Authors	Titles	Journal	Year Published
Bender A; Clune L; Guruge S	***Considering Place in Community Health Nursing***	Canadian Journal of Nursing Research	2009
Ackatia-Armah, Nana M.; Addy, Nii Antiaye; Ghosh, Shibani; Dubé, Laurette	**Fostering reflective trust between mothers and community health nurses to improve the effectiveness of health and nutrition efforts: An ethnographic study in Ghana, West Africa.**	Social Science & Medicine	2016
CLARENCE, DIANNE	Love and boundaries in relational practice	Canadian Nurse (CAN NURSE)	2018

Richard Griffith, Cassam Tengnah	Maintaining professional boundaries: keep your distance	British Journal of Community Nursing	2013
Not listed	Nurses On Guard - Best Practice in Patient Safety Establishing Professional Boundaries in the Community	Texas Board of Nursing Bulletin	2011
Aysha Mendes	Nursing care and maintaining professional boundaries	British Journal of Community Nursing	2017
Carolynn Briggs	***Nursing practice in community child health: Developing the nurse--client relationship ** issues converting this document and copy and pasting from the PDF***	Contemporary Nurse	2006
	Nursing the social wound: public health nurses' experiences of screening for woman abuse		
Mulcahy H; McCarthy G	**Participatory nurse/client relationships: perceptions of public health nurses and mothers of vulnerable families.**	Applied Nursing Research	2008

SmithBattle L	Pregnant with possibilities: drawing on hermeneutic thought to reframe home-visiting programs for young mothers	Nursing Inquiry	2009
Megan Aston	Public health nurses as social mediators navigating discourses with new mothers	NUrsing Inquiry	2008
Aston M; Meagher-Stewart D; Edwards N; Young LM	***Public health nurses' primary health care practice: strategies for fostering citizen participation***	Journal of Community Health Nursing	2009

** Broken link, article not found	Public health nursing practice with 'high priority' families: the significance of contextualizing 'risk'.		
BRADBURY-JONES, CAROLINE ** broken link, article not found	Recognising and responding to domestic violence and abuse: the role of public health nurses	Community Practitioner	2016
Kathleen M Stoddart	Social meanings and understandings in patient-nurse interaction in the community practice setting: a grounded theory study	BMC Nursing	2012
Richard Griffith	The changing nature of the district nurse patient relationship.	British Journal of Community Nursing	2016
Alison White	The client partnership	British Journal of Community Nursing	2012

Edna Foley	The nurse's first visit	Public Health Nursing	2013
Aston, Megan; Price, Sheri; Etowa, Josephine; Vukic, Adele; Young, Linda; Hart, Christine; MacLeod, Emily; Randel,	**The Power of Relationships: Exploring How Public Health Nurses Support Mothers and Families During Postpartum Home Visits**	Journal of Family Nursing	2014

Falk-Rafael, Adeline; Betker, Claire	**The primacy of relationships: a study of public health nursing practice from a critical caring perspective**	Advances in Nursing Science	2012

**Article link broken	The Power of Relationships: Exploring How Public Health Nurses Support Mothers and Families During Postpartum Home Visits
Northrup-Snyder, Kathlynn; Van Son, Catherine R.; McDaniel, Cynthia ** article link broken	"Thinking beyond wheelchair to car"
Novak D *** link broken, unable to retrieve article	Upfront. Resurrect the 'nurse'

Psyhcinfo Articles

Caroline Porr,1 Jane Drummond,2 and Karin Olson2	***Establishing Therapeutic Relationships With Vulnerable and Potentially Stigmatized Clients***	Qualitative Health Research	2012

DUPLICATE***	Fostering Reflectiv Trust ….

L SmithBattle, R Lorenz and S Leander	Listening with care: using narrativemethodstocultivatenurses'responsive relationships in a homevisiting intervention with teenmothers	2012

Bender, Amy; Peter, Elizabeth; Wynn, Francine; Andrews, Gavin; Pringle, Dorothy.	***Welcome intrusions: An interpretive phenomenological study of TB nurses' relational work***	International Journal of Nursing Studies	2011

DUPLICATE***	Considering Place in Community Health Nursing
DUPLICATE***	Pregnant with Possibilities ….
DuPLICATE***	Social Exchange As a Framework for Client Nurse Interaction

Tveiten, Sidsel; Severinsson, Elisabeth.	***Communication--a core concept in client supervision by public health nurses.***	Journal of Nursing Management	2006

Medline Articles

Lambing, Fara.	You matter to me. I care about you.	Canadian Nurse	2015
Amanda Phelan	***Examining the Synergy of Practice***	Global Pediatric Health	2014

Study Design	Subject Charactertistics
N/A	The authors review the health geography literatures, then discuss the implications for practice and research in community health. They invite community health nurses to critically examine their practice and research with reference to such issues as the power of the nurse, marginalized places as determinants of health, and how best to care for clients living in diverse community settings
Ethnographic study	Public health nurses working in a community in Ghana, Africa
N/A	Not a study

N/A	Not a study
N/A	Not a study
N/A	Not a study
Review Paper (does not state how many articles were reviewed)	Revew Paper
cross-sectional quantitative design	44. dyayds

not stated	Inthis study, I argue that articulating and cultivating nurse–par-ent relationships will be hindered as long as clinical tria lsand nursing models follow the log ic of techne and a scien-tific–clinical gaze that misrepresents teen mothers andclinical practice. After describing the emergence of thescientific–clinical gaze, and its limits for guiding practicewith young mothers, I draw on contemporary hermeneuticsto describe how skillful relationships promote dialog, under-standing, and astute clinical judgment
This is a review paper which includes research and insight into the author's personal experiences as a public health nurse	Not a study
Qualitative study	This article presents findings from an interpretive qualitative study of pub- lic health nurses' perceptions of their role in fostering citizen participation in an eastern Canadian province at a time of significant health care restructuring. The findings from this study clearly profile public health nurses as integral to the practice of fostering citizen participation

Qualitative study using grounded theory methodoly	Analysis of formal and informal interviews with nurses at a community health centre
Not a study	Not a study. Review paper written by a professor of health law about the regulations that govern british community health nurses
Not a study	Not a study

Given the need to better understand the social construction of mothering and PHNing practice, feminist poststructuralism and discourse analysis were used in this study to explore the experience of home visits.

At the time of this research study in 2011, public health services in Nova Scotia offered two home visiting programs. The targeted program was available to mothers who screened in with a score of 9 on the Parkyn Tool (Public Health Services, Capital District Health Authority, 2013) and were therefore potentially at risk for poor health outcomes. The universal program was available to mothers who did not score as high on the Parkyn Tool but still needed support with other postpartum issues and would like a home visit. Both programs were voluntary. The screening process was usually conducted in the hospital and always with the mother's permission. If they had been discharged before a PHN could meet with them, they would be contacted by phone or letter. Mothers eligible for the universal program would be con- tacted within 72 hr of discharge from the hospital and a home visit scheduled. Mothers who participated in the targeted home visiting program were also contacted within 72 hr and then provided with additional services and sup- ports from both PHNs and community home visitors for up to 3 years.

Critical caring is a midrange theory proposed as a framework to guide public health nursing practice. This article reports findings of a study that examined the relevance of the theory to the practice of expert public health nurses (PHNs). Twenty-six PHNs participated in this study: 10 in interviews and 16 in 2 focus groups.

A total of 36 participants were interviewed for this study: 16 new mothers, 16 PHNs, and 4 public health managers. Six new mothers were enrolled in the targeted program and 10 in the universal program. Nine PHNs worked in the universal program, 5 in the targeted program, and 2 in both programs. Direct quotes from public health managers are not used in this article as the focus is on the relationship between PHNs and mothers during home visits. PHN participants had experience working in the postpartum home visiting programs from 2.5 to 12 years, and were 32 to 59 years old (average age of 44). All PHNs had a bachelor of nursing degree, 5 had a master's degree, and 2 were certified lactation consultants. Mothers were 18 to 38 years old (average age of 28). All mothers had Grade 12 education, 9 had an undergraduate degree, and 2 had a college diploma. All were first-time mothers, and 12 lived in urban areas. No economic data were collected for this study. Participants were recruited and interviewed during a 6-month time period

The grounded theorist generates substantive theory through direct exploration of how people respond to, manage, and negotiate meaningful events, situations, and circumstances in their natural settings. In this article we report the findings from our grounded theory study of how PHNs establish therapeutic relationships with LISMs, but first we present a brief overview of the study design. In adherence with grounded theory's operational procedures, the study design included purposive and theoretical sampling to collect data to generate theory. We also relied on the constant comparative method, memoing, and substantive and theoretical coding techniques, as described below.

The 15 PHNs who partici- pated were White Canadian with 18 median years of relevant experience. The 21 mother participants were of mixed ethnicity, aged 22 to 40 years, with 11.1 median years of primary education and 0.67 median years of postsecondary education. Mothers averaged 2.3 chil- dren; 3.6 years as lone parents; and 3 years on social assistance.

This mixed-method pilot study included a quasi-experimental design to examine the effect of the intervention on teen mothers' depressive symptoms, self-silencing, repeat pregnancy, and educational progress compared to teens who received usual care.

Six PHNs volunteered for the study; four were black and twowere white. One PHN had 1 year of PHN experience; theremaining nurses had a minimum of 7 years of home-visitingexperience. Twenty-seven teen mothers signed the consentform . One dropped out early in the study, and seven werelost to follow up. The final sample of 19 teen mothersincluded ten in the UC group and nine in the LWC group.At baseline, the ages of the teen mothers ranged from 15 to19 years, with the mean age in the LWC group being youn-ger (M = 16.7; SD, 1.5; range, 15–19 years) compared to theUC group (M = 17.3; SD, 1.5; range, 16–19 years). Ethnicityof all teen mothers was black. Three of the ten teens in theUC grou p had graduated from high school before the studybegan; the remaining seven teens were attending school.Only one of the nine teens in the LWC grou p had graduatedfrom high school at intake, and three teens had droppedout before the study began.

This paper describes an interpretive phenomenological study which was undertaken to understand the nature of TB nurses' relational work.

The study setting was a large multicultural city in Canada, in a variety of places including clients' homes, nurses' cars, the street and other public settings. The participants were recruited from the public health department and included nine female nurses and 24 of their clients. Nurse participants were part of the 'Case Management', 'Directly Observed Therapy' (DOT), and 'Homeless' Teams, with the majority working in DOT. An introductory letter outlining the study was sent to all nurses via email. This was followed by presentations introducing the study at regional team meetings. Inter- ested nurses contacted the first author directly. In the initial meeting, the study was explained, consent obtained, and nurses were asked to act as recruiters of client participants. Clients were recruited via nurses because (1) we needed to match nurses and clients to ensure that observation of relationships would be possible, and (2) TB clients as a vulnerable group are difficult to access directly. Using a selection guideline to allow for maximum variation, they introduced the study to their current clients and obtained permission to bring the first author to a visit to explain it further. During the initial visit to those clients who agreed, the first author explained the study and obtained consent

Transcript-based qualitative content analysis was used to analyse thefindings from individual interviews with 13 female public health nurses.	The sample in this study was purposive, which means thatthe researcher’s knowledge of the subjects was taken intoaccount when selecting the respondents. The subjects areconsidered typical of the study population and capab le ofanswering the research questions (cf. LoBiondo-Wood &Haber 2002). The subjects were 13 female PHNs,working in communities in a city in the east of Norway.They had all postgraduate public health education
Author's personal reflection as a public health nurse	N/A
Not a study	N/A

Sample Design	Research Questions
Not described	Our aim in this article is to extend the ideas presented in nursing geography to community health nursing.We believe that when nurses think and talk about how they navigate actual geographic places, they are articulating an aspect of community practice that is important to the nature of the work but often goes unnoticed in health-care discourses. Specifically, we suggest that health geography can be used to critically examine community nursing research and practice. Such a perspective can highlight issues of marginalization and vulnerability not only in how clients belong (or are assigned) to certain diagnostic, economic, racialized, or gendered groups, but also in the places of community practice. It can also highlight issues of power and proximity in the nurse-client relation- ship.
interviews with 39 nursing mothers, three focus groups – with mothers, health-workers, and community leaders – as well as 941 h of participant observation	We contribute to informing such strategies by explaining how mothers' “reflective trust” in community health nurses develops as a key influencer in their health-related decision-making and behavior
Reflection paper by RN	Not a research study

Not a research study	Not a research study
Not a research study	Not a research study
Not a research study	Not a research study
	Aim of the review is to describe and compare the pracitces of community child health nurses in establishing therapeutic relationships
Not a research study	
A cross-sectional quantitative design was used to investigate the needs identified and provided, as well as satisfaction with the level of involvement and response, from the perspective of both sides of the dyad.	The primary purpose of this pilot study was to determine similarities in perceptions on participation between nurses and mothers of vulnerable families

Sample not described in this study	
Not a research study	This paper will present acritical review and discussion of the author's own workand research over the years that will suggest how feministpoststructuralist theory may be used to guide and under-stand information exchange between PHNs and mothers asthey mediate different social, cultural and personal discourseson mothering
Participants in both the individual interviews (*n* = 43; one drop out) and focus groups (*n* = 31) had worked an average of 14.5 years (range = 4) as public health nurses. The majority were baccalau- reate-prepared (72%) with 16% masters-prepared and 12% with a public health diploma; 91% worked full time; 78% practiced in program focus; and the majority described their practice as ru- ral (46%) or combined rural/urban (42%)	his article presents findings from an inter- pretive qualitative study of public health nurses' perceptions of their role in fostering citizen par- ticipation.

Grounded theory methodology was used and the research process was characterised by principles of theoretical sensitivity and constant comparative analysis. The field of study was four health centres in the community. The participants were patients and nurses representative of those attending or working in the health centres and meeting there by scheduled appointment. Data collection methods were observations, informal interviews and semi-structured interviews	What social meanings and understandings can be identified in patient-nurse interaction in the community practice setting and, what influence do they have within that interaction?
N/A	Not stated
	N/A
N/A	

Discourse analysis was used to analyze all of the transcripts. The first few transcripts were reviewed by the principal investigator (PI), research coordinator (RC), and co-investigators and discussed at a team meeting to identify initial emerging themes. The PI and RC analyzed the remaining transcripts. Analysis started by identifying contextual moments based on individual participant's descriptions of beliefs, values, and practices associated with the home visit, the program, and mothering. These descriptions were then ana- lyzed by paying close attention to the language and meaning used to describe their experiences and how social and institutional discourses informed their experiences. Common experiences and themes across participants were then organized into themes.	Not stated explicitly wihtin the study, but possible "What are the experiences of PHNs and mothers in home visitng programs?"

What is the role of critical caring within public health nursing?

