**Treading carefully and offering respect to build and preserve the client-PHN relationship**

The PHNs described how client acceptance of PHNs’ services depends on careful attention to building trust in their early encounters. Knowing that a mother had experienced an emotionally traumatic pregnancy and birth, PHN6 remarked: “she had been through a lot of emotional trauma, so I was just wanting to tread very lightly…just to get to know her very carefully; I didn’t want to delve into it all.” PHN3 also described her sensitivity in an initial encounter with a couple living with multiple disadvantages: “I want to be very careful how I approach things just with regard to trust being an issue right away with a couple coming from these circumstances.” This same nurse went on to describe how her attention to respect created the foundation for a positive relationship: “This couple was just so receptive to support and really always honest like obviously trust had been built enough that they just felt they could be honest. I was always very clear of who I was going to communicate, who I could contact, get a sense so there were never any surprises.”

Several PHNs described how they felt clients were more likely to accept services if they began by offering a ‘non-threatening’ reason to visit. PHN3 talked about her initial encounter with one client: “I got involved in a nice way because breastfeeding support is always a very non-threatening way to get in the door.” PHN4 described how infant weight checks were a means of establishing a relationship with a client who was experiencing postpartum depression: “well a couple of moms were very much going through postpartum depression and they knew it and I spent a lot of time just coming out like follow-up visits to see them, so we’d weigh the baby and for a few weeks that was all she could handle…it was a reason for me to be
there that was normal for her.” PHN1 also mentioned the value of connecting with clients by offering to visit and assess the weight gain of an infant: “I’m dropping in to check the weight, but actually that’s the presenting question, but then we get there and there’s a ton of other things that we just cover.”

The PHNs described an acute awareness of the need to approach their clients without judgment, in order to build a trusting relationship. In her explanation of how she sustained a working relationship with a client, PHN6 said, “I think a lot of it was that I didn’t judge her, I didn’t judge her at all…and you know, I got the sense that she didn’t really want to talk about that decision that she made and I respected that.” PHN2 also described her interactions that illustrated her respect for her client:

She appreciated my visits and, not that I contributed a lot, it was almost like she would allow me to point her in a direction that might be helpful for her…she would embrace that, like she would take that in the spirit that it was meant to be helpful, and not judging her; like this would be something that could be useful to her family.

The PHNs also talked about the way they navigate between providing standardized health recommendations and the importance of sustaining the relationship with their clients. PHN1 reflected on her observation of another public health nurse advising a parent about the introduction of solid food, using standardized guidelines:

In different ways I’ve been struck by two things: one is good for that nurse she’s sticking to her guns, she’s actually teaching according to the book and I should do more of that. Whereas I will be more of, okay, and just try to be, maybe it sounds more wishy-washy, but you know that approach, because if they’re going to come back to see me all the time I don’t want to put them off.

Similarly, PHN6 remarked about the caution that is necessary when giving health information and advice, in order to preserve the client-nurse relationship:

I think you have to be very careful that you’re not preaching and I think that as public health nurses we often are expected to deliver the gold standard but I think you have to use your judgment around do you want to lose your connection with this client by preaching to them or can you say it in a subtle
manner…find a way to touch on it without preaching about it because you’ll break the relationship that you have with them.

**Recognizing the extent to which some clients benefit from a relationship with PHNs**

The persistent efforts to provide nursing services to clients, as discussed above, reflected a belief that clients will benefit from their working relationship with PHNs. Several of the nurses made explicit comments about the value of PHNs’ services. PHN1 commented: “there is value in our involvement with people throughout their span whatever it is where we see them.” PHN5 also reflected on the benefit of her work with families living with disadvantages: “it’s an opportunity for sure, it’s definitely an opportunity to see me, hopefully for me to help.” PHN4 commented about the impact of her involvement with a particular client: “I don’t think she has anyone to guide her…so I feel like I’m needed in ways maybe that I’ve never been needed before.”

Despite the time and attention given to developing working relationships with families, it was also observed that the skills required for relationship development may be less valued compared to ‘task-oriented’ skills. PHN2 commented: “I think it’s really under-appreciated…as a skill, I mean, it is a skill, but it’s not quantitative…it’s not a physical task; it’s an emotional task.” PHN6 adds, “It’s not task oriented, because there’s so many variables; it’s not something you can teach, it’s something you learn over time. I think as public health nurses we know that that’s part of our job, but it’s not something concrete.”

**PHNs are one agent, among many, that may influence change**

While PHNs expressed the belief that their services are beneficial to clients living with disadvantages, they also recognized that positive changes may result from interaction with many other care providers. Although PHNs described persistent efforts to directly impact the lives of their clients, these nurses readily referred clients to other agencies for additional assistance. The PHNs acknowledge that it is difficult to predict which encounter will trigger change. While discussing whether PHNs experience a feeling of responsibility for influencing change, PHN6 said, “I don’t think it’s something that we carry primarily; I think
it takes a full community to raise a child…we are just one prop that helps to support this mother so that she
can take care of her child.”

There was recognition of the limits of PHNs’ influence when clients are perceived in their wider social
context, as described by PHN1:

It’s not my choice to decide that my involvement is the time where change is going to be obvious in
the peoples’ lives…and then it’s time number 10, or it’s time number 8 or it’s person number 5…so I
don’t get to choose if I’m going to be the one that’s going to be around when change starts to happen.
I no longer need to feel or see that something I’ve been doing is going to suddenly make change, but
it might.

PHN5 also placed PHNs within a context of many service providers who may influence change: “I
know they will be in contact with many, many more people down the line. And I’m just one of many that
will be a stepping-stone further.”

Nurses working in smaller communities described more limited health and social resources than
larger centers, possibly reducing the opportunities for clients to connect with the provider that would be most
beneficial for their circumstances. PHN1 spoke about her frustration with reduced social resources in a small,
rural community:

There are not enough resources and tools to do the job. I would love to have integrated case
management where you could actually feel; they could look at the people in the team as their
supporters through their ups and downs through integrated case management. I am definitely
overwhelmed by the resources that I see having been pulled out and talk has never been more and
there’s never been more insight and we have a lot of clinical knowledge and a lot of research
knowledge but I just don’t see it being resourced with the people that can be there to just keep people
on track.
Recognizing the significance of small increments of change

It was noted earlier that the PHNs recognized how conditions of social and material disadvantages may limit the choices that are available to their clients. For families facing multiple challenges, PHNs understood that clients may not have the capacity to reach ideal health standards, so PHNs frequently look for ways to impact small, positive changes. This understanding of client context leads PHNs to place less emphasis on standardized health recommendations as they guided clients to identify ways they might make modest improvements to their health. Despite recognition of contextual limitations to the achievement of optimal health, it is clear that the PHNs believed their clients were capable of making autonomous decisions that make positive impacts on the health of their families.

PHN6 offered her observations about the expectations that may be realistic for her clients living with disadvantages. She also commented that her priorities for interventions are infant safety, basic infant care and the parent-infant bond. Efforts to address other health issues may be out of reach to some families, given their social context:

Where I struggle with public health is, you know, I think we were led to want to deliver the gold standard, but the gold standard is unachievable to many people. And we, it’s not that you lower your standards, but you just have to praise them for what they’re doing correctly and, for lack of a better word, meet them where they’re at and support them with where they’re at…I think that when you walk into some of these homes of these high risk clients. I mean we are taught the gold standards, but really we’re just hopeful that that baby is safe, that bond is created, that the baby is fed and cared for and safe, but I mean that the fact that the baby hasn’t started with pablum first and iron and all that…if that mom doesn’t even have money, no, you adapt to the situation.

The PHNs expressed their observation that their nursing impact may lead to small changes in the lives of clients. PHN5 comments on the satisfaction she experiences seeing modest change towards healthier behavior:
So everyday one person and just an impact, a small impact, whatever it may be…yesterday they smoked 5 packs (of cigarettes) and today they’re smoking 4.9, you know, this is it…I find those, I celebrate a lot of those things, so I don’t get myself down.

PHN6 commented further on her belief that the disadvantages experienced by some clients create barriers to optimal health and, as a result, PHNs may make only modest impacts. However, she also celebrates small changes and expressed optimism that these may have a significant impact on the primary goal of supporting a nurturing parent-child relationship:

Sometimes I feel that my working with them might not really prove to amount to much, however, over the time that I’ve been a public health nurse I have understood the value to having a relationship with them…you know, bounce some health ideas or health concerns off you and where they might not feel comfortable doing that with anybody else…I don’t have great goals. I think the goals change as you work with them, but I am cognizant of the fact that maybe just little baby steps is what you are going to get and if that’s moving them forward into being able to nurture their children more then that’s great.

PHN5 described her perspective on clients’ behavior change and her efforts to reduce unhealthy behaviors in terms of ‘harm reduction,’ rather than expecting clients to achieve their optimal level of health: “I’m always reassured by the concept of harm reduction…I think of it as if they’re choosing an option that’s healthier and less harm than the previous option then I’ve done success.”

When discussing standardized nutrition guidelines, PHN2 offers these comments about guiding clients living with disadvantages and how she adapts her nursing interventions according to the client context:

Well sometimes I kind of avoid and kind of try to find out what they are able to provide, like, what would a lunch look like? What would they normally have as their first nutrition of the day, because quite often it’s not what we would consider breakfast; so using what they are having; how could you bump it up nutritionally, even a little bit…it is just hard, because just around nutrition a lot of people, they might actually have a little bit of funds to buy some more nutritious food, but they really don’t know what to do with it; they don’t have a good enough pot…or you want me to eat that raw?
While recognizing the limitations created by social and material disadvantages, PHN2 also discussed her view that her clients still have the agency to make autonomous decisions that can create positive health outcomes, within the constraints of their circumstances:

Are we just really hoping that these people can have, can rise to their potential within the circumstances that they’re in, you know, I mean they’re limited by their circumstances. I mean they know they are limited, we know they’re limited, but they can actually make the best of it and consciously make some decisions…so they could say to some guy or their partner, no, you know, no, that’s not what I want to do; yes, I am going to pick up my baby and hold my baby and I’m not going to let my baby cry to sleep. Yeah, maybe it’s just a little, I mean, there is such disparity between the way we live and the way many of our families live. But even if they just go with their heart of hearts; and giving them the power to do or giving them the support to do that; but maybe that’s the best they can do.

Mothers as the focus for PHNs’ interventions

The PHNs described working relationships with families beginning with a pregnancy or the arrival of a newborn. The perinatal period is when most families are identified for PHNs’ services: through self-referral; referral from other care providers or community agencies; or direct notification to health units from hospitals or community midwives after the birth of an infant.