Not described

Interviews with PHNs took place in the pri- vacy of the office and interviews with mothers were con- ducted in their respective homes. We also collected nonverbal data by observing interactional behaviors of 14 dyads involving 4 PHNs and 14 mothers (7 mothers of low-income status and 7 mothers of high-income

status). After obtaining written informed consent, we observed PHN–mother dyads during immunization appointments and at unscheduled drop-in clinics

Although the therapeutic relationship has the potential to serve as the medium to promote the health of the vulnerable and stig- matized client, the existing literature offers PHNs limited knowledge about the explicit process by which the thera- peutic relationship develops. We have begun to address this gap in practice understanding by constructing a the- oretical explanatory model grounded in the relationship experiences of both PHNs and LISMs.

The first author held team meetings with the PHNs to collectqualitative data every two to 3 months as LWC was deliveredover 16 months. The 62-hour meetings were tap e recorded,professionally transcribed, and corrected for accuracy. Asemi-structured interview guide was used at each meeting toobt ain a full description of how the PHNs used the therapeu-tic tools, how the tools shaped their clinical understandingand nursing care, and how the teens responded to the visitsfrom the nurses' perspectives. To capture PHNs' clinical rea-soning and relational skills, they were also asked at eachmeeting to discuss two cases: one teen who was relatively easyto engage and a teen who was more difficult to engage in vis-its. Because PHNs were encouraged to respond to	Not stated explicitly within study

In general the study reflects a collection of relational experiences structured by the mandate of Public Health, in a relatively long time frame, and over numerous visits in private and public spaces. Descriptions of these experi- ences were informed by participants' various under- standings of TB, of nursing, and of broader social ways of relating, as well as observations of these nurses and clients as they related to one another. The overall theme of welcome intrusions and its related sub-themes of 'getting through the door', 'doing TB but more than that', and 'beyond a professional' capture the seemingly paradoxical nature of relational work in TB.

This paper describes an interpretive phenomenological study which was undertaken to understand the nature of TB nurses' relational work.

The data consisted of individual interviews with 13PHNs on the subject of dialogues they had had withclients in their practice 2 weeks earlier. The dialogueswere considered natural (cf. Silverman 2002), thus notcreated for this research, and representative of clientsupervision by the PHNs, as they themselves sent thetape-recorded dialogues to the first author for analysis.Twelve of the 13 PHNs read the transcriptions of theirdialogue prior to the personal interview for this study.The interviews covered the grounds for choosingsupervision as an intervention strategy, the way it wasconducted and the challenges as well as the ethicalaspects of client supervision. The PHNs were sent themain topics to be covered in the interview together withthe transcriptions of their dialogues with the clients(transcribed by the first author) about 1 week prior	The aim of this study was to explore PHNsÕ reflectionson client supervision. Two research questions wereaddressed: (1) What are the PHNsÕ views on their provision of client supervision? (2) Which possibleassumptions can be made regarding PHNsÕ theories-in-use related to client supervision?	
	N/A	
N/A		
N/A	This article focuses on an exploration of this synergy through 3 practice competencies: effective communication, assessment of the family as a unit, and individual family members	

Include / Exclude for coding

INCLUDE FULL TEXT as it relates to research question 4

INCLUDE FUL TEXT as it relates to research questions 1 and 2

EXCLUDE FULL TEXT It is important to note that this is not a research article but a personal reflection.

EXCLUDE FULL TEXT It is important to note that this is not a research article but an editorial.

EXCLUDE FULL TEXT as this editorial does not answer research questions 1,2,3 or 4

ECLUDE FULL TEXT as this is an opinion piece by a health journalist with very no scholarly evidece/ discussion

INCLUDE FULL TEXT as it relates to question 1

EXCLUDE FULL TEXT as the research question is focused on the nurse's feelings regarding the therapeutic relationship. Not directly related to research questions 1,2,3, or 4

EXCLUDE as it does not address research questions

EXCLUDE as it is not a research study

INCLUDE FULL TEXT as it is related to research question 1

EXCLUDE FULL TEXT Upon inspection it becomes clear that the participants in this study were patients and nurses in a community health centre and not working from a public health model

EXCLUDE FULL TEXT as it does not answer research questions

EXCLUDE FULL TEXT, does not answer research questions

This article was initially published in 1918 althought it does address some of the key concepts in research questions 1 and 2

INCLUDE FULL TEXT as it addresses research questions 1,2,

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Conclusion

We need to become aware of our prejudices about the places in which we work, of the value judgements we make about, for example, supposedly high-risk neighbourhoods or the cleanliness, noisiness, comfort, and even tidiness of our clients' homes. It is our responsibility, as practitioners and researchers, to be aware of aspects of place and how they may play out in the situations and concerns of each of our clients or res

Mothers articulated that the nurses employ strategic means in their interactions, facilitating reflective trust, which is based on openness and inclusiveness (Adler, 2001). The relationship between the mothers and the CHPS nurses was both professional and personal.

After working five years in this program, I now know that relational practice takes root in our mutual humanity. I've learned that I don't need
to fear countertransference; I must anticipate
and honour it. My client's feelings are hers alone to de ne. Trust is her privilege to share, if she
so chooses. My job is to meet her at the place where our boundaries intersect. My professional responsibility is to be emotionally mature and ethically aware and to always, always act in her best interests.

Maintaining professional boundaries is essential to an effective nurse- patient relationship whose sole focus must be on the care and treatment needs of the patient. Complaints about failures to maintain professional boundaries are increasing, with the Nursing and Midwifery Council reporting some 247 new cases in the year 2011-12.

Remaining within strictly pro- fessional limits as a caring and supportive nurse, rather than a friend, will protect nurses and the health care organisations for which they work

Themes of trust, openness, power and persuasion are all discussed in light of the Australian nursing contetx

There were more similarities than differences in perception found in the dyads, indicating participatory relationships

So lon g astechne is privileged over phro nesis, teen mothers will besubjected to a scientific gaze and paradigm of control thatoverlooks the life-world as a source of meaning and socialexclusion. Hermeneutic thought offers a corrective to thescientific gaze and a liberating view of clinical practic e.This perspective moves PHN practice away from an objec-tive truth and disengaged relationships to a dialogicaltruth that respects difference, affirms meaning, and cri-tiques oppressive aspects of the life-world. Developinghome-visiting programs and clinical trials from this per-spective invites researchers and clinicians to engage inquesti ons of meaning so that the appl icati on of scientificevidence and detached reasoning is subordinated toclinical understanding.

Public health nursesare in a unique position to act as social mediators andsupport new mothers as they work through social, culturaland personal discourses on mothering. Feminist post-structuralism offers a guiding framework from whichto understand how PHNs can work with new mothers.Recognizing that power relations exist between PHNs andmothers, as well as through the uptake of certain informationinformed by different discourses, will help PHNs understandtheir practice and actions with new mothers. Public healthnurses need to be aware that mothers will understand andincorporate bonding, separation and other mothering prac-tices in different ways depending on their life circumstances

Public health nurses in this study demonstrated their commitment to primary health care and pop- ulation-focused health beginning with citizen participation. The relational work between clients and public health nurses created empowering processes whereby citizens were supported to par- ticipate in assessing, planning, implementing, and evaluating their health and health care... Building trusting relationships, confidence, and skills was integral to the empowerment pro- cess. Other authors similarly concluded that nurses' empowering practices occur within nurturing

nurse-client relationships through trust, support, encouragement, and building capacity (Falk-Rafael, 2001). Caring and trust (Schulte, 2000) are facilitated through mutual relationships that involve negotiating a more equitable power balance (Charles & DeMaio, 1993).

The importance of social meanings and understandings in patient-nurse interaction is not fully apparent to nurses, but important in the patient experience. Seeking understanding from a social perspective makes a contribution to enhancing knowledge about patient-nurse interaction with subsequent impact on practice, in particular the development of the patient-nurse relationship. The implications are that the meanings and understandings patients and nurses generate from experiences beyond and within their situated interaction are pivotal to the development of their relationship in the transforming community healthcare environment.

The ruling of the Supreme Court in Montgomery v Lanarkshire Health Board [2015] now requires nurses to base the disclosure of information about the risks inherent in care and treatment on what a prudent patient would consider material in helping them decide if they should consent to treatment.

The Supreme Court decision gives legal force to the pro- fessional requirement on district nurses to listen to people and respond to their preferences and concerns. It also under pins the requirement for a patient centred partnership set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that are the basis of inspec- tions by the CQC.

The judgment recognises the changing relationship between district nurses and their patients, which is now based on partnership and the recognition of personal autonomy, rather than the paternalistic nurse knows best approach of last century

Home visiting was an important component of the Public Health Nurses (PHN) role inthe early twentieth century. In this reprint, originally published in 1918 and reprinted in 1926, Edna Fo-ley discusses the significance of the first visit the PHN makes to a family. Critical themes in the paperinclude the importance of first impressions, communication and observation skills, obtaining the statisti-cal data needed by the agency and collaboration with other community social service agencies. Many ofthe themes and strategies discussed by Foley are cogent to PHNs and visiting nurses in the contempo-rary health care arena

The consistent message, spoken by both PHNs and mothers in this study, was the overwhelming importance of developing supportive relationships that were non-judgmental, friendly, and fostered trust. PHNs and mothers worked together to identify strengths and nurture confidence in mother's abilities to take care of their babies and families. Relations of power were negotiated in very positive ways by the majority of PHNs and mothers in our study.

The study, through the findings reported here and previously,16 supports the relevance and fit of critical caring to public health nursing practice. The findings thus support the theory's potential as a framework to guide public health nursing practice

Achieving a therapeutic relationship with LISMs can influence how mothers think about themselves, their situation, and their parental competence, and can optimize maternal/child health outcomes and the child's developmental trajectory. Evident from our study is the tenuous nature of establish- ing a therapeutic relationship in the context of vulnera- bility and stigmatization.

Teen mothers are unlikely to receive the attentive caredescribed by Stern (1995) as long as home-visiting inter-ventions emphasize fidelity to protocols over ope nness tothe diverse forms of knowl edge that make it possible fornurses to respond with compassion, skill, and flexibility tothe complexities of each clinical situation (Benner, Hoo-per-Kyriakidis and Stannard 2011). The study's findingssuggeste d that the therap euti c tools used in this interven-tion cultivated nurses' relational skills and clinical under-standing with narrative methods. PHNs' feedback alsoindicated that the therapeutic tools were well accepted andpromoted dialogue and clinical understanding.

Together these themes emphasize the importance of nurses' skill of involvement in two key domains of TB nursing practice: providing comfort and being watchful.

This study shows that public health nursesÕ reflection and reflectingrelated to their provision of client supervision revealed one possible assumptionregarding their theories-in-use; communication is a core concept in clientsupervision. Communication is viewed from a hermeneutic perspe ctive – as themeaning of the interaction between the public health nurses and the client in thesupervision is reflected upon and interpreted

Not stated explicitly within this article

Comments

Article discusses themes of power, marginalization, and how physical places relate to the development of therapeutic relationships with clients

Article themes include the building of trust and the nurses' place as community members

This article offers reflection of a registered nurse after a client tells her she loves her during one of their home visits. Topics covered include the start of the nurse-client relationship after the homeless and pregnant client agreed to participate in home visits from a public health nurse, the coverage of the home visits: the basics of pregnancy, labour and delivery, and the trusting relationship they developed over time. Discussed also are relational practice, boundary and transference.

This article outlines the scope of the nurse-patient relationship, what activity is considered to be outside the professional relationship and considers the consequences for community nurses if they are found to have breached a professional boundary.

This article summarizes the board staff recommendations for maintaining professional boundaries

This article offers guidance to nurses and provides examples f boundary crossing and how this places clients in a vulnerable position.

This paper describes the practices of community child health nurses in engaging the parent and developing a complementary and therapeutic relationship that enables the nurse to promote the health of the child and family. Published accounts of community child health nursing practice in the United Kingdom, Scandinavia and northern America are described and compared to the Australian context.

This article is not available via CINAHL EBSCO database. Journal not found

This paper focuses on hermeneutic thought as a framework for re-orienting public health nursing practice

This article discusses themes of power dynamics between public health nurses and new mothers

This articles discusses themes of power, building trust, and specifically the importance of empowering clients

Grounded theory was employed to elucidate how public health nurses (PHNs) develop therapeutic relationships with vulnerable and potentially stigmatized clients, specifically, single mothers living in low-income situations.We named the emerging theoretical model Targeting Essence: Pragmatic Variation of the Therapeutic Relationship, after discovering that although PHNs strove to achieve relational goals, their attention was primarily focused on the goal of ascertaining concerns foremost on the hearts and minds of mothers, and that PHNs had to accomplish these goals within short practice timeframes.The study's focused context elicited a nuanced explanation of the dynamic relationship-building process derived from subjective relationship experiences of PHNs and single mothers living in low-income situations.

Themes such as openness and communication strategeies are discussed in this article.

The author conveys her concerns as a public health nurse on the human value of kindness and its impact on the physical health and emotional well-being in children, youth, and adults. Topics discussed include the impact of media, technology, and cyber communication on young people's physical health and academic achievement, information on the Mindful Kindness program, and the increased concern about peer pressure.

Article Selected

Ackatia-Armah, N. M., Addy, N. A., Ghosh, S., & Dubé, L. (2016). Fostering reflective trust between mothers and community health nurses to improve the effectiveness of health and nutrition efforts: an ethnographic study in Ghana, West Africa. *Social Science & Medicine* , *158* , 96-104.

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Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., ... & Randel, P. (2015). The power of relationships: Exploring how public health nurses support mothers and families during postpartum home visits. Journal of family nursing, 21(1), 11-34.

Aston, M., Meagher-Stewart, D., Edwards, N., & Young, L. M. (2009). Public health nurses' primary health care practice: Strategies for fostering citizen participation. Journal of Community Health Nursing, 26(1), 24-34.

Porr, C., Drummond, J., & Olson, K. (2012). Establishing therapeutic relationships with vulnerable and potentially stigmatized clients. *Qualitative health research* , *22* (3), 384-396.

Bender, A., Peter, E., Wynn, F., Andrews, G., & Pringle, D. (2011). Welcome intrusions: An interpretive phenomenological study of TB nurses' relational work. *International journal of nursing studies*, *48*(11), 1409-1419.

Phelan, A. (2014). Examining the Synergy of Practice: The Irish Public Health Nurse's Potential From the First Postnatal Visit and Beyond. Global pediatric health, 1, 2333794X14553623.

Tveiten, S., & Severinsson, E. (2006). Communication–a core concept in client supervision by public health nurses. *Journal of nursing management*, *14*(3), 235-243.

Bender, A., Clune, L., & Guruge, S. (2007). Considering in Community Health Nursing. *CJNR (Canadian Journal of Nursing Research)* , *39* (3), 20-35.

Briggs, C. (2007). Nursing practice in community child health: developing the nurse–client relationship. Contemporary Nurse, 23(2), 303-311.

The nurse and client get to know each other so that suffi- cient common ground

Passage (Direct Quotation) From Article

Trust which in our paper refers to “confidence in the other's goodwill” (Ring and Van de Ven, 1992: 488) e has em
important factor un- derlying relationships between nurses and their client

Noting tensions between trust in community members' traditions around feeding and community nurses' messages
we highlight the reflective trust exhibited by mothers in our case study.
Mothers allow themselves to be influenced by nurses, who they perceive to be members of their communities (bec
relationships they develop with these nurses over time), as well as holders of “modern scientific knowl- edge” (Wa
162), who provide advice that, over time, they find is effective in their communities.
Yet, during our study, it emerged that community nurses e who are agents of the formalized healthcare system e w
influencing mothers' feeding beliefs, de- cisions, and behaviors
Mothers overwhelmingly pointed out that during post-natal visits, community nurses pro- vided them with informa
feeding, including nutritious foods for infants, and mothers “trusted” them regarding what to feed their infants.
Community-based Health Planning and Services (CHPS) nurses in Ghana are community-based public health nurs
deliberately incorporated traditional approaches, such as social trust customs employed by traditional healers to fa
relationship building, and have integrated an understanding of child feeding concerns and practices handed down f
into their practices (Binka et al., 2007; Nyonator et al., 2005).
As part of their reorientation, nurses live in these communities and strategically build relation- ships with the com
members and leaders (chiefs, elders, opinion leaders) by organizing health and nutrition discussions, pre and post-
home visits, peer educational sessions, and educational durbars for the whole community, including fathers and op
(Phillips et al., 2006). CHPS nurses also work with volunteers within communities who help with mobilization and
promotion among community members
Although we are unable to directly attribute trust building to CHPS nurses' training as we did not obtain detailed in
the training content (a limitation of our study), our findings suggest that community nurses who incorporated both
scientific knowledge engaged more effectively with mothers and built relationships of trust through repeated instan
interpersonal contact with them (Granovetter, 1985). Through this holistic approach, mothers perceived nurses as s
commit- ment to their children's wellbeing and development, which made them receptive to health messages, and i
feeding decision-making and behaviors.
Trust as driver of behavior in community models
As our findings show, the trust and authority of nurses' ideas also partly emerged from mothers' observations abou
that such ideas had in improving the wellbeing of infants in their community, consistent with a skill-biased model
Reflective trust lies in-between, and is distinguished from the other types by its emphasis on process (Adler, 2001;
2011). It is not purely calculated, but rather a combination of knowledge-based and affective factors, including em
and obligations, and is “generated through repeated interaction” (Gilson, 2003: 1456).
Thus, the goodwill, competence, consistency, honesty, or openness of a CHPS nurse may provide the basis of trust

Thus, the CHPS model provides useful empirical evidence of reflective trust and how it develops and becomes vita
encing mother's beliefs, decision-making, and behaviors related to feeding

Tensions: trust in elders' traditions versus nurses' messages

The quote above points to conflict between old and new ideas about infant feeding, as well as some elders' mistrust

The existence of identification-based trust does not occlude the other kinds of trust. This primary-caregiver pointed
mother's desire to feed her daughter complementary foods at six weeks old and her subsequent refusal. However, v
turned five months, she gave in. Her reluctance to follow tradition earlier on was suggestive of her trust in the nurs

This mother reported that her child was very healthy, was rarely sick and was meeting all his milestones, and she
the results to the nurses' advice. She also mentioned that she would not hesitate to follow the same advice with
child, as she was pregnant at the time of the interview.

We found that in the communities in which community nurses live and work, the nurses organize ante- and post-
hold peer educational sessions, home visits, health and nutrition discussions, durbars, and interventions targetin
munities as a whole, including fathers, opinion leaders, etc. They actively engage and partner with mothers in the
communities to address specific health challenges, including malnutrition as well as on non-health issues. Someti
conversations centered on farm yields, the children's education, politics, etc. Outside of working hours, nurses ar
attend social events in the commu- nities, all of which fostered deep relationships between mothers and nurses,
engendered trust

Our findings from the case in Ghana indicate that the CHPS model fosters trust that influences mothers' decision-
could lead to changes in health-related behaviors, particularly among marginalized populations.

Another participant, also working with a marginalized population, reflected, “every- thing hinges on relationships,”

Now I can’t walk down the street without some- body that I don’t even know yelling, “Hey, nurse!” . . . People that I’d
come to me and say, “I’ve known you for years because I’m part of this community.” . . . People know people I’ve help
watch how you relate to people. [They] will come back to you and say, “I remember when you did this and helped som
you realize that really what you’re doing is investing in a rela- tionship with a whole community that happens on a level
even aware of and it’s crucial. . . . It’s hard to articulate because it’s largely invisible and intangible.

Being in relation with clients, whether individuals, families, groups, or communi- ties, was characterized by mutuality, a
participation of clients, and shared power as appropriate to the situation

I think as soon as you start engaging in a relation- ship with somebody, my goal is to try to help them make that better
trick. I’m not mak- ing it better. I’m helping them make it better I hope. And sometimes it is you making it better beca
for whatever reason, or aren’t able to at the time.

I think a lot of times it’s because we didn’t . . . [in the] beginning check in to see what is it that these people or this pers
values and what is it that we value and what is it that we can do that will work with them rather than doing work that r
place in that person’s life or within that com- munity.

In a few instances where practice was more strongly characterized by a population-based approach, participants depen
least, on either relationships they had estab- lished in the community in previous PHN roles or the relationships they h
as citizens in the community.

It was really re- lating to him person-to-person, human-to-human, coming from very different lives and very different
But it was an equal sharing in that experience and learning from one another.
Similarly, the expertise of clients might be sought when preparing educational mate- rials, resulting both in a better pro
bolstering client's self-worth
Basically we were saying to women, "You gals are the experts here and we want to help people be safer when they use
your advice." And so they both helped create a useful pamphlet that we could use in practice but the process of doing
them feel as though they had something to contribute and that they had something to teach us
"The advantage that public health nurses have is we're in the homes, we're in the community, and we see what's happe
we've got that knowledge base to move it up."
We have such a breadth of knowledge about com- munities and how they work and interact right from the grass roots
having the experi- ence of being in an individual's home and seeing what's going on and what the stresses are. . . . to th
different agencies and how they communicate with one another, . . . working with a municipality, looking at the broad
then relating that to how . . . [it] impacts people throughout the life span.
But [my mentor] taught me you can hang out and sit and let people talk to you and you listen. And she fortunate
valuable work." . . .
The self-awareness to which the afore- mentioned participant referred was a com- monly identified prerequisite to ente
engaging in a previously estab- lished relationship
It might be one person who starts talking about her baby. It might be another one who starts talking about her homela
be [that] you notice something on the person's clothing and make a comment. You never know where those are going
And it's not engineered. It's genuine and creative.
Par- ticipants had different opinions about what the latter meant—some spoke of being care- ful not to power dr
dressing mindfully of socioeconomic differences but others be- lieved as long as respect was shown, dress did no
I have size 10 feet and so I'd put on these little slip- pers and I remember this one family and that was the breaktl
moment! They were laughing at me and my big feet hanging over. . . . If people knew some of the things that we
lationships, whether it's eating pigs' hoof stew or other things that we do because that's how you gain the trust a
able to do our work with communities.
"It's a two-way kind of street. One asks a lot of private ques- tions and it's a balance of power to be able to have inforı
that way."
But more often, trust developed grad- ually over time and by meeting the immedi- ate needs of people, as in this exam
the participant describes her evolving relationship with Tent City, a community of homeless people that grew over tim
people
[S]he didn't talk to me for the longest time but I would see her and I would acknowledge her and say hello. . . . I knew
interested in talking to me. . . . [T]his went on for many, many months. And I would give her the odd cigarette and say
like, "Thanks a lot for cleaning up the parking lot. That really helps a lot." So we had a little bit of a relationship that w
much but just daily sight. And then one day she approached me and she said, "So you're some kind of nurse, right?" A
"Yes, I am." I thought I was going to get a tirade 'cause I was the enemy. . . . But she said, without looking at me still .
Modicaid injections?" And I said, "Well sure, I can." And she says, "Would you give me one?"
One aspect of respect was honoring the belief system and cultural practices of indi- viduals, families, and communities
times, were in direct conflict with the partic- ipants' belief systems.

[In the] beginning one has a little window of op- portunity . . . And then just kind of quietly talking, . . . asking wha
concerns are, how is that per- son, and then it just builds up from there. . . . [She describes a visit to a Mother an
who had
been referred to her and asked the Mom] "What are your concerns?"

Assessments often took place in the mo- ment. One participant recalled being part of an H1N1 immunization clin
was approached by a man who disclosed to her that he had AIDS, was facing surgery in 10 days of which he was f
needed to talk. She remembered thinking, "Oh my good- ness! There's so much going on around me and this ma
talk."
One of the strengths that participants be- lieved they brought to individual client situa- tions was their knowledg
community and its services and resources that might be useful to individual and family clients.
to describe the process and their role in it. Some expressed discomfort with too great a focus on needs and goal
could be experienced as top-down and controlling. They preferred speaking in terms of a strength-based approac
We use the English term 'facil- itator' which means to help. In French we use the term 'animateur' which means bring
life."
I feel very privileged to kind of walk with people on their various journeys and one of the things I love about bein
that you get to know people intimately and you get to know things about them that you don't normally get to kn
strangers
I cannot believe in the spiritual, mysterious and existential dimension piece. Not part of who I am . . . [and] it's not par
practice at all though I would use the word intimacy. You develop an intimate relationship. And some people might ca
some people might call that spiritual, mysterious, but I call that intimacy
As reported earlier in CHPP II, relationships with clients were equated to PHN effective- ness. It was not surprisin
that par- ticipants believed their effectiveness was lim- ited when changes rendered relationships no longer poss
whose practice had be- come more population-based saw a problem in being "based in an office and not out in t
community."
A number of examples provided evidence that power was being shared between nurse and client on a situationa
established basis.
Consistent with participants' descriptions of practice, nurs- ing care that occurs within these relation- ships is gro
unconditional caring presence, openness and perseverance in al-
lowing action possibilities to emerge."
Client centeredness occurred within the context of mutuality and there were in- stances, such as with the Health
initiative, where PHN expertise was clearly critical in planning the best course of action
In practice, meeting needs and build- ing capacity often occurred simultaneously; moreover, these activities often led t
formed political advocacy
PHNs described attributes such as "being yourself" and interacting with mothers "at their level" along with the n
to present themselves as a person first and foremost and not necessarily approach the relationship only as a mo
nurse–client clinical interaction. Mothers noticed the difference in how the PHN related to them on a personal le
often characterize their relationship with the PHN as "friendly" and repeatedly described their PHNs with terms s
"approachable," "bubbly," and "polite."

PHNs' general persona of approach- ability and openness seemed to help ease concerns and hesitations that a m
have experienced prior to their home visit. However, upon closer examination, the practice of being friendly was
personality trait exhibited by PHNs during home visits. For all of the PHN's in this study, it was considered a neces
practice or strategy they specifically used to engage with mothers as they worked to establish collaborative thera
relationships.

They described, either directly or indirectly, that a large part of their relationship development was centered on s
power dynamic that often tradition- ally or historically existed between PHNs (or any health care professional) ar
I'm not going in there as an authority figure [. . .] and so it makes them feel more comfortable [. . .] so if I want
they're more willing to have me back. Or if I'm going to introduce a program, they trust me enough that they're v
the next step to do that program.

The majority of PHNs spoke about how they recognized the perception of new mothers who may see them as a per
position of authority who might judge them. Because of these potential feelings of discomfort or fear, most of the I
about how they always attempted to shift the relation of power in the relationship and encourage the mothers to fee
had more "control" and choice

During home visits in both the targeted and universal pro- grams, the mothers were encouraged by PHNs to lead
which clearly shifted the power dynamic

So that's the wonderful thing about Public Health Nursing is that when you go in, you don't have a set agenda. An
a checklist but you don't go in like okay, I have to do this A to Z and out the door I go. The reason I say that is bec
to meet mom where she's at

The majority of PHNs believed having a set agenda created a relation- ship that was dominating and potentially o
a mother. They told us that delivering a prescriptive agenda would contribute to a negative rela- tionship betwee
and the mothers. Therefore, the majority of PHNs preferred to follow a health discourse that was client-led

However, the PHNs in this study identified the importance of attending to mothers' feelings to build a therapeuti
effective relationship that could lead to positive health outcomes.

PHNs fully acknowledged the unique and changing needs of mothers and allowed the mothers to identify their ov
and stressors and organize the visit around the mothers' understandings

We reassure them. We offer that feedback that you're doing a good job, you know, or this is not going the way yo
but you couldn't have done anything about that. It's the propping up that people need sometimes when they're g
a difficult time. Because there's nothing more difficult than that role adjustment and that physical adjustment in
even if things go well

It is important to note that the strength-based interactions described by the PHNs and experienced by mothers in
programs were more than just positive interactions. It was the way that PHNs purposefully chose their words, tin
interventions, or assessed a mother's readiness or point of view.

The development of these relationships clearly included shifting the relations of power that have traditionally po
PHNs as a perceived negative and hierarchical authority figure with power.

Another important aspect of building effective relationships between PHNs and mothers was evident in many of
interviews as they spoke about how the PHN was very respectful to them, their babies, and family with many exa
centered around breastfeeding.

she showed me a lot of respect. I found she was very respectful and very . . . you know, especially of your privacy
Like she would say, you know, "If you're uncomfortable while you're breastfeeding, I can give you a blanket or I c
something." And it seemed that she was always aware of how you're feeling

For example, PHNs “asked permission” to help with breastfeeding.
It was I’m here to help you and make sure you’re comfortable and that you feel comfortable as a mom and confi
was like they try and build the confidence for you to make sure that you know what you’re doing. They give you t
to have the confidence. And otherwise I wouldn’t have had a lot of that. Like in the beginning, I was so shaky
In other words, we needed to understand the meaning attributed to friendly. It appeared to be a very important
mental aspect of the relationship as well as the practice of PHNs that then led to positive health outcomes.
Using the lens of feminist poststructuralism allowed us to analyze how the “friendly demeanor” of PHNs was inst
navigating power relations between PHNs and mothers that ultimately led to positive interactions, thor- ough ass
and positive health outcomes that were expressed by both PHNs and mothers
The PHNs and mothers in this study clearly articulated how being “friendly” was an effective strategy that led to
relations and ultimately positive health outcomes for new mothers
The consistent message, spoken by both PHNs and mothers in this study, was the overwhelming importance of dev
supportive relationships that were non-judgmental, friendly, and fostered trust
Citizen participation is heralded as a critical element of community health programs that emphasize empowerment
promotion strategies

Full citizen participation attends to client values, interests, and concerns, with citizens having the right and duty t
participate in and be in control of assessing, planning, implementing, and evaluating their health and health care
individually and collectively
Public health professionals in Canada have historically been concerned with establishing pub- lic policies that add
and environmental conditions that deny access to health care/ services

Public health nurses have more than a century-long legacy of addressing broad inequities in health and building c
people who are disadvantaged by their life circumstances (Reutter & Ford, 1998). Their practice focuses on vulne
populations, issues of social justice, and em- powerment (Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic, &
Edwards & Davison, 2008)
The central tenants of primary health care support a *provider-as-partner* role with lay persons and other health pro
characterized by reciprocity and equality in the levels of status, control, and responsibility be- tween the professior
person
Other important concepts related to citizen participation and empowerment can be found in Kretzman and McKn
discussion of asset-based community development that fo- cuses on strengths of communities as well as Freire’s
on critical consciousness and trusting relationships. Similarly, Jackson, Cleverly, Poland, Burman, Edwards, and Ro
(2003) developed a model that focused on strengths and assets of community members within a socio environm
They noted that the empowering process is contingent on the attitudes of professionals toward local knowledge
experience, and the quality of com- munity involvement that the professional encourages

Furthermore, overcoming disem- powerment includes professionals’ ability to understand and shift their power rel
their communities.