In the PHNs’ descriptions of their work with families living with disadvantages the focus was primarily on mothers and their children, with less attention on fathers and other family members. For these families, mothers were seen as the critical focus for interventions to improve health outcomes for the family. The PHNs’ narratives suggested a number of explanations for their understanding of this work focus: (i) absent or limited involvement of fathers in many families living with disadvantages, (ii) programmatic limitations, (iii) nurturing the maternal-child relationship seen as a central goal of PHNs’ interventions.
Throughout the interviews there was a consistent theme of PHNs focusing on women and their children. PHN2 described a teen mother with whom she worked for several years. PHN2 guided this young woman towards community resources and information “that could be useful to her family.” However, PHN2’s involvement with the woman’s male partner was very limited:

She had a partner who was a couple of years older, was kind of an on and off relationship, but they went on to cohabit most of the time that I knew her, during her children’s infancy. He was a fellow who’d had a head injury, probably as a teen, and may or may not have been developmentally delayed. I really was never clear on all that stuff…I didn’t have very much to do with him.

Describing her practice, PHN1 noted that, “I deal primarily with moms and their babies and not very often; I’m always surprised, pleasantly surprised, when I’ve got an involved dad.” PHN6 also suggested a more consistent focus on mothers and their children in her work:

We often, I mean, you’re not really ever dealing with specific hands on care with that father, we’re more concerned with income providing or substance abuse or something like that, but parenting expectations and certainly at the beginning are certainly, I mean, you’re really focusing on that mum.

It is important to note that although the PHNs spoke primarily of working relationships with mothers, their descriptions of families encompassed many different configurations, including extended family groupings, grandparents and stepparents. As the interviews progressed, I wanted to learn more about the emphasis on a maternal relationship with the PHNs, so I directed questions towards consideration of fathers in the PHNs’ practices. I did not expand the discussion to a consideration of the significance of other family members.
Absent or limited involvement of fathers in many families living with disadvantages

PHNs have an understanding that their work with families living with disadvantages primarily focuses on mothers and children, as fathers frequently have little, or no, involvement with their children. A number of PHNs’ narratives described families headed by a sole mother, so there was no opportunity for PHNs to involve fathers in their work. PHN2 reflected on her working relationships that focus on mothers and acknowledged that many mothers living with disadvantages are sole parents. However, she also observed her own hesitation to attempt to work with fathers who are not a consistent presence in the life of their family, “In fact, many of our more disadvantaged mums are alone. Some of these guys are so transient you never really know whether you should invest in them.” PHN5 described the expectation of the teen mothers, with whom she works, regarding the involvement of their partners. These young mothers may maintain a relationship with their infant’s father, but have no expectation that the father will assume responsibility for the infant. As a result, PHN5 focuses her attention exclusively on the mother and her infant:

And I don’t know if it’s a cultural, social society thing but the girls end up taking a lot of responsibility on themselves even though I don’t think they’re aware of it. Like because I’ll say, oh well, you know, you could always go walking with him and then he could always help change a diaper and things like that, no it’s more like a visit. It’s more like let’s hang out, let him have, let him enjoy the baby but it’s not let him take care of the baby. We had one girl where she did drop him off because she wanted some independent time away but otherwise expectation-wise, no, there’s no expectation of the father being involved.

Programmatic limitations

Observations were made by the PHNs about perceived expectations of public health family programs that limit involvement with fathers. PHN5 described her work with pregnant and parenting youth who are in the care of the Ministry of Children and Families. While these young women were not living with their partners, some maintained a relationship with them. PHN5 worked exclusively with the young women, but added, “I would like to work with them (fathers) on a visit, but I don’t think I have the mandate for that, so I won’t.”
PHN2 pointed out that PHNs’ programs may not be structured in ways that support involvement of fathers. She also suggested that the limited resources of PHNs may contribute to decisions to focus more on working relationships with mothers:

I think we haven’t, as in public health nursing, we haven’t made a real effort to engage the dads. I mean we say sometimes have a clinic that night be a little bit later in the evening that a dad will come if the dad is working. But I guess, you know, because we have to go for the biggest bang for our buck in our limited resources, because there’s so few of us, and we seem to be getting eroded away; is that we have to go for the women who have their luckily one year maternity leave and kind of focus on that, because those are the people we are going to see the most.

**Nurturing the maternal-child relationship as the priority of PHNs’ interventions**

In the context of multiple challenges faced by families, the PHNs placed priority, for their interventions, on nurturing the maternal-infant relationship. While there may be many factors that could impact family health in the perinatal period, PHNs placed highest priority on supporting the bond between mother and child. With this priority in mind, PHNs focused their attention on mothers and their children. When discussing how she navigates between standard health recommendations and the context of many families’ lives, PHN1 outlines her priority:

Sometimes maybe I compromise a little bit, you know, thinking what’s most important here, but right now it’s more about the bonding attachment stuff; it’s more about that mother being encouraged and pointed out to her as she’s connected with her child.

When PHN1 made observations about areas where health might be improved she placed maternal-infant attachment ahead of other concerns: “You’re taking it in for sure, but as you’re working with that mum you are actually stroking the care, the attention, the bonding kind of stuff. And so this (other) stuff is going to, something maybe will have to be done about it, but it can wait.”
PHN6 echoed the same sentiment that the mother-child attachment is her priority: “It’s more important that that mum is nurturing that child and taking care of herself and if she’s giving that child pop every once in a while…it’s not the end of the world.

Observations were made by several PHNs that the focus on mothers and their children in PHN work may be related to the female gender of most PHNs and an assumption that women provide the best support to other women, particularly in the perinatal period. PHN1 reflected on her experiences developing effective working relationships with clients:

It’s just what happens when you meet people that have a personality that is similar because we’re female; quite often it’s the mums we’re working with; there’s something about their context that just fits into more of that; not mother/daughter thing but, you know, there’s just an easy relationship that happens.