Byrne (1998) conducted research with nurses who facilitated an empowerment group with people experiencing me
and noted that there was a shift in the nurses' practice from *doing to* to *working with* .
Falk-Rafael (2001), in her qualitative study of public health nurses, identified a client-centered approach that incl
relationship of mutuality and trust as central to their practice and consistent with an empowerment process.
Building capacity for partnership and citizen control emerged as a meta-theme from descrip- tions of the nurses'
individuals, groups, and communities. Many of the nurses talked about the importance of making a difference in
lives that focused on doing with rather than doing for, so the clients themselves felt empowered to take ownersh
health deci- sions.
All participants spoke about how their role had shifted in the last decade from a more singular fo- cus on individu
population-focused approach. This required a shift in thinking by the nurses, as well as by the clients and instituti
whom they worked. The nurses described try- ing to encourage teachers and students, to think from a populatio
health perspective in contrast to the historical one–on-one interactions.
You try lots of different ways to get that message out, and if it means being involved in community group things, f
on an advisory committee for the teen health centre and making it so that they don't call it a "teen clinic," they call
health centre because we don't do any band-aid stuff [anymore
Many nurses described how working with individuals and families required attending to social determinants of h

With a focus on citizen participation and authentic partnerships, all nurses noted that they used strategies such a
from the client's perspective, tuning into client readiness and imple- menting a holistic assessment

All the nurses repeatedly stated that building an individual's or group's capacity to take control over their health
health of their community starts with a mutually trusting and respectful relationship between the client and the h
professiona
Most of the nurses spoke of the need for a balance of power in this relationship, one in which the nurse saw herself
more egalitarian approach and strove to shift the balance of power away from the *nurse as expert* and include the c
perspectives, and ideas.
They used several strategies in exercising a provider-as-partner role: engaging in respectful dialogue and active lis
believing in clients' capabilities and focusing on their strengths; and creating a safe, welcoming and accessible en
As one nurse stated, "The important thing is trust. Trust is incremental. It comes in little waves. If [a] mum's havi
with her breastfeeding, you just build gradually upon it. But it works only if you have trust.
Many nurses across all programs stated that it was important to establish a partnership where the nurse truly be
the client could make their own informed decisions, as well as ac- knowledge the hierarchy between expert and c
often exists and work to reduce the tradi- tional power imbalance in the relationship between client and health c
professional.
Most of the nurses maintained a long-term relationship with several of their clients, and many stated the importanc
ability to build rapport with their clients. These were the basis for strong trusting relationships and allowed them to
beyond the surface of a client's situation. As one nurse stated: "But you know the day to day work with clientele [i
users] and establishing the relationship with them and gaining their trust, all those things take time."
Many nurses established collaborative relationships with the schools by getting to know the teachers and promotin
as resource people and partners at staff meetings.

The nurses identified confidence and skills as two key outcomes of building relationships with in- dividuals and gr
then had the potential to lead to empowering citizen participation.
trategies included supporting people from marginalized populations to participate in various de- cision making gro
with the clients' strengths, and giving positive feedback, or *affir- mation* , on what was working well.
Most nurses, in all program areas, expressed a need to seek out the voices of vulnerable individ- uals and groups w
previously been excluded from decision-making processes. They sought input from the less empowered populatio
encouraging them to have a say in setting directions and make decisions about their own issues and health concern
those living in poverty, and isolated moms were examples offered. Several nurses spoke of the need to take these v
ously throughout decision making processes
Most nurses started with the client's strengths, encouraged them to voice their concerns, and gave positive reinforc
these helped to build confidence
hey sensed opportunities for more group ownership, and they stepped back from the process, giving space for cl
the lead

A more prominent educational role was revealed in the nurses' use of process-focused meth- ods. This approach
asking questions, providing information, and discussing possible next steps as a way of building the client's decisi
capacity
The nurses described starting where the client was at, creating open dialogue, and listening to client needs. To ill
If they don't have an interest in what you're doing, that whole adult education type of thing, or if you're not com
where they are, then they're not going to learn anything. They're just not go- ing to come, or not going to be the
going to take advantage of the information that you have.

All of the nurses reported actively connecting individuals and groups to broader social networks.

To accomplish this, many nurses indicated that it was important to know community needs, as well as available p
services. For example, they had established relations with com- munity services and family resource centers.
Tapping into the strengths of clients was a com- mon thread throughout many of the subthemes, that was understo
empowering, client fo- cused, and located in a population health promotion framework.
Most public health nurses described their knowledge and ability to make connections happen for their clients as
skill

So you have to go to your community, to the grassroots, to be able to get community support. So that means goi
women's groups, going to the men's groups, going to church groups, going to your community health boards, an
who are the movers and shakers in your community.
Most people in my area, they're still a lot of people that don't know we're not coming in to put a band-aid on, and
only understand nursing as that. And that, all by itself, is a bit of a barrier. Education isn't seen or valued, as the re
care, in caring for the sick as opposed to helping people learn how to keep themselves well. So education on all lev
population to the government.
The relational work between clients and public health nurses created empowering processes whereby citizens were
par- ticipate in assessing, planning, implementing, and evaluating their health and health care
Building trusting relationships, confidence, and skills was integral to the empowerment pro- cess.

Caring and trust (Schulte, 2000) are facilitated through mutual relationships that involve negotiating a more equi balance

Our findings are congruent with the model developed by Hardina (2003). She specifically highlighted mutuality ar social justice, focus on vulnerable populations, inclusion of personal and social levels, and organizational support f professionals to foster empower- ing relations with communities.

Creating participatory infrastructure was suggested by Sadan and Churchman (1997) as essential to lay the ground partnership. S

Similarly, Moyer et al. (1999) found that capacity-building activities between public health nurses and elderly clie identifying common ground, working cooperatively, working in partnership, and working across the community.

This study adds to the limited research that highlights the often invisible work of citizen partici- pation by public h (PHNs). The practices of PHNs that focus on strengths, trust, affir- mation, partnerships, and clients' perspectives all provide unique evidence to sup- port how PHNs foster citizen participation through empowering relations.

Our study offers many examples of how the nurses fostered citizen participation by acting on the determinants of h implementing strategies to achieve longer-term health outcomes. Their empowerment vision of primary health care as linking agents between clients and a broad range of services especially for vulnerable populations

Public health nurses act as initia- tors, community planners, collaborators, enablers, educators, and advocates in th empowerment process.

The first two stages (projecting optimism and child as mediating

presence) broke through the LISM's walls of defensiveness by means of the PHN's friendly disposition, verbal pra on the child, and increased the chances for rapport.

Ascertaining motives was the third stage, during which the LISM solidified her trust in the PHN, and was a critical the relationship-building process.

So too was exercising social facility, the fourth stage, wherein we witnessed the PHN's capacity to know when an probe into sensitive subject matter without threatening the LISM.

he final stages (concerted intentionality and redrawing professional boundaries) promised a deeper level of conn because the PHN privileged the unique concerns of the LISM, and facilitated the LISM's innate capacity to pursue determined goals.

The PHN and LISM established a therapeutic relationship by the final stages and for an indefinite period of time b was no formal closure.

Projecting optimism was the critical first stage of estab- lishing a therapeutic relationship. The PHN set the tone d initial moments of the encounter with two interactional strategies: engaging positively and offering verbal comm

Engaging positively. From the outset it was imperative that the PHN exuded what mothers described as a "peppy "chipper" disposition. LISMs explained that the happy, friendly demeanor put them at ease. "Friendly" was exhib nonverbal communica- tive behaviors of the smiling face, eye contact, relaxed body posture, and soft voice qualit to loud, harsh, or stern.

I think I liked Laverne [PHN] because she was friendly. Like she really, to be perfectly honest, had this thing about reminded me of an old hip- pie woman. I really liked that. I liked her because she was laid back and friendly. I like thing about her, and she was always positive

An essential property of this first stage was that the PHN's enthusiasm was authentic, that there were no "crocod suggestive of insincerity. It was important for initiating engagement that the PHN's overall mood revealed a joyfu was congruent with her facial displays of happiness and her verbal enthusiasm.

Offering verbal commendations. The PHN then attempted to draw out and acknowledge the LISM's maternal strengths in and measure they happened to appear or which the PHN could discern. Her commenda- tions might have been what she terms of maternal–infant bonding, the "little connections" that were "positive strokes but that the mom might not even no example, she might have affirmed mothering behaviors by saying, "The baby already knows you. Look how well you cuddle boy she settles down when you pick her up." Verbal commendations were most effectual when the PHN's praise did not to superficial flattery but was more in keeping with concrete manifestations of quality parenting practices.

Child as focal point. Acting on the assumption that a mother's love for her baby is "universal," the PHN ador- ingl the LISM's new pride and joy regardless of how unfavorable circumstances might have appeared. Julie (PHN) poi all mothers wanted to do what was best for their baby. Referring to her clients who were former prostitutes, she know what, they all care." Despite what Julie described as their "bad" lifestyle choices, "they all still want to be a that baby, like there is still that maternal piece."

What was deemed a satisfactory visit depended on the mother's assessment of the quality of the PHN–child inte how much effort was put forth "getting to know" her child. Benchmarks included the extent to which the PHN "c her child, displayed interest in her child, "played" with her child, made her child "feel comfort- able," "talked" to "remembered his name." We learned that if PHNs behaved in a perfunctory, imper- sonal manner, and ignored t they sabotaged the opportunity for rapport.

Among mother participants was a predominant propen- sity for mistrust, and thus it took more than smiles and v to assuage the mother's fears and to convince the LISM that the PHN could be trusted.

Mothers during this stage were afforded an opportunity to assess the PHN's "real" intent

To trust or mistrust. Mothers shared that they learned to mistrust human service workers, agency personnel, and officers when they were young. Diane (LISM) remembered being told as a child to "be scared of social workers or stuff like that." When the PHN

showed up at her door on a routine postpartum visit, Diane was fearful: "I was really, really nervous. I thought sh to try and take my baby or see if I was a bad mom."

Mothers like Diane, who as children were taken out of their family home and placed in foster care, learned that the not a safe place, and if people in their nuclear family and in systems of authority were unpre- dictable and undepen could be trusted? In response, mothers "watch," explained a social worker: "They will read you as soon as you wa that is, where you are, where you have come from, what you do, whatever." LISMs wanted to ensure that the PHN trusted not to render judgment.

The litmus test. If the LISM remained uncertain, she would continue to ponder: What are the PHN's unspoken wo me? What are her innermost thoughts concerning me? Do I want to share anything with her, or do I just want to think she is looking for and then leave? Lacking sufficient information, the LISM relied on cues, hints, and express as substitutes for factual knowledge about the PHN's thoughts and feelings. However, the cues were inade- quat necessitating that LISMs implement the litmus test to judge the PHN's motives accurately. The litmus test entaile posing certain benign questions to the PHN and then evaluating the PHN's returning ver- bal and nonverbal comm the PHN met the mother's expectations, then the LISM was more apt to delve into topics of a personal nature, ar engagement would proceed with far more real disclosures on the part of the mother than polite, conventional di

It became apparent that the PHNs had acquired an advanced skill set that we believe parallels social intelligence (Goleman, 2006). Empathic accuracy and responding strategically enabled the PHN to maneuver her way through interaction in such a way that she could pro- ceed to probe more deeply without threatening the LISM.

Empathic accuracy. Empathic accuracy was a combi- nation of the PHN's spontaneous ability to detect the mothe facial expressions, to sense her emo- tions, and to be cognitively aware of what the mother was thinking and feel (LISM) believed that the PHNs who had contributed to her overall well-being were those who could "actually rea person is not looking themselves." She explained, "If their facial expression looks different then they [PHNs] will a what's wrong, if they [mothers] want to talk about it they [PHNs] are there to listen."

Responding strategically. After the PHN was confident that she had accurately perceived the LISM's emotions, th feelings, the PHN then decided how she would respond. Responding strategically involved the PHN fine-tuning he communicative behaviors to ensure that they were appropriate and effective.

The antecedents to empathic accuracy included the PHN's comprehension of the mother's multiple chal- lenges v social environment. The antecedent to responding strategically was the PHN's respect.

Much was realized through the interactional strategies, painting a new canvas, eliciting the client's agenda, and b capacity in terms of finding out who this LISM was and what she needed and wanted to fulfill her mothering resp

Painting a new canvas . The PHN moved from universal understanding of a lone parent in poverty to this particu- lar person before her "like starting with a new slate.

Building capacity . Mothers early on, during the first stage, would have been recognized for their strengths in terms o competencies. Building client capac- ity entailed the PHN bringing forward those earlier allu- sions of maternal se enhance and optimize the LISM's competence and positive functioning. The PHN extended the strengths-based ap tailoring it to accommodate the mother's personhood and unique circumstances.

Assuming pseudo roles. Assuming pseudo roles reflected the PHN's continuance as mediator between the broad network, resource access, and the unique needs of the LISM as a kind of social worker, advocate, mentor, or coa with LISMs involved considerable effort to ensure that even the most basic physical needs were met. Julie (PHN) she assumed the role of social worker because

with this job you need some health background, but you have to look at health in that bigger picture, all the dete health. If someone has no food and no place to sleep, it's really hard to get them to think about the other pieces

Sharon (PHN) acknowledged that occasionally she struggled because, she explained, "You want to be doing every some of these moms, at least trying to help them out as much as you can. Your role only goes so far." She found keep that line straight between PHN and advocating as social worker, because "with some of these moms" she w "offer them more resources, more tangible things" that extended beyond her "bounds as a PHN."

The PHN had been addressing concerns that just as well could have been or should have been carried out by a fri mother's partner or family members. What culminated by this final stage were some LISMs seeking to fill a social causing PHNs to, again, revisit and redraw their professional boundaries.

Poverty stigma is widely prevalent in Canada (Reutter et al., 2010). Participants in our study acknowledged that t or had experienced firsthand the stigma associated with the LISM status. Some mother partici- pants attributed b and living on social assis- tance to personal character flaws, and felt that people "looked down" on them. Many h level of stigma consciousness

Achieving a therapeutic relationship with LISMs can influence how mothers think about themselves, their situatic parental competence, and can optimize maternal/child health outcomes and the child's developmental trajector from our study is the tenuous nature of establish- ing a therapeutic relationship in the context of vulnera- bility a stigmatization.

‘Welcome intrusions’ characterizes the nature of TB nurses’ relational work and its inherent tensions, which resist
interpretations.

At the level of embodiment, the effects of TB are an intrusion—physiological as well as social. Added to this disru
intrusion of the Public Health Department with its authority over individual lives in matters of contagious disease,
manifests concretely in the nurse’s immediate presence. This encounter is the pivotal point in relational work.
‘‘That’s part of my job. On the one hand, I’m setting up all these things, helping him out. But on the other hand, he
I’m kind of the bad guy in that, ‘if you don’t comply with this, this is what’s going to happen’, that sort of thing. A
be difficult; I don’t necessarily want to be perceived as the bad guy . . . it’s much easier to be the person who’s hel
But usually over time and through regular daily visits, intrusion fades to the background, and what formerly was
as intrusive visits by a public health official shifts to non-intrusive and even welcomed meetings with a familiar pe
clients, feels more like a friend.
Offers of food and drink were common in most visits, and there seemed to be an unspoken understanding that a
things was not a breach of ‘professional boundary’ rules. To accept such could be a formal gesture conveying acc
client’s efforts to welcome and/or a completely informal part of ordinary exchanges.
An obvious goal of surveillance is to physically observe the client. Yet once inside the home, only focusing on surv
might create negative consequences in terms of gaining future access. All nurses experienced this phenomenon,
as ‘‘getting through the door’’ and ‘‘what gets you through the door’’. They were aware that how they entered th
significance in terms of reinforcing the intrusion or diminishing it. Part of the goal of each visit therefore was to b
back.
From clients’ perspectives, deciding to open the door to the nurse seemed to be a way of maintaining their own
power in the situation.
‘[If] you don’t create that environment of friendship or, relationship . . . what I can say?, you are likely to get chal
because I might even decide to harass you, might even, like, you come, you are knocking on the door, and I don’t
like, ‘oh god, she has again come’.’’

Getting through the door then is a sign of some level of acceptance or welcome. Tangible incentives help with thi
grocery vouchers and public transit tokens), yet it was the nurses’ respectfulness, trustworthiness, and preservat
that seemed to have a stronger influence. Getting through the door involves respect for clients’ homes by taking
waiting to be shown where to sit, and even continuing the visits under the distracting conditions of the house, su
telephones, and loud televisions. As clients feel respected, trust also develops as described by this nurse

‘‘I think it’s a trust thing. Because I’m going into their house, they’re not coming to my office. I’m on their territor
makes a relationship work is based on trust because once a patient trusts you, they take your advice ... I’m in the
they’re trusting me with being in their home. And also I’m trusting them being in their home.’’

''. . . people say, 'well, why are you meeting this person in the parking lot?' And then you kind of tell little white li
introduced me as a nurse he met in the hospital because they knew he'd been sick in hospital the year before, ar
struck up a friendship... So then you kind of go with the flow... You have to be careful. People, wherever you're g
identifying you as somebody regular.''
In short, getting through the door involves respect, trust, and sometimes, a kind of honest dishonesty, the neces
inseparable dimensions of not intruding too much. Client privacy is central in order for nurses to be welcomed in
of surveillance, and getting in the door leads to ''doing TB''.

Being watched under surveillance, according to most participants, was infantilizing for clients and the nurses' aw
such potential feelings was a key facet of their observation skills.
There are many situations in which support, not the TB medications or isolation strategies, was the focus of visits,
Leslie explained:
''Just doing TB, giving the TB pills, that's such a small part of it. The rest of it is support. Because TB does have t
and they're afraid of it or they've come from a country where they've seen people die from it. And so you realize y
objective is much bigger. Your scope is much bigger than just watching them, making sure the right pills going at
. . or monitoring for symptoms and that kind of thing. It's really about how they're feeling, and about how you're g
them get through the whole thing.''
And then she told me that 'the medicine you are taking is this strong or that. . . and after some time, the reactions w
less. . . . that is the main reason why I somehow kept on taking the medicines. Otherwise, I would have seriously s
had she not come or had she not been so friendly, I would have found some way to throw out the medicines.''
The stigma of TB was a significant concern identified by most participants as myths of TB continue to abound soc
contagiousness to personal moral judg- ments. Three clients shared experiences of how the TB label affected their
relationships, including family, friends, and roommates who cut ties with them when their TB diagnosis was revea
addition, TB care is often complicated by other serious health concerns that tend to carry their own stigmatizing so
meanings. Several clients in this study were also dealing with HIV, diabetes, mental illness and addictions

The theme 'beyond a professional' addresses the ways nurses and clients get to know each other over the long c
treatment, and include subthemes of socializing- with-purpose, knowing the person-in-place, and cultural learnin
According to clients, their nurses were ''beyond a nurse''; ''like a friend''.
Nurses talked about being firm, setting limits, and having clients understand their role.

''Nobody gives you a whole book before your first home visit and says, 'ok, in [this] culture, don't do this, this an
this', right? So. . . you have to laugh at yourself because it's like, 'oh nice to meet you I'm here to help your wife'
as if shaking a hand]. 'Oh, no m'am. We don't touch the females' hands' [Takes a big gasp. We both laugh]. . . An
how stupid do I feel; now does my patient feel I'm making a pass at her husband or what?' So it's hard sometimes
that's why I'm so eager to learn. Because I'm thinking, the more I know about their culture, the more I can also rel
also relate to me, if they know that I'm making the attempt to learn about them.''
Although their role is to monitor TB treatment and connect clients to resources, as TB nurses become more perso
with clients and their situations, they often take up other concerns which could be argued academically as not wi
professional responsi- bility.

Benner et al. (1996) suggest that forming a relationship in nursing is often seen merely as based on personality o than on particular knowledge and skill that develop with education and experience (p. 242). Relational work for t is, instead, a kind of involvement that includes social exchanges, negotiation, and ultimately a connection betwee client that creates possibilities and enables change. Specifically, the skill of involvement refers to integrating und the disease, the client's interpretation of it, and the client's life context, and responding in particular situations to problem at hand and the person (Benner et al., p. 90). Nurses do this by listening and being attuned to clients as reflective about their own feelings

Emotional engagement with the clinical problem is paying attention to ''vague or global emotional responses'' w not have a good clinical grasp in situations, or acknowledging gut-feelings as a sign of not fully understanding the (Benner et al., 1999, p. 15). Such emotional cues are an indication that adjustments in perspective are needed fo understanding the problem or that different approaches to better appreciating the situation must be tried. Emot engagement with clients involves responding compassionately to them as people.

As nurses engage in better and worse situations with clients, in being too close and too distant, over-stepping and r far enough into personal lives, they sort out the appropriate level of involvement in each relationship and situation Notably, engagement may be required with clients considered noncompliant or difficult, which means withstand (one's own and the client's) such as frustration, impatience, or anger, and staying open to the cues they offer for perspectives in understanding.

Proximity, or how close nurses get to clients physically, emotionally, and morally (see Malone, 2003), is an import consideration in developing the skill of involve- ment as it draws attention to the fact that emotional engagement w persons potentially has both effective and problematic aspects. The perils of proximity (Peter and Liaschenko, 200 that by emotionally engaging with the person in particular locations and circumstances, the nurse opens herself up anxieties.

Likewise positive emotions elicited in care-giving moments with likeable clients can pull nurses to being too close involved. Lack of recognition of this distancing or extreme closeness is problematic because either level of involv shift the center of concern away from the clients' needs toward the nurses'. It is in recognizing and reflecting on proximity, and through trial-and-error, that nurses learn and develop their skill of involvement.

Comforting means ''to strengthen, aid, and encourage, as well as to soothe and console'', and the need for it con experiences of distress, loss, or suffering (Benner et al., 1999, p. 244). Because comfort means different things to people, providing comfort is an uncertain practice. It depends on timing, trust, cultural knowledge, openness and In the context of public health, being contagious is part of the suffering experienced by clients. Providing comfort particularly important for diminishing feelings of stigma and alienation. Contagiousness also implies the need for with regard to physical closeness and distance. With this in mind, choice about one's proximity in client meetings important aspect of comforting. As seen in this study, getting up close to infectious clients, offering a quick greet masking, or sitting next to them, goes far in sustaining a sense of trust and being cared for.

Providing comfort also depends on discerning how to be available without being intrusive (Benner et al., 1999, p. 273). This means recognizing when one is too close and clients' indications of withdrawing or distan- cing themselves (Benner et al.). Yet, by law, TB clients cannot refuse isolation when the disease is active, and therefore cannot choose to withdraw. Providing comfort in this sense do entirely address the surveillance reality of TB nursing practice.

Nurses may want to respect clients' signals of withdrawal, thereby comforting them, but the situation of surveilla
treatment adherence may demand that they remain present, keeping clients in view.
Indeed nurses' power in ensuring adher- ence can contribute to a feeling of intrusion for clients.

A stance of watchfulness does not require always directly staring. It thereby can convey respect for the person's
while under the surveillance of Public Health and diminish the sense of being scrutinized
A fundamental differ- ence in home visiting is that the PHN is a guest in the family's home and should always resp
that families have their own internal commitments and self- determination.

Consequently, a phone call to arrange a time demonstrates the belief that the family requires respect in terms of ne
visit time, but also raises the probability of successful access to the home.

The initial family encounter with a health care profes- sional can be a difficult experience.22 Therefore, meet- ing
the first time requires well-developed, careful communication strategies to continue access and promote positive
partnerships. Often, the first postnatal visit can reveal how families struggle with a first or subsequent baby
Communication is tailored to facilitate age and understanding; thus, conversational styles and nontechnical term
clarity.
Thus, health chal- lenges can be explored openly and the PHN employs a cooperative partnership that evokes the
ideas about health and emphasizes autonomy. As a result, either the family as a unit or individual family member
self-efficacy to initiate change
An important element of communication is the abil- ity of the PHN to reassure the family and to be respon- sive to
presenting realities. Central to this process is a nonjudgmental attitude that demonstrates uncondi- tional positive r
empathy.
Rather than being constructed as the "expert," the PHN's interactions focus on building up family members' conf
ing support, making suggestions, and discussing possi- bilities for partnership with family members. Another imp
element of communication is self-awareness, which has been identified as a key component in under- standing w
interactions are challenging
For example, linking families to com- munity support groups has a positive impact on adjust- ment to new roles a
extend social contacts.

Accordingly, careful listening and empathy are important competencies for PHNs so that cues may be identified r
appropriate, real- istic goals being articulated in collaboration with the family.
Inherent in this therapeutic conversation is the need to acknowledge the normality of finding parent- hood challe
empowering parents to overcome challenges.

Social support is also an important aspect of adapting to motherhood and in particular grandparents, peer-mothe
various community supports

The PHNs in this study tried to build a trusting and dy-namic relationship with their clients through confirmingand them, sharing thoughts, experiences,reactions and knowledge, and respectfully approachingthe client at his/her

One of the PHNs reportedthat she was satisfied with the dialogue with the clientbecause she Ôconsidered that th secure, andthat the atmosphere was safe and trustingÕ

To have a dialogue, to reflect together, to listen tothe client's needs, problems and concerns seemed to beimpor PHNs.

important to the PHNs. To listen to the client in order toreally understand the meaning of what he or she ex-pres supporting, confirming, teaching andchallenging the client in accordance with his/her needsand expressions was important by the PHNs

Furthermore, the PHNs found it important to baseclient supervision on familiarity with the client and his/her con

The findings showed that the PHNs regarded theclients, be they children, parents or young people ,as the subject supervision. This indicatedthat the concerns addressed were based on what theclients themselves expressed or r response tothe PHNsÕ questions, as illustrated by the followingquotation: ÔDuring the dialogue, the client herse what she needed and what she thoughtabout it, I did not provide her with a solutionÕ.

Thus, the PHN s werewilling to support the clients, which the followingstatement also demonstrates: ÔThe moth topostpone the vaccination and I found it important toback her up in this regard. I think it is best to meet thepare as far as possibleÕ

The findings showed that, when performing clientsupervision, the PHN s often had to look beyond thecurrent situ order to deal with the client at his/her own level and to identify needs and problems.

My job as a public health nurse is to preventdisease and to promote health. The point is how to. focus upon this, same time supporting theclient, relating the topics in the dialogues to research-based knowledge and conducting whichincludes reflecting wi th the client and not acting as anexpertÕ!

The PHNs stated that the aim of their supervision wasto contribute to strengthening the clientsÕ coping ability.

ÔThe mother leads the dialogue between us ,but I lead too. I had planned what to focus upon in thedialogue witl but at the same time Iwanted the mother to feel that we focused on issues thatwere im portant to herÕ! This qu shows thePHNsÕ sensitivity and attentiveness to client concerns.

Thus, sheshowed the parents that she believed in their ability tomake decisions and, although she was an expert andrecommended the vaccination, she nevertheless wantedthe parents themselves to decide

uring the interviews, ethical aspects of clientsupervision were focused upon. Some PHNs appearedto have difficu identifying and describing the eth-ical aspects of their su pervision. Some of them describedethical aspects in ter and wrong, while othersreferred to the power inherent in thei r professional roleand expressed that their handlir power repre-sented an ethical aspect of client supervision, whichthey considered important to be aware of

The PHNs reported that one central challenge wasthe contradiction related to, on the one hand, acting asan expe other, allowing the client to be theexpert.

According to the PHNs in this study, the contradic-tion between confirming, supporting and creating atrusting rel the parents and at the sametime having a controlling function also represented achallenge

Furthermore, the PHNs stated that it was a challengewhen their personal values differed from those of theclient. PHNs described the situation of amother who was worried because her baby's weightfailed to increase as expect mother wanted togive the baby formula milk, while the PHN thought thatit would be better to breastfeed more o thusincreasing the milk production. The PHN commented:ÔWhat I think is imp ortant is that if the mother choose breastfeed the ba by any longer , then it is veryessential that the decision is based on know ledge andreflection, t choiceÕ.

Sometimes the PHNs experienced that the client'sdecisions differed from recommendations set out inNorwegian or from what they as profes-sionals considered a qualitatively good choice. To haveknowledge, but not act as a Ô thus representeda challenge.

The fact that the PHNs followed up the clients over along period of time represented a challenge in itself,because difficult to be aware of one's ownassumptions or prejudices when meeting the clients.However, some of the PHN when follow-ing up the clients over a long period of time, theylearned to know and understand them and achieve with regard to the children's growth anddevelopment.

On the contrary, they found it challengingthat some clients became dependent on the PHNsÕ ser-vice and the PH as a result of the long-term nature of the relationship. Furthermore, when theclients had a poor social network o problems,then the relationship with the PHN became even moreimportant and the empowering process more co

One of the PHNs expressed: ÔMy problem is thatI am now so important to these parents that it is difficultto encc to act independentlyÕ

A relationship based on trust is also fundamentalin the empowering process (Gibson 1991, Ryles 1999).Furtherm trusting relationship is im-portant in client supervision, which is supported by thefindings of a study related to th underlyingnursesÕ professional identity; which require interactionsaimed at recognizing the patient as a person, exploringhis/her perceptions of the situation and creating a senseof trust (Fagermoen 1997).