Later, PHN1 also reflected further on those clients with whom she has made an effective professional connection, describing the importance of the relationship between women:

When you do a home visit, have conversations and they come up with things that you should come and talk to them about or things they need you to check in on, because those are the women that understand how women support works. And you get hopeful that these are the ones actually that we can reach, they respond to that.

PHN2 offered her observation that the focus on mothers may be a reflection of a wider perspective in the nursing profession that views childbearing and childcare as a female experience:

Perhaps we focus our attention in a very sort of matriarchal kind of way because most PHNs are female…we are basically a female profession looking at females who have just gone through a very intimate experience birthing their kids and looking after their kids.

When PHNs did consider involvement of fathers, some remarks suggested that fathers were seen primarily as a support to mothers:
I think all of us are very open to having dads attending appointments and, in fact, are really quite thrilled to see them. And when they participate in the way that is so positive, I mean, we can see that it’s really supporting the mom. I know if there’s a happy mum there’s a happy baby here.

It is important to note that there were PHNs who described a nursing focus that was more inclusive of both parents. PHN3 described interventions that addressed the needs of the whole family. In her narratives, both parents engaged together with the public health nurse in the identification of their priorities for nursing care. PHN3 was the only nurse who specifically mentioned the use of the ‘Parent Survey,’ a family assessment tool designed to create an understanding of the historical and current social context of both parents and the potential impacts on parenting.

Finally, PHN6 offered her perspective about expanding the focus to include fathers in family nursing work:

I think you have to take each situation into perspective. I think you kind of start out focusing on the mother and child, but you can kind of expand that when you see what’s going on with the family. I think we are cognizant of the fact that the husband or that father is very much part of that unit. And I think that when I do visits and that dad is not there, because he wants to give time with the mother, as the PHN I’m really kind of disappointed. I want that dad to be there, because he’s very much part of it and I want to see the interaction between the mum and dad and the baby.

**Self-Reflection as a key to improving nursing care to families living with disadvantages**

The perspectives described in the previous section emerged from thoughtful PHN consideration of their work with families living with social and material disadvantages. PHNs described their understanding of their work and their assumptions about their clients. The PHNs were also asked to describe self-reflection as it relates to their understanding of their work with families living with significant social disadvantages and how it is incorporated into their nursing practice. Self-reflection was described, in general terms, as a way of evaluating the effectiveness of client encounters, particularly in instances where the PHNs experienced
something unsatisfactory about their nursing efforts. PHNs described self-reflection as a process of thoughtful review of client encounters, individually, or through discussion with a colleague. Some PHNs also noted the use of social science literature to expand their perspectives about their clients.

PHN5 described self-reflection this way:

Self-reflection is, I think, thinking really deeply about the scenario; what happens; what was said and how if it was positive, why was it positive. And if it was negative what could I have done wrong; I mean, what could I have done better the next time, yeah, differently next time, yeah. So that to me is self-reflection.

PHN6 echoed a similar description of self-reflection: “I think it’s just kind of go home and think about it. And just, just think, gosh, could I have done that better?” PHN4 also spoke about self-reflection as a way to evaluate her care: “I think I do reflect. I think after every CHC (Child Health Clinic) I reflect. And I think about what I could be doing differently for this family, because maybe it went way better than I thought, right? Or maybe I think what can I do for the next time.”

PHN3 also evaluates her work through self-reflection, but expanded her description to include an empathetic stance:

So all along I do a lot of self-reflecting partly just to try to see things through their lens, not mine. I’ve always been one that can kind of remove myself from a scenario and be objective. And even after the visit I normally will do a, whether it’s in the car or just where I sit down and chart, I’ll just really kind of go through and tell myself how it could have been better…or I could have done better or should ask next time.

PHN2 offered her thoughts about the circumstances that might prompt her to engage in self-reflection and how this leads to an examination of her own assumptions:

Sometimes it’s around those times I think where you get rebuffed and so, what was that about? Oh that’s obviously something that they’re not seeing as having value or I’m reading it wrong. Or the type of work that I’m doing is not; I’m not presenting it in a way that is acceptable to them…or is the judgment that I have of this individual; like is my read on this individual really correct, you know?
PHN1 had a unique observation about checking her assumptions when she feels she has comfortable working relationships with families:

I guess if there’s assumptions I have to make and be really careful of when I first start to meet families right away check in on that one. And not be, not be broadsided or, or put off by the ones that have more easy, more natural connection with somehow…when I find that most of the time a family or a young mum that I really, really like…just find it’s such an easy relationship…and yet those are the families where I know that that’s going to be the easiest place for me to just assume there’s more going on than there is. Assume things that aren’t there; just having that good feeling that they’re being well, they’re doing well, everything is good…and then developing unrealistic expectations.

In addition to general descriptions of independent reflective thought about their client encounters, there were also PHNs’ descriptions of engagement with colleagues and reading in the social sciences, as ways to gain new perspectives.

PHN1: What I love to do is read. I like to read about these kinds of things. I guess the easy word would be just the psychology of some of the situations of people. And that just helps gain insight and hopefully reinforce people are people no matter how they are presenting.

PHN2: I also do self-reflection sometimes when I’m reading articles or things like that and I’m like, oh yeah, that’s how I felt at that time; I really didn’t know that I was feeling that or I didn’t realize that this could be; could have been what she’s experiencing.