Confirming and supporting the clients seemed to beimportant components in creating and maintainingrelationsh corresponds with Severinsson's(2001) research, which shows that confirmation is a coreconcept of supervision.

The PHNs reported that it was important to knowand understand the client and his/her concerns in orderto cond supervision.

Looking beyond the curre nt situation seemed to be amain aspect of client supervisio n. The PHNs Õ relation-ship could last for years, and thus the con-tinuity and length of the relationships influenced theimmediate situation.

or example, Wakefield and McMullan (2005) present a case study of Hamilton, Ontario, a steel-manufacturing cit everyday geography.They point out that while there are places that are typically understood as healthy, there are that are deemed unhealthy, unpopular, on the margins of society, and therefore stigmatized, and that these plac one's well-being.

Carolan et al. (2006) identify the nurse-client relationship as an important element in nursing geography in terms of the heali places, questions of situated- ness, and nurses' social location in the context of gender and power.

The infectious disease perspective calls to mind the work of present-day TB nurses, who provide care in a range o locations such as homes, workplaces, coffee shops, parks, and shelters.

This obligation is complicated by the need to navigate multiple places of care.

Care begins with the general assumption that the nurse is a guest in the client's place, whereas the hospital is oft
by both health professionals and clients, as the health profes- sional's place.

Home is "a place offering a wider view of the patient's life, disease, illness and suffering" (Liaschenko, 1997, p. 5
private place, a haven of physical and emotional well-being that shelters individuals from public scrutiny and surv
place from which they can pro- hibit unwanted outsiders.

Yet once the nurse enters, the home's privacy is challenged and the client's ability to restrict public surveillance is
compromised.

Likewise, the nurse's sense of a controlled workspace is altered, along with her/his sense of power, authority, an
Care in community health nursing is not restricted to the home but also occurs in places such as schools, commu
and drop-in clinics. Unlike hospital and home-care nurses, community health nurses observe and engage with pe
broader community context of their daily lives

Areas of different social, economic, and ethnic groups often have more subtle boundaries, expressed colloquially
side of the tracks," "a neighbourhood too rich for my blood,""gay village,""subsidized housing,""inner city,""Chin
"Little Italy." Such labels often determine how the inhabitants of an area are perceived and judged. Nurses worki
neighbourhoods may see their clients through these generalized and often stigmatizing labels.

We believe that addressing such problematic attitudes about marginalized people and places is part of the respo
community nurses

Whether it be hospital, home, or other location, the place itself can enhance or diminish the power of the individ
2002), which in turn can positively or negatively affect the care provided.

McGarry (2003) discusses the balancing of power between nurse and client, which can be partially understood by
nurse as a guest in the client's home.

In McGarry's study of community nursing, the location, as well as the longevity and structure of relation- ships, w
both satisfaction and tension for nurses.This raises the question of how close to or distant from (both spatial con
another nurses and clients feel.

Physical proximity is direct bodily contact between nurse and client and is the nest for narrative proximity, which
nurse listening to the client's story, engaging with the client as a person beyond the illness

Nurses and clients must negotiate proximity, particularly in home and community settings, as part of the nurse-c
relationship. This negotiation requires that nurses and clients make choices about their closeness to one another
become problematic when examined with an awareness of place.

She expands on the notion of proximity by suggesting that nurses choose how close to or distant from clients the
choices are based on who their clients are, their unique life circumstances, the specific health situation, and the g
sociopolitical, and cultural places in which nursing is carried out.The choices call for self-awareness, self-knowled
to set boundaries, and empathic understanding. Choices regarding proximity are part of nurses' obligation to con
examine their power as professional

Second, the social and cultural location of nurses as professionals, practitioners, and researchers raises questions
Are we simply guests in clients' homes? How do we overtly and subtly exercise our authority as we make decisio
homes? How do the places in which we find ourselves working affect our choices about how close we get to clien
choices about proximity contribute to healing and well-being, or do they inadvertently reinforce clients' feelings
displacement?

Peter and Liaschenko suggest that dialogue, a way for nurses to theorize their practice, is one avenue for such re
that it ought to occur among nurses, administrators, and policy-makers so that discussions of nurse-client proxim
at all levels. How might community health organizations foster and promote this dialogue?

We need to become aware of our prejudices about the places in which we work, of the value judgements we ma
example, supposedly high-risk neighbourhoods or the cleanliness, noisiness, comfort, and even tidiness of our cli
There is recognition in the literature of the importance of the personal qualities which the nurse brings to the rel
the client. Value is placed on an empathetic and caring health professional, able to understand and appreciate th
(usually the mother's) point of view.

Normandale 2001). Jack et al. (2005) record that reliability, genuineness, warmth and ability to be caring and em
cited by participants in their study as being of para- mount importance.
These mothers preferred a professional demeanour which was not overly bureaucratic, and which respected the
confidentiality.
The mothers in a study by Fager- skiol et al. (2003) wanted the nurse to be sensi- tive to their emotional needs, t
voiced concerns seriously and to see things from their perspective.
Flexibility, or moving with the client, is seen as a positive attribute of the nurse. Being flexible enables the nurse t
focus when a more important or immediate problem arose unex- pectedly (Cowley 1995a). The nature of the pra
that the nurse has to be pre- pared to attend to whatever is identified by the client as important, rather than rigi
pre-set agenda. According to Cowley's (1995a) study, this was so commonplace in health visit- ing practice that t
necessarily con- sciously aware that they were shifting focus, rather it was explained in terms of remaining respo
needs.
Whilst these attributes may be seen as rele- vant to all nursing roles, they have particular relevance in communit
nursing. In this type of nursing work, conducted in the largely informal setting of a community clinic or the client'
literature suggests that per- sonal qualities that engender a strong nurse– client relationship and the ability to re
rapidly shifting demands are most suitable to the community nursing role
If the health service in which the nurse is located is well known and accepted in the community this is noted as a pivotal means
to clients
Community child health nurses must gain entry to the house and to the family if they are to undertake the work
the family health and 'entry work' is the process which obtains access to the client and the home.
Health visitors use a combination of commercial techniques to make their services accessible, acceptable and rel
clients, such as promoting the service to the prospective client, adjusting the delivery of the service to suit the cli
tailoring the 'product' of health pro- motion to the client's needs.
In home visiting the community child health nurses may contact the client even before a request to visit is made,
that sales personnel describe as 'cold calling'. Therefore they must in the first instance convince the client of the
the contact and get them to agree to continue with the contact. For example, one of the tactics used by health vi
access to families with new babies was to present the service as a routine or expected requirement
Luker and Chalmers (1990) identified women as the 'gatekeepers' to the family for health visit- ing services. They
factors that either facilitated or blocked entry to the client and thereby the nurse's work.
The health visitors were aware their behaviour had an effect in determining their entry to the house, so they con
presented in a non authoritarian manner respectful of the client's needs and their position as a guest in the clien
The nurs- es also consciously modified their speech and behaviour to suit the situation in an attempt to make the
acceptable to the client
The client is not passive in the interaction and will establish his or her own grounds for the interac- tion so the nu
identify the position and basic beliefs of the client.

A second and parallel process of ‘getting known’ occurs, in which the nurse explains her role, assuming that to do encourage clients to accept the service. Cowley postulates that if clients could predict a helpful response from th visitor they might ‘open out and express needs, especially about sensitive or private con- cerns’
A high value was placed on respecting the rights, needs and explicit wishes of the client expressed as ‘not imposi 654)

The nurse and client get to know each other so that suffi- cient common ground is established to enable the building of trust.

Trust is seen as central to the relationship before the client would be able to open up and express their needs. Th particularly important if the topics were sensi- tive or deeply personal.
For a mutually respectful relationship to grow and develop the nurse must demonstrate to the parent her trustw Jack et al. (2005: 190) found that for the mothers, the most important outcome of the interaction with the nurse development of a connected rela- tionship’ with the home visiting nurse built on a foundation of trust. The moth the nurse to see if they were trustworthy.
The mother’s decision to trust the nurse and the extent of the trust was influenced by the per- sonal characterist mother and the nurse.
Mothers judged the nurse’s trustworthi- ness according to whether they perceived the nurse as reliable, maintai confidentiality and was accepting. How rapidly it was established differed with whether the mother was willing t personal and sensitive issues. If they did not trust the nurse then the mothers limited the nurses work by keeping ship at a superficial level, ‘playing along with the nurse’ (2005: 187), not openly sharing.
Jack (2005) notes that mothers felt more connected when they per- ceived the nurse as having had similar perso experiences. The development of a rapport with the mother allows the formation of a more egal- itarian relation characterises as mutuality.
Seedhouse (1997) argues that persuasion and coercion are intrinsic to health promotion practice, although frequ knowledged. The community child health nurse may not be consciously exerting power over the client but none t present in the nurse–client relationship.
Part of the exercise of power lies in the abili- ty of the community child health nurse to con- trol the direction and interaction. Control can be exercised in many ways: by ignoring questions, by deflecting the conversa- tion into s or by imposing strict guidelines on what is acceptable or not accept- able in the conversation.
rsuasion may be used to induce clients to change lifestyle or simple health habits, to accept a referral to another or to take up preventive health actions such as immu- nisation. For example, the health visitors in de la Cuesta’s (persuaded clients to take up immunisations by commenting in posi- tive terms about the benefits of the immunis the professional expertise of the immunisers. Similar tactics were used to per- suade clients to join a group
here are hints of the exercise of social con- trol in the nurses’ practices. Robinson (2004) suggests that in offering parents the nurses are able to disguise their role in ensuring compliance with socially determined conditions of a mothering.
Normandale (2001) describes the personal qualities deemed as necessary for health visitors to work in a social su of health vis- iting but, interestingly, she thinks the psychoso- cial model is not always achievable in practice as no to health visiting practice exhibit the necessary empathetic skills.

Code Assigned	Comment/ Code Description
14	trust
10. 14	conflict in the relationship, trust
16	Nurses as community member
15	power
14	trust
16	nurses as community member
16	nurses as community member
4, 14	nurses ability to engage, trust
14	trust
14, 16	trust, nurses as community members
14, 4	trust, the process of developing trust
11,13, 14	trust

	power
10	conflict in the relationship
10	conflict in the relationship
1. a	fragility of ther relationship in the early stages
14	trust
14, 16	Nurses as community member, trust
14, 3	trust , marginalized populations
3	vulnerable/ marginalized at risk populations
16	Nurses as community member
19, 15	clients as active, power
20	nurses as empowering agents for clients
24	client centeredness
16	Nurses as community member

8	respect
18	collaboration, client centeredness
20	nurses empowering clients
16	Nurses as community member
16	Nurses as community member
25	listening
5	nursing self awareness
22, 26	therapeutic friendliness, genuineness
15, 8	power. Respect
16	Nurses as community member
2, 15	Boundaries, power
11, 12, 14	continuity of care, length of relationship, trust
12, 14, 11, 3, 16	LOR, trust, continuity of relationship, vulnerable clients, nurses as community members
5,8	nurses self awareness, respect

24	client centeredness
24	client centeredness
16	Nurses as community member
15, 18a	power, strengths based approach
20	nurses as empowerment
9	professional intimacy
9	professional intimacy
16	Primcay of relationshpis, nurses as community members
15	power
24	client centeredness
20	empowerment
4, 22	nursing actions to engage, therapeutic friendliness

4, 22	nursing actions to engage, therapeutic friendliness
15	power
14	trust
15, 20	power, nurses empowering patients
15	power
23	nurse responsiveness
23, 15, 24	nurse responsiveness, power, client centeredness
5	nursing self awareness
24	client centeredness
18a	strengths based approach
13	therapeutic communication
15	power
8	respect
8, 24	respect, client centeredness

8	respect
20	nurses as empowerment
22	therapeutic friendliness
22,15	therapeutic friendliness, power
22	therapeutic friendliness
14	trust
20	nurses as empowering agents for clients , patients as active
24	client centeredness
21	social determinants of health as part of the therapeutic relationship
20,3	nurses as empowering, vulnerable clients
18, 15, 19	collaboration,power, patients as active
18., 18 a, 14	collaboration, strengths based approach, trust
20, ?	nurses as empowering, nurses as community memebrs
15	power

18	collaboration
14, 20, 24	trust, empowerment, client centeredness
20	nurses as empowering
17	nurse patient expectations
16	Nurses as community member
21	Social Determinants of Health as part of the tehrapeutic relationship
24, 4	client centeredness, nurse actions to engage
14, 8, 20	trust, respect, nurses as empowering
18, 14	collaboration, power
8, 25	respect, listening
14	trust
15	power
11, 12, 14	continuity of care, length of relationship, trust
16	Nurses as community member

20	nurses as empowering
3	vulnerable clients
18a	strengths based approach
20, 15	nurses as empowering, power
20	nurses as empowering
25	listening
25	social determinants of health as part of the therapeutic relationship
16	Nurses as community member
18a	strengths based approach
16	nurses as community member
16	nurses as community member
10. 14	conflict in the relationship
18	collaboration
20, 14	empowerment, trust

15, 14	power, trust
	collaboration, vulnerable populations, nurses as empowering
18	collaboration
21, 18	SDH as part of the TR, vulnerable population
22,14,13	therapeutic friendliness, trust, therapeutic communication
14, 17	trust, nurse-patient expectations
13	therapeutic communication
2	boundaries
12, 11	length of relationship, continuity of care
13, 22	therapeutic communciation, therapeutic friendliness
22, 14	therapeutic friendliness, trust

4, 26	nursing actions to engage, genuineness
18a	strengths based approach
3	vulnerable clients
14, 1	trust, stage of the relationship
14	trust
17	nurse patient expectations
14, 15	trust, power
3, 14	vulnerable clients, trust
14	trust

13, 7, 14	therapeutic communciation, empathy, trust
7, 25	empathy, listening
13	therapeutic communication
8,7	respect, empathy
24	client centeredness
24, 3	client centeredness, vulnerable clients
18a	STREngths based approach
21	SDH as part of the TR
2	boundaries
2, 22	Boundaries, therapeutic friendliness
3, 5	vulnerable clients, nurse self awareness
3, 10	vulnerable clients, conflict in the relationship

10, 2	conflict in the relationship, boundaries
10, 2, 15	conflict in the relationship, trust, power
5, 15, 10	nurse self awareness, power, conflict in the relationship
11,12,22	continuity of care, length of relationship, therapeutic friendliness
2	boundaries
2, 4	boundaries, nurse actions to engage
15, 2	power, boundaries
10, 2, 22	conflict in the relationship, boundaries, therapeutic friendliness
8, 14, 9	respect, trust, professional intimacy
2, 14	boundaries, trust

2, 12, 11	boundaries, length of relationship, continuity of care
2, 14, 8	boundaries, trust, respect
8, 15, 10	respect, power, conflict in the relationship
3, 21	vulnerable clients/populations, social determinants of health as part of the TR
4, 22	nurse actions to engage, therapeutic friendliness
3	vulnerable clients
22, 2	therapeutic friendliness, boundaries
2, 17	boundaries, nurse clients expectations
5	nurse self awareness
2	boundaries