The PHNs also noted the value of self-reflection with a colleague:

PHN3: What I often do in the self-reflection piece, if I find I’m really questioning but feeling like I need to speak with someone or reflect with someone, I’ll look at (PHN colleague). I’ll often just reflect with her to get kind of her perspective; get someone else’s perspective. She is very good at the motivational interviewing coaching piece and how I can sort of word things. So I really do try, to yeah, just find someone, a nurse that I really feel that can help me work with the family.

PHN6: I think maybe it’s just sometimes you need, I mean it’s not self-reflection, but sometimes you just need to debrief with a coworker and just talk about it and sometimes having another perspective
on it is very helpful and getting somebody’s perspective that maybe has more experience. But it just allows me to think about, ok, what could I do differently next time?

When discussing self-reflection, the PHNs did not explicitly describe a consistent, intentional consideration of their personal assumptions about their clients. However, in the PHNs’ narratives about their work with clients, the PHNs demonstrated occasions where they have clearly reflected on their personal beliefs. PHN3 described her reflection on her personal beliefs about household cleanliness and employment when she engaged with clients who held different perspectives:

So I really had to look at my own value of, ok, this is absolutely filthy to me and be a safety concern in my eyes or my lens, but not for these family’s perspective. The same thing with regards to employment. I had an issue with both families why they seem to be quite comfortable just staying on income assistance and not necessarily working to even take advantage of work training opportunities to seek employment.

PHN5 described how self-reflection has helped her re-evaluate her assumptions about the teen mothers with whom she works:

I learned that from self-reflection because I walked in assuming this and this and this of a family and it totally was…that sixteen-year-old that I thought was, you know, it’s going to be a war zone and it turned out completely different. So now I’ve learned that from experience and so I tell myself you know, not every 16-year-old is going to be the same; it all really depends on their support; it all really depends on your conversation with them.

PHN6 commented that self-reflection has led to her awareness of the social position of PHNs relative to clients living with disadvantages: “I think with experience then you kind of, and maybe with reflection, you get to kind of re-evaluate what is success and success to a fifty-year-old middle class person is different than somebody who’s struggling to put a plate in front of their family.”

Consideration of some assumptions, such as an individualistic work focus and a primary focus on mothers, were not critically considered by the PHNs until prompted by discussion with the researcher. Reflection on these assumptions expanded with dialogue between PHNs and the researcher, possibly
supporting the view that reflection is enhanced when there is an exchange of views between colleagues. As noted above, the PHNs placed value on the contributions of colleagues when they reflect on their nursing practice.

While previous quotes demonstrated that some PHNs consistently engaged in some form of self-reflection in their daily practice, others suggested that workload demands are barriers to opportunities for self-reflection with colleagues. PHN2 described the value of self-reflection with a colleague, but also suggested that there is decreased organizational support for nurses to engage together:

I think that certainly as public health nurses over the years in different structures the organizational structures we have had more opportunity to talk and do some, some case discussions. But certainly over the last number of years when the organization has been rather chaotic and non-supportive that opportunity hasn’t really been there. So, I feel like I’ve really stagnated in this…I also haven’t really reached out for support around it, but I think it is really essential that we do reflect on the stuff that, that we as we work with families, you, know, to debrief about it because for people who are working with it all the time, when you work with anything all the time you need to put some perspective in there.

PHN1, working in a single public health nurse office, commented that, in recent years, managers have had to spend more of their time on administrative responsibilities and less time focusing on support of direct clinical care, creating fewer opportunities for reflection on family nursing work:

And we were talking about our caseload back then, we were talking about our work with our families…not in recent years has anybody asked me why I’m visiting these people, look at your scores, look at your numbers, why aren’t you visiting them, where, I’d love to have it dialogued. I think supervision in many areas changed from that client-centered kind of feedback...versus nowadays where it’s all program and administrative.

PHN4 commented about her work with families living with disadvantages and the barriers to self-reflection creased by workload demands:
I phone a lot of people but like in these situations I try not to, everyone is so busy right like, you don’t have time to listen to people. I mean, I know if there was a big problem anyone would listen and everyone is so very supportive of me when I call them, but there’s just not time, there’s that element of time…I would never phone someone to reflect.

PHN6 also acknowledged the impact of workload demands on opportunities for self-reflection, but observed that (i) PHNs may not place enough value on this activity and (ii) PHNs have some responsibility for making self-reflection a consistent part of nursing practice:

I think we don’t value the time that we should take afterwards. And I think it’s because the work of the family…there’s so many different variables, there’s so many successes, there’s so many failures and we never really strategically take the time to debrief about you family work. I guess maybe in the big picture of things when you have a clinic to get done and you have a home visit to do and time to sit and evaluate is not a priority, however, when we’ve done it off the side of our table it does provide you with growth and how you may tackle the next family. So is it entirely the organization or is it a combination of both, because maybe we need to also take ownership of the fact that we need that time to do it. And we see other task-related things as being more pressing than this time to reflect. But you do grow from it and you do gain support or suggestions from your coworkers who have walked maybe in a slightly different walk.
Chapter 5: Discussion, Implications and Recommendations

The purpose of this study was to explore the range of understandings and assumptions PHNs may hold about families living with social and material disadvantages, how PHNs understand their work with these families and the ways in which PHNs reflect on their assumptions and nursing practice. As described in Chapter 3, in-depth interviews were conducted with six experienced PHNs about their practice with client families to understand the PHNs’ perspectives on working with families facing challenging life circumstances.

The analysis of the interviews with the PHNs illustrated that they held appropriately complex views of families who are living with multiple social and material disadvantages. Although liberal individualism continues to influence nurses and nursing, (Browne, 2005; Pauly et al., 2015), in this study the PHNs clearly demonstrated a robust understanding of the context of their clients’ lives and the impacts of disadvantages on the physical, social and mental health of individuals and families. The findings from this study resonate with findings from other research that has found that PHNs are particularly attuned to the impacts of social and material disadvantages (Browne et al., 2010; Aston et al., 2014). It was evident that the PHNs recognized that their clients’ circumstances emerged from their social context, rather than primarily attributing outcomes to individual choices and behaviors.

Fostering relationships as a core competency for improved health outcomes: One of the striking findings from this thesis was the attention PHNs paid to the relationships with their clients. For families living with disadvantages, experiences of stigmatization and social exclusion may have resulted in mistrust of health care providers and expectations of negative judgment by those in positions of power (Yanicki, Kushner & Reutter, 2015). The relationships with PHNs may develop over the course of many weeks or months, requiring a significant investment of time, flexibility, creativity and relational skill. The PHNs practice of developing relationships with client families demonstrated a number of ways to mitigate social exclusion: the recognition of client strengths and capacity for change; offering a non-judgmental, flexible approach; the
recognition of the value of small changes; and recognition of client autonomy in the relationship with the PHNs. All the PHNs in this study spoke at length about the critical importance of trusting relationships with clients living with disadvantages. However, research suggests that creating relationships with clients has not been adequately recognized as a valuable PHNs’ skill. Aston et al (2015) argue that PHNs need to develop a strength-based discourse to frame their work of creating relationships with clients, to bring ‘recognition and credibility to their practice that continues to be invisible and considered to be “less than.”’ (p.27). Aston et al (2015) note that a strength-based discourse seen in PHNs’ practices is different from the historical medical discourse that positions nurses and other health care professionals to be experts. These authors argue that the nursing skill of building relationships ‘continues to not be recognized “as important” because of the social construction and prioritization of health care practices and health care outcomes’ (p. 27).

**PHNs’ practice insights regarding broader advocacy initiatives:** The PHNs clearly recognized the significance of the social determinants of health and worked with individuals and families to reduce the negative impacts of detrimental social and material contexts. However, the PHNs described a number of factors that constrain their involvement in wider advocacy efforts: emphasis on individual-level interventions and a reduced programmatic focus on advocacy efforts to address fundamental causes of inequities; workload pressures; a sense of personal inadequacy in terms of skills and knowledge needed to address social determinants of health; and feelings of personal powerlessness to influence health inequities beyond the individual. These barriers have been acknowledged by other authors (Yanicki, Kushner & Reutter, 2015). Despite a call for nurses to respond to health inequities, individual PHNs feel powerless to respond beyond the individual level.

Professional nursing documents, presented in the literature review, clearly describe the responsibility of nurses to consider, and respond to, the social context of health in the populations we serve. While individual nurses must understand the social and material context experienced by each client and recognize the root causes of health inequities, there is also a call by researchers and academics for health care organizations and professional associations to provide leadership for health advocacy (Falk-Raphael & Betker, 2012a; Yanicki, Kushner & Reutter, 2015). Yanicki, Kushner and Reutter (2015) point out that
“nurses routinely witness the impacts of social injustice in the lives of their clients and play a key advocacy role” (p. 127). PHNs might consider ways their collective observations of health inequities in their work with families could contribute to wider policy changes. Health authorities must recognize the expertise and unique position of PHNs and make room for the contributions PHNs can make to the understanding of families living with disadvantages. Individual PHNs can also add their voices to collective efforts being made by professional nursing organizations to address health inequities (Falk-Raphael & Betker, 2012a).

It is evident from the interviews that the PHNs see valuable impacts of their work with families living with disadvantages. Health authorities in British Columbia continue to recognize that the provision of support to families living with disadvantages is a significant component of PHNs’ practice. However, the PHNs expressed their view that their work with families living with disadvantages has faced pressures from the demands of other programmatic expectations and is a less visible or recognized aspect of their practice. Similar observations have been made by other authors who report that PHNs experience a lack of visibility and misunderstanding of their role by politicians, the general public and managers (Aston et al., 2009; Aston et al., 2014). The PHNs in this study clearly described their experience of workload pressures and organizational changes that have redirected their practices and reduced their ability to engage effectively with families facing challenges.

Evidence-informed practice and organizational infrastructure: In the current economic health care climate there is a demand for evidence of positive outcomes (Reimer Kirkham & Browne, 2006). While there is an existing body of research that demonstrates positive outcomes as a result of PHNs’ relationships with families living with disadvantages, there is a need for evidence that is consistently monitored, linking particular PHNs’ practices with specific health outcomes in the communities in which PHNs work. Concrete demonstration of health benefits of PHNs’ practice would lend greater visibility and credibility to PHNs’ work with families. Aston et al (2014) comment that clear documentation of PHNs’ practices and health outcomes would help make nursing practice more visible. Further research, conducted by nursing researchers, is needed to identify the types of evidence that would capture PHNs’ interventions that lead to positive health outcomes.
Further work is needed to develop ways of capturing evidence that can illustrate the positive outcomes stemming from effective working relationships between PHNs and clients. It is clear from this thesis and previous research that PHNs understand that positive outcomes resulting from their work with families living with disadvantages depends on the formation of trusting relationships (Aston et al., 2015; Moules et al., 2010). Efforts to identify evidence of positive impacts of PHNs’ practice with vulnerable families must capture the significance of the relationship between PHNs and clients, successful strategies to form those relationships and discourses that frame these skills as the credible foundation of PHNs’ interventions.