5, 25	nurse self awareness, listening
7	empathy
2	boundaries
10	conflict in the relationship
2	boundaries
2, 5	boundaries, nurse self awareness
7,14	empathy, trust
3, 14	vulnerable clients, trust
5, 2	nurse self awareness, boundaries

8	respect
15, 10	power, conflict in the relationship
8	respect
8, 19	respect, patients as active
4, 2	nursing action to engage, boundaries
4, 13	nursing actions toe egage, therapeutic communication
13	therapeutic communication
19,18	patients as active, nurses as empowering
13, 23	therapeutic communication, nurse adaptability
18a	strengths based approach
21	social determinants of health as part of the therapeutic relationship
25,7	listening, empathy
13, 20	therapeutic communication, nurses as empowering
21	SDH as part of the tehrapeutic relationship

8, 24, 14	respect, client centeredness, trust
13, 14	therapeutic communication, trust
13, 25	therapeutic communication, listening
25	listening
24	client centeredness
24, 18a	client centeredness, strengths based approach
24	client centeredness
24	client centeredness
13, 20	therapeutic communication, nurses as empowering
20	nurses as empowering
13, 20	therapeutic communication, nurses as empowering
20	nurses as empowerment
15	power
10, 20	tension in the relationship, nurses as empowering
14, 15, 2	trust, power, boundaries

10, 24	conflict in the relationship, client centeredness
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12, 11, 10	length of relationship, continuity of care, conflict in the relationship
10, 20	conflict in the relationship, nurses as empowering
10, 20	conflict in the relationship, nurses as empowering
14, 20, 24	trust, empowerment, client centeredness
20	nurses as empowering
24	client centeredness
11, 12	continuty of care, length of relationship
3	vulnerable clients
16	nurses as community member
16	nurses as community member
16, 17	nurses as community members, nurse-patient expectations

17, 2	nurse patient expectations, boundaries
15, 14, 9	power, trust, professional intimacy
14, 2, 15, 9	trust, boundaries, power, professional intimacy
15, 2	power, boundaries
16	nurses as community member
3	vulnerable clients
3	vulnerable clients
15	power
8, 15, 9	respect, power, professional intimacy
12, 10, 2	length of relationship, conflict within the relationship, boundaries
25, 13	listening, therapeutic communication
9	professional intimacy
9, 5, 6, 2, 15	professional intimacy,, nurses self awareness, nurses self knowledge, boundaries, power
15	power
8, 2, 15	respect, boundaries, power
5, 6	nurses' self awareness, nurses' self knoweldge

3, 5	vulnerable clients, nurses' self awareness
7	empathy
7, 22, 26	empathy, therapeutic friendliness, genuineness
8,9	respect, professional intimact
7, 24	empathy, client centered care
23	nurse flexibility
23	nurse flexibility
16	nurse as member of the community
2, 4	boundaries, nurse actions to engage
24, 4	client centered, nurse actions to engage
4	nurse action to engge
2, 15	boundaries, power
2, 8, 15	boundaries, respect, power
24	client centeredness
19	client as active

4	nurse action to engge
8, 2, 15	respect, boundaries, power
4, 14	nurse actions to engage, trust
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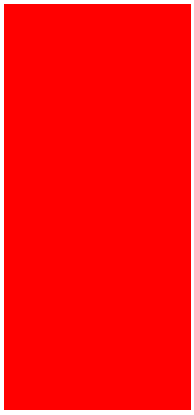
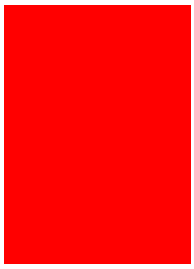
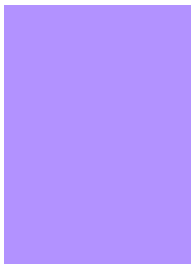
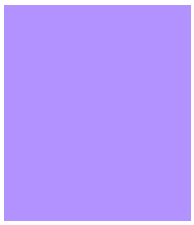
7	empathy

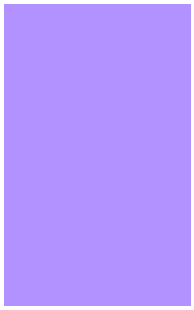


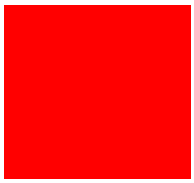


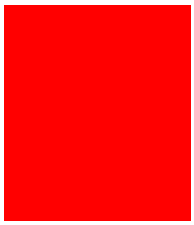


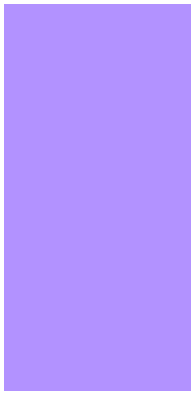


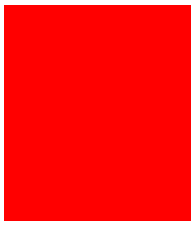


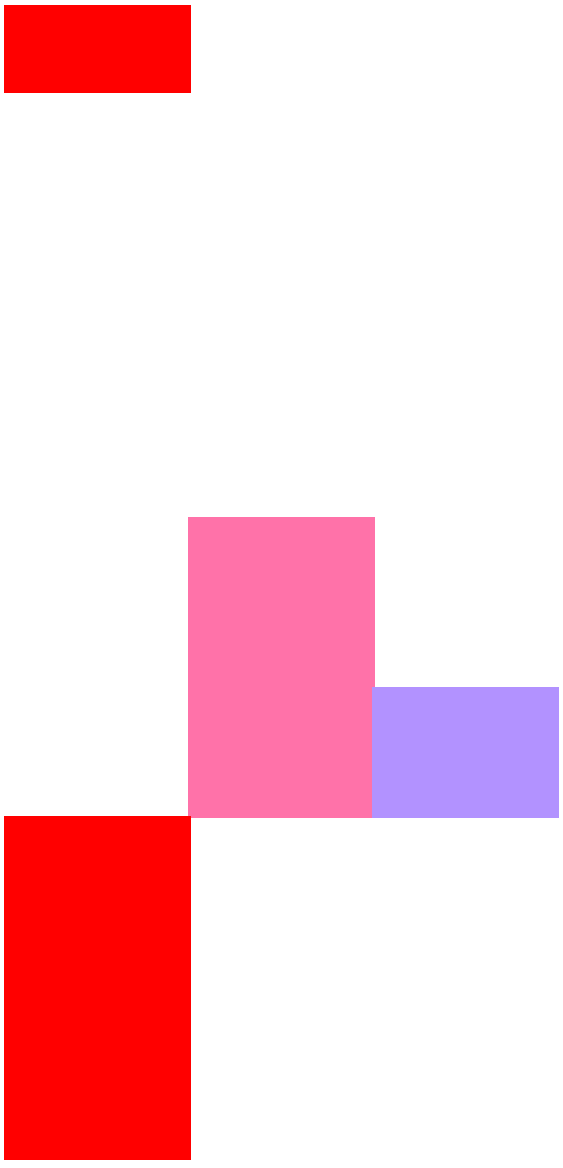


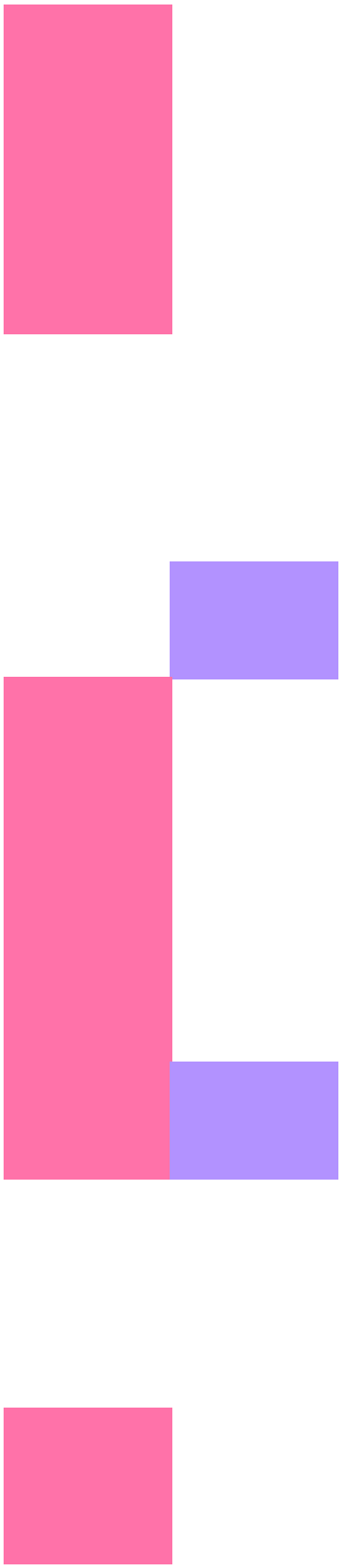


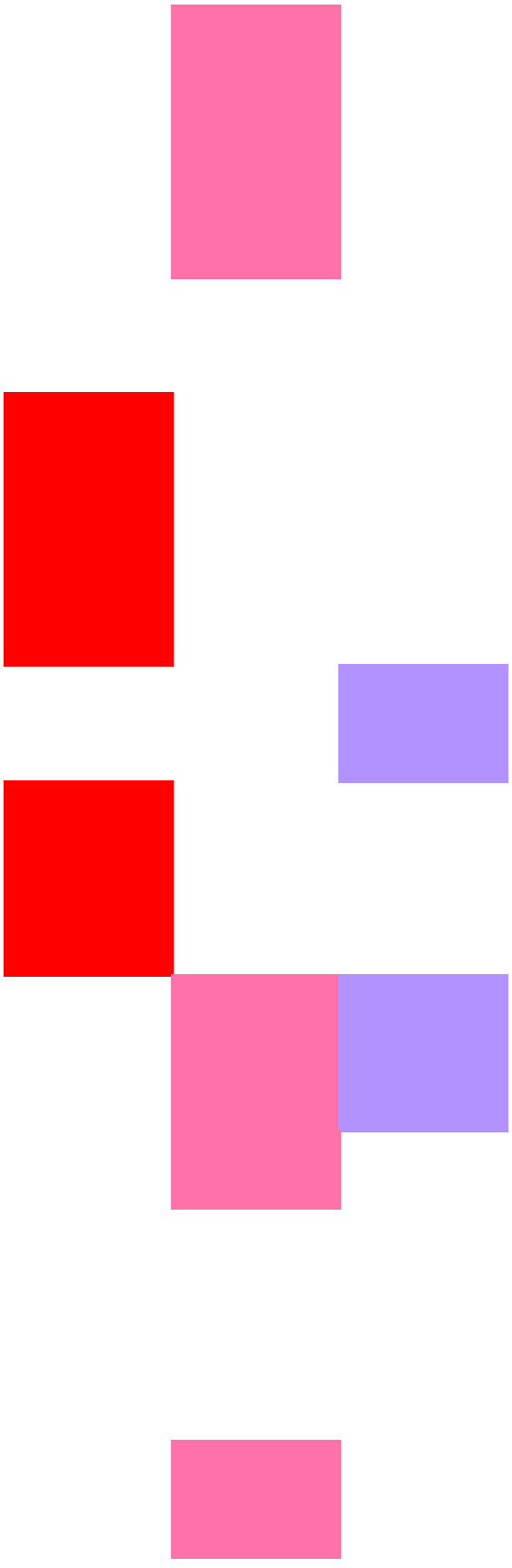


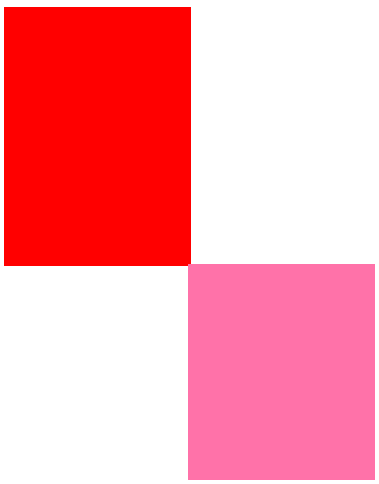












Code	Sub-codes within text
Power	
	clients as active
	respect
	boundaries
	strengths based approach
	nurses empowering clients
	nurse responsiveness, client centeredness
	therapeutic friendiness

collaboration

nurses as empowering

trust

trust

nurse self awareness, conflict in
the relationship

boundaries

respect, conflict in the relationsip

conflict in the relationship

trust, boundaries

trust, boundaries , professional intimacy
boundaries

professional intimacy,, nurses self awareness, nurses self knowledge, boundaries, power

respect, boundaries

boundaries

boundaries, respect

respect, boundaries

Trust

nurse actions to engage

power, professional intimacy

empowerment, client centerdness

power, boundaries

vulnerable clients

empathy

boundaries, respect

boundaries

respect, professional intimacy

conflict in the relationship, power

therapeutic communication,
empathy

vulnerable clients

stage of the relationship

therapeutic friendiness

nurse patient expectations

therapetuic communication and therapeutic friendliness

power

empowerment

continuity of care, length of relationship

respect, nurses as empowering

empowerment, client centerdness

collaboration, strengths based approach

vulnerable clients

	nurses as community members
	nurses as community members
	nurses ability to engage
	conflict in the relationship
Boundaries	power

therapeutic friendiness

conflict in the relationship

nurse actions to engage

power

conflict in the relationship,
therapeutic friendliness

trust

length of relationship, continuity
of care

trust, respect

therapeutic friendiness

nurse self awareness

nurse self awareness

nurse actions to engage

trust, power

nurse patient expectations

trust, power, professional intimacy

professional intimacy,, nurses self awareness, nurses self knowledge, boundaries, power

	respect, power
	nurse actions to engage
	power
	respect, power
Nurses as empowering	
	conflict in the relationship
	conflict in the relationship
	tension in the relationship
	therapeutic communication
	therapeutic communication

patients as active

collaboration, vulnerable populations

power

trust, respect

vulnerable clients

patients as active

power

Client
centeredness

power

respect

trust, empowerment

nurse actions to engage

vulnerable clients

respect, trust

strengths based approach

conflict in the relationship

trust, empowerment

empathy

Nurses as community members

empowerment

LOR, trust, continuity of relationship, vulnerable clients, nurses as community members

trust

	trust
Respect	boundaries, power
	boundaries, power
	professional intimacy
	boundaries, power
	power, professional intimacy
	client centeredness, trust
	patients as active

	power, conflict in the relationship
	boundaries, trust
	trust, professional intimacy
	empathy
	listening
	trust, nurses as empowering
	client centeredness
	power
Conflict in the Relationship	trust

therapeutic friendiness

respect, power

power
client centeredness

length of relationship, continuity
of care

nurses as empowering

Excerpt

Yet, during our study, it emerged that community nurses e who are agents of the formalized healthcare system e were key in influencing mothers' feeding beliefs, de- cisions, and behaviors

Thus, the CHPS model provides useful empirical evidence of reflective trust and how it develops and becomes vital to influ- encing mother's beliefs, decision-making, and behaviors related to feeding

Being in relation with clients, whether individuals, families, groups, or communi- ties, was characterized by mutuality, active participation of clients, and shared power as appropriate to the situation

Par- ticipants had different opinions about what the latter meant—some spoke of being care- ful not to power dress or dressing mindfully of socioeconomic differences but others be- lieved as long as respect was shown, dress did not matter:

"It's a two-way kind of street. One asks a lot of private ques- tions and it's a balance of power to be able to have information shared that way."

to describe the process and their role in it. Some expressed discomfort with too great a focus on needs and goals, fear- ing it could be experienced as top-down and controlling. They preferred speaking in terms of a strength-based approach

A number of examples provided evidence that power was being shared between nurse and client on a situational, mutually established basis.