Tracking health outcomes by health authorities would also necessitate collection of evidence regarding the challenges faced by families living with social and material disadvantages. As noted, PHNs are in an ideal position to provide observations about the impacts of the social and material context on their clients’ lives. Recognition of PHNs’ understanding of the social determinants of health within communities may also lead to an acknowledgement of the effective role PHNs may play in community development activities.

Yaniki, Kushner and Reutter (2015) make a number of recommendations of social justice actions for nurses: a greater emphasis on social justice in nursing curricula; nursing leadership to challenge environments that limit nursing activities in promoting social justice; dialogue among nursing organizations to stimulate sharing of best practices for social justice and equity action; critical scholarship to develop nursing knowledge on approaches to address social justice within differing practice settings. Each of these actions would support engagement by nurses (collectively and individually) in social justice efforts and help alleviate the powerlessness experienced by the PHNs in this study, and to advocate for those living with disadvantages.

*PHNs’ engagement with families may reflect gendered practices:* Throughout the interviews the PHNs described their practices, with families living with disadvantages, primarily focused on mothers and their children, with less attention given to fathers or other family members. There were a number of reasons given for this practice direction: absent or limited involvement of fathers; programmatic limitations; and the belief that nurturing the mother-child relationship is a central goal of PHNs’ interventions. The PHNs also
made observations that this practice focus may be influenced by social assumptions that female nurses (the majority of PHNs) are able to form more effective working relationships with mothers, rather than fathers. It was also noted that with limited PHNs’ resources, the greatest positive impacts may be realized by interventions that focus on the parent that is at home with an infant in the early postnatal period (most commonly, the mother).

While there may be legitimate reasons to provide PHNs’ support to women and their children, a recent review of literature related to fathers, suggest that there are also important reasons to make greater efforts to involve fathers in PHNs’ work with families (Yogman & Garfield, 2016). This review of literature from the past decade, focusing specifically on fathers, demonstrates that fathers have a significant influence on the health and development of their children: positive father involvement is associated with positive development, cognitive outcomes and psychological well-being in their children. A father’s own wellbeing can also influence the wellbeing of the family. Like maternal depression, recent research shows that paternal depression also has negative effects on child behavior, mood and development. These authors point out that poor mental health in fathers is associated with conditions of increased levels of stress, like unemployment and poverty.

While the recommendations emerging from the Yogman and Garfield (2016) review are directed to pediatricians, they are applicable to the practices of all health care professionals engaged with families (eg. welcome fathers and express appreciation for their attendance; speak directly to the father, as well as the mother; offer flexible times of service to accommodate the schedules of working parents). PHNs might consider how they could modify their practices with families living with disadvantages to implement some of these recommendations. While this thesis did not examine the health impacts of other care providers (grandparents, step-parents, same sex parents), PHNs may also consider research that addresses a variety of family configurations.

While the scope of my study did not examine family assessment frameworks, it was noted that one public health nurse specifically mentioned the use of a tool (Parent Survey) that attends to the history, current circumstances, and expectations, of both the mother and father. It may be useful for PHNs to consider
methods of family assessment and how different frameworks direct attention to particular aspects of a family context.

Self-reflection as a core component of PHNs’ practice: The PHNs in this study were also asked to consider how they incorporate self-reflection into their practice. The PHNs agreed that self-reflection is an important component of their practice with families living with disadvantages. The process of self-reflection was described as a way of evaluating specific encounters with clients and as a way to examine personal biases. The PHNs engaged in self-reflection by reading social science literature, by taking time alone to think critically about client encounters, or through direct engagement in discussion with a public health nurse colleague. There was a consensus that PHNs value opportunities to reflect with other PHNs and their careful consideration of their work, during the interviews, demonstrated their ability to critically examine their practices. However, the PHNs also described barriers to self-reflection (primarily workload pressures and organizational restructuring that has reduced opportunities for PHNs to engage together).

It has been noted that critical reflection on personal beliefs about clients and the social context in which these assumptions exist is an essential component of cultural safety (Pauly et al., 2015). Self-reflection is also an expected competency for good nursing practice (College of Registered Nurses of British Columbia, 2012). Asselin and Fain (2013) suggest that it cannot be assumed that all nurses know how to reflect and research is needed to determine effective strategies for teaching and maintaining a reflective practice.

Finally, this thesis drew attention to the need for health authorities to provide support and leadership for self-reflection and that PHNs should consider ways to include self-reflection consistently in their family work. Research and education may be needed to determine the most effective practices and ways to support nurses to engage in this activity. Self-reflection provides opportunities for new nurses to learn from experienced PHNs, as well as a continuous examination of nursing assumptions that may impact nursing practice.
Recommendations

Recommendations emerging from this study are organized according to areas of education, organizations, PHNs’ practice and research.

Education:

Findings from this thesis highlight the need for nursing curricula to place an emphasis on the recognition of the root causes of health inequities and strategies for action. PHNs require skills in family assessment and intervention that considers the social and material context of clients’ lives. PHNs also require a broad foundation of current knowledge in family development, cultural safety, early childhood development, community development and understanding of the health impacts of social and material disadvantages. PHNs also require skill in self-reflection and an understanding of ways to incorporate new insights into their practice.

Organizations:

Health authorities should provide leadership in health advocacy and recognize the contributions PHNs can provide through their position of engagement with families living with social and material disadvantages in many unique communities. Health authorities can support effective PHNs’ practices with families by monitoring health outcomes associated with PHNs interventions. Health authorities can support effective PHNs’ practices by providing support and leadership for self-reflection. Health authorities can support the development of a PHNs’ Community of Practice focused on nursing practice with families living with social and material disadvantages. A PHNs’ Community of Practice should allow for online exchange between PHNs throughout health authorities.

PHNs’ practice:

PHNs should participate in the development of a Community of Practice focusing on their work with families living with disadvantages, to share effective practices, resources and research evidence. PHNs should recognize self-reflection as an essential component of their work with families, not only as a way to
evaluate the success of specific interactions, but also to examine their personal biases and assumptions and their impact on nursing practice. PHNs might consider how particular family assessment frameworks direct attention to particular aspects of the family context and whether new frameworks should be considered. PHNs should clearly document their nursing interventions and associated outcomes.

PHNs should consider how to incorporate recent evidence into their practices related to the impact of fathers on children’s the health and development and on the wellbeing of families. PHNs can contribute their observations of health inequities, as well as suggested strategies to address inequities, to the collective voice and actions of professional nursing organizations.

Research:

Further research is needed to determine what constitutes evidence of positive outcomes emerging from PHNs’ practices with families living with social and material disadvantages. Research should continue to identify specific PHNs’ practices that are associated with positive health outcomes. Research is needed to identify the most effective ways for PHNs to engage in self-reflection.
Conclusion

PHNs in this study demonstrated a complex understanding of the social and material context of their clients’ lives and the many ways this context impacts the health of their clients. While PHNs work with individuals and families to mitigate the effects of disadvantages, they described a number of barriers to their engagement in efforts to address the root causes of health inequities. There is a need to develop ways to capture the unique observations made by PHNs in their work with families and evidence that can illustrate the effective practices of PHNs that lead to positive health outcomes for families living with disadvantages. PHNs also have the opportunity to work collectively, through professional nursing organizations, to influence contexts that impact health.
**References**


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Othering and being othered in the context of health care services. *Health Communication*, 16(2), 253-271.


Appendix 1

January 19, 2015

Consent Form

Public Health Nurse Assumptions and Self-Reflection About Families Living With Social and Material Disadvantages

Study Team: Principal Investigator: Dr. Judith Lynam

UBC School of Nursing

Co-Investigator: Nancy Gunn, BA, BSN

UBC Master of Nursing Student

This research will be part of a Master of Nursing thesis.

Study Purpose:

You are being invited to take part in this research study because of your experience as a public health nurse working with families living with social and material disadvantages. We want to learn more about the assumptions public health nurses make about these clients; how nurses engage in self-reflection on their assumptions and the impact of these assumptions and self-reflection on their nursing practice.

Study Procedures:

If you decide to participate in this research study, you will be asked to engage in 1-2 face-to-face interviews with the co-investigator; each interview lasting 1-2 hours. The interviews will be audio-recorded.
Study Results:
The results of this study will be reported in a graduate thesis for the UBC School of Nursing.

Is there any way being in this study could be bad for you?
We do not think there is anything in this study that could harm you or be bad for you. You are free to choose whether or not to answer any questions and we invite you to let the investigator know if you have any concerns.

Will being in this study help you in any way?
You may find that you will gain additional insights into your own nursing practice that may result in more effective engagement with clients. Your contribution to the research may also benefit other nurses who wish to enhance their practice with families living with disadvantage.

How will your privacy be maintained?
Participant identifiers will be removed from the data (participants will be identified by a coding system). Audiotapes, transcripts, and copies of the coding system will be kept in a locked filing cabinet.

Will you be paid for taking part in this research study?
We will not pay you for the time you take to be in the study, but we will cover the cost of refreshments during the interview(s).

Who can you contact if you have concerns about the study?
If you have any questions or concerns about what we are asking of you, please contact the study leader or co-investigator. The names and telephone numbers are listed at the top of the first page of this form.

Who can you contact if you have complaints or concerns about the study?
If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.
Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason.

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

<table>
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<th>Participant Signature</th>
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Printed Name of the Participant signing above
Appendix 2

Preamble: The interview begins with open-ended, exploratory questions that set the stage for further discussion. As the interview proceeds questions become more focused on an exploration of issues and themes that have been revealed in the early stages of the interview.

Interview Script

My research focuses on the work of public health nurses with families living with material and social disadvantages (families living with poverty, unemployment, low levels of education, mental health challenges, drug and alcohol misuse, etc.). These are families with infants and young children that PHNs often engage with prenatally or soon after the birth of an infant. It is clear from existing research that social determinants impact the health of individuals and families. It is also apparent that conditions that create vulnerabilities intersect with social processes that can create further marginalization or mitigate the impact of these conditions. Part of the social context within the work of PHNs is the assumptions we hold about the families with whom we work. I am interested in learning more about how these assumptions and beliefs impact our work with families. I am also interested in the ways PHNs reflect on their personal assumptions and how that reflection impacts nursing practice.

Could you tell me a story about a family living with disadvantages, with whom you worked, where you felt things went well? How did you feel about that family? How did that affect how you worked with them? Could you also tell me a story about a family living with disadvantages, with whom you worked, where you found things more challenging? How did you feel about that family? How did that affect how you worked with them?

I am also interested in how PHNs engage in self-reflection in their work with families living with disadvantages. What does self-reflection mean to you? What prompts you to engage in self-reflection? Could you describe how you engage in self-reflection? How does self-reflection change your practice?