They described, either directly or indirectly, that a large part of their relationship development was centered on shifting the power dynamic that often tradition- ally or historically existed between PHNs (or any health care professional) and mothers

The majority of PHNs spoke about how they recognized the perception of new mothers who may see them as a person in a position of authority who might judge them. Because of these potential feelings of discomfort or fear, most of the PHNs spoke about how they always attempted to shift the relation of power in the relationship and encourage the mothers to feel that they had more "control" and choice

During home visits in both the targeted and universal pro- grams, the mothers were encouraged by PHNs to lead their visits which clearly shifted the power dynamic

The majority of PHNs believed having a set agenda created a relation- ship that was dominating and potentially oppressive for a mother. They told us that delivering a prescriptive agenda would contribute to a negative rela- tionship between themselves and the mothers. Therefore, the majority of PHNs preferred to follow a health discourse that was client-led

The development of these relationships clearly included shifting the relations of power that have traditionally posi- tioned PHNs as a perceived negative and hierarchical authority figure with power. Using the lens of feminist poststructuralism allowed us to analyze how the "friendly demeanor" of PHNs was instrumental in navigating power relations between PHNs and mothers that ultimately led to positive interactions, thor- ough assessments, and positive health outcomes that were expressed by both PHNs and mothers

Furthermore, overcoming disem- powerment includes professionals' ability to understand and shift their power relationships in their communities.

Most of the nurses spoke of the need for a balance of power in this relationship, one in which the nurse saw herself as taking a more egalitarian approach and strove to shift the balance of power away from the *nurse as expert* and include the clients' voice, perspectives, and ideas.
Many nurses across all programs stated that it was important to establish a partnership where the nurse truly believed that the client could make their own informed decisions, as well as ac- knowledge the hierarchy between expert and client that often exists and work to reduce the tradi- tional power imbalance in the relationship between client and health care professional.
hey sensed opportunities for more group ownership, and they stepped back from the process, giving space for clients to take the lead

Caring and trust (Schulte, 2000) are facilitated through mutual relationships that involve negotiating a more equitable power balance
To trust or mistrust. Mothers shared that they learned to mistrust human service workers, agency personnel, and police officers when they were young. Diane (LISM) remembered being told as a child to "be scared of social workers or cops and stuff like that." When the PHN
showed up at her door on a routine postpartum visit, Diane was fearful: "I was really, really nervous. I thought she was there to try and take my baby or see if I was a bad mom."
''That's part of my job. On the one hand, I'm setting up all these things, helping him out. But on the other hand, he knows that I'm kind of the bad guy in that, 'if you don't comply with this, this is what's going to happen', that sort of thing. Anyway, it can be difficult; I don't necessarily want to be perceived as the bad guy . . . it's much easier to be the person who's helping''.

From clients' perspectives, deciding to open the door to the nurse seemed to be a way of maintaining their own
power in the situation.

Being watched under surveillance, according to most participants, was infantilizing for clients and the nurses' awareness of such potential feelings was a key facet of their observation skills.

Indeed nurses' power in ensuring adher- ence can contribute to a feeling of intrusion for clients.

uring the interviews, ethical aspects of clientsupervision were focused upon. Some PHNs appearedto have difficulty in identifying and describing the eth-ical aspects of their su pervision. Some of them describedethical aspects in terms of right and wrong, while othersreferred to the power inherent in thei r professional roleand expressed that their handling of this power repre-sented an ethical aspect of client supervision, whichthey considered important to be aware of

According to the PHNs in this study, the contradic-tion between confirming, supporting and creating atrusting relationship with the parents and at the sametime having a controlling function also represented achallenge

Yet once the nurse enters, the home's privacy is challenged and the client's ability to restrict public surveillance is compromised.

Likewise, the nurse's sense of a controlled workspace is altered, along with her/his sense of power, authority, and control.

Whether it be hospital, home, or other location, the place itself can enhance or diminish the power of the individual (Peter, 2002), which in turn can positively or negatively affect the care provided.

McGarry (2003) discusses the balancing of power between nurse and client, which can be partially understood by viewing the nurse as a guest in the client's home.

She expands on the notion of proximity by suggesting that nurses choose how close to or distant from clients they will be.Their choices are based on who their clients are, their unique life circumstances, the specific health situation, and the geographical, sociopolitical, and cultural places in which nursing is carried out.The choices call for self-awareness, self-knowledge, an ability to set boundaries, and empathic understanding. Choices regarding proximity are part of nurses' obligation to continually re-examine their power as professional

Second, the social and cultural location of nurses as professionals, practitioners, and researchers raises questions of power.

Are we simply guests in clients' homes? How do we overtly and subtly exercise our authority as we make decisions in clients' homes? How do the places in which we find ourselves working affect our choices about how close we get to clients? Do our choices about proximity contribute to healing and well-being, or do they inadvertently reinforce clients' feelings of displacement?

Luker and Chalmers (1990) identified women as the 'gatekeepers' to the family for health visit- ing services. They identified factors that either facilitated or blocked entry to the client and thereby the nurse's work.

The health visitors were aware their behaviour had an effect in determining their entry to the house, so they consciously presented in a non authoritarian manner respectful of the client's needs and their position as a guest in the client's home.

A high value was placed on respecting the rights, needs and explicit wishes of the client expressed as 'not imposing' (1991: 654)

Seedhouse (1997) argues that persuasion and coercion are intrinsic to health promotion practice, although frequently unac- knowledged. The community child health nurse may not be consciously exerting power over the client but none the less it is present in the nurse–client relationship.

Part of the exercise of power lies in the abili- ty of the community child health nurse to con- trol the direction and depth of the interaction. Control can be exercised in many ways: by ignoring questions, by deflecting the conversa- tion into selected topics, or by imposing strict guidelines on what is acceptable or not accept- able in the conversation.

rsuasion may be used to induce clients to change lifestyle or simple health habits, to accept a referral to another health service or to take up preventive health actions such as immu- nisation. For example, the health visitors in de la Cuesta's (1994a) study persuaded clients to take up immunisations by commenting in posi- tive terms about the benefits of the immunisa- tion and the professional expertise of the immunisers. Similar tactics were used to per- suade clients to join a group

here are hints of the exercise of social con- trol in the nurses' practices. Robinson (2004) suggests that in offering assistance to parents the nurses are able to disguise their role in ensuring compliance with socially determined conditions of adequate mothering.

Mothers judged the nurse's trustworthi- ness according to whether they perceived the nurse as reliable, maintained confidentiality and was accepting. How rapidly it was established differed with whether the mother was willing to discuss more personal and sensitive issues. If they did not trust the nurse then the mothers limited the nurses work by keeping the relation- ship at a superficial level, 'playing along with the nurse' (2005: 187), not openly sharing.

The mother's decision to trust the nurse and the extent of the trust was influenced by the per- sonal characteristics of both the mother and the nurse.

For a mutually respectful relationship to grow and develop the nurse must demonstrate to the parent her trustworthiness. Jack et al. (2005: 190) found that for the mothers, the most important outcome of the interaction with the nurse 'was the development of a connected rela- tionship' with the home visiting nurse built on a foundation of trust. The mothers 'tested' the nurse to see if they were trustworthy.

Trust is seen as central to the relationship before the client would be able to open up and express their needs. This was particularly important if the topics were sensi- tive or deeply personal.

The nurse and client get to know each other so that suffi- cient common ground is established to enable the building of trust.

Home is "a place offering a wider view of the patient's life, disease, illness and suffering" (Liaschenko, 1997, p. 50). It is a private place, a haven of physical and emotional well-being that shelters individuals from public scrutiny and surveillance, a place from which they can pro- hibit unwanted outsiders.

A relationship based on trust is also fundamentalin the empowering process (Gibson 1991, Ryles 1999).Furthermore, building a trusting relationship is im-portant in client supervision, which is supported by thefindings of a study related to the values underlyingnursesÕ professional identity; which require interactionsaimed at recognizing the patient as a person, exploringhis/her perceptions of the situation and creating a senseof trust (Fagermoen 1997).
According to the PHNs in this study, the contradic-tion between confirming, supporting and creating atrusting relationship with the parents and at the sametime having a controlling function also represented achallenge
In the context of public health, being contagious is part of the suffering experienced by clients. Providing comfort therefore is particularly important for diminishing feelings of stigma and alienation. Contagiousness also implies the need for sensitivity with regard to physical closeness and distance. With this in mind, choice about one's proximity in client meetings is an important aspect of comforting. As seen in this study, getting up close to infectious clients, offering a quick greeting before masking, or sitting next to them, goes far in sustaining a sense of trust and being cared for.

Comforting means ''to strengthen, aid, and encourage, as well as to soothe and console'', and the need for it comes about in experiences of distress, loss, or suffering (Benner et al., 1999, p. 244). Because comfort means different things to different people, providing comfort is an uncertain practice. It depends on timing, trust, cultural knowledge, openness and acceptance
In short, getting through the door involves respect, trust, and sometimes, a kind of honest dishonesty, the necessary and inseparable dimensions of not intruding too much. Client privacy is central in order for nurses to be welcomed in the context of surveillance, and getting in the door leads to ''doing TB''.

''I think it's a trust thing. Because I'm going into their house, they're not coming to my office. I'm on their territory. What makes a relationship work is based on trust because once a patient trusts you, they take your advice ... I'm in their home and they're trusting me with being in their home. And also I'm trusting them being in their home.''

Getting through the door then is a sign of some level of acceptance or welcome. Tangible incentives help with this (such as grocery vouchers and public transit tokens), yet it was the nurses' respectfulness, trustworthiness, and preservation of privacy that seemed to have a stronger influence. Getting through the door involves respect for clients' homes by taking off shoes, waiting to be shown where to sit, and even continuing the visits under the distracting conditions of the house, such as cooking, telephones, and loud televisions. As clients feel respected, trust also develops as described by this nurse
At the level of embodiment, the effects of TB are an intrusion—physiological as well as social. Added to this disruption is the intrusion of the Public Health Department with its authority over individual lives in matters of contagious disease, which manifests concretely in the nurse's immediate presence. This encounter is the pivotal point in relational work.

It became apparent that the PHNs had acquired an advanced skill set that we believe parallels social intelligence competencies (Goleman, 2006). Empathic accuracy and responding strategically enabled the PHN to maneuver her way through the interaction in such a way that she could pro- ceed to probe more deeply without threatening the LISM.

The litmus test. If the LISM remained uncertain, she would continue to ponder: What are the PHN's unspoken words telling me? What are her innermost thoughts concerning me? Do I want to share anything with her, or do I just want to tell her what I think she is looking for and then leave? Lacking sufficient information, the LISM relied on cues, hints, and expressive gestures as substitutes for factual knowledge about the PHN's thoughts and feelings. However, the cues were inade- quate, necessitating that LISMs implement the litmus test to judge the PHN's motives accurately. The litmus test entailed the mother posing certain benign questions to the PHN and then evaluating the PHN's returning ver- bal and nonverbal communication. If the PHN met the mother's expectations, then the LISM was more apt to delve into topics of a personal nature, and engagement would proceed with far more real disclosures on the part of the mother than polite, conventional discourse

Mothers like Diane, who as children were taken out of their family home and placed in foster care, learned that the world was not a safe place, and if people in their nuclear family and in systems of authority were unpre- dictable and undependable, who could be trusted? In response, mothers "watch," explained a social worker: "They will read you as soon as you walk in the door; that is, where you are, where you have come from, what you do, whatever." LISMs wanted to ensure that the PHN could be trusted not to render judgment.

To trust or mistrust. Mothers shared that they learned to mistrust human service workers, agency personnel, and police officers when they were young. Diane (LISM) remembered being told as a child to "be scared of social workers or cops and stuff like that." When the PHN

showed up at her door on a routine postpartum visit, Diane was fearful: "I was really, really nervous. I thought she was there to try and take my baby or see if I was a bad mom."

Among mother participants was a predominant propen- sity for mistrust, and thus it took more than smiles and verbal praise to assuage the mother's fears and to convince the LISM that the PHN could be trusted.

What was deemed a satisfactory visit depended on the mother's assessment of the quality of the PHN–child interaction, and how much effort was put forth "getting to know" her child. Benchmarks included the extent to which the PHN "cared" about her child, displayed interest in her child, "played" with her child, made her child "feel comfort- able," "talked" to her child, and "remembered his name." We learned that if PHNs behaved in a perfunctory, imper- sonal manner, and ignored the child, that they sabotaged the opportunity for rapport.

I think I liked Laverne [PHN] because she was friendly. Like she really, to be perfectly honest, had this thing about her that reminded me of an old hip- pie woman. I really liked that. I liked her because she was laid back and friendly. I liked that whole thing about her, and she was always positive

Ascertaining motives was the third stage, during which the LISM solidified her trust in the PHN, and was a critical juncture in the relationship-building process.

The first two stages (projecting optimism and child as mediating

presence) broke through the LISM's walls of defensiveness by means of the PHN's friendly disposition, verbal praise, and focus on the child, and increased the chances for rapport.
Caring and trust (Schulte, 2000) are facilitated through mutual relationships that involve negotiating a more equitable power balance
Building trusting relationships, confidence, and skills was integral to the empowerment pro- cess.

Most of the nurses maintained a long-term relationship with several of their clients, and many stated the importance of their ability to build rapport with their clients. These were the basis for strong trusting relationships and allowed them to probe beyond the surface of a client's situation. As one nurse stated: "But you know the day to day work with clientele [injection drug users] and establishing the relationship with them and gaining their trust, all those things take time."
As one nurse stated, "The important thing is trust. Trust is incremental. It comes in little waves. If [a] mum's having a challenge with her breastfeeding, you just build gradually upon it. But it works only if you have trust.

All the nurses repeatedly stated that building an individual's or group's capacity to take control over their health and the health of their community starts with a mutually trusting and respectful relationship between the client and the health care professiona
Falk-Rafael (2001), in her qualitative study of public health nurses, identified a client-centered approach that included a relationship of mutuality and trust as central to their practice and consistent with an empowerment process.
Other important concepts related to citizen participation and empowerment can be found in Kretzman and McKnight's (1993) discussion of asset-based community development that fo- cuses on strengths of communities as well as Freire's (1970) ideas on critical consciousness and trusting relationships. Similarly, Jackson, Cleverly, Poland, Burman, Edwards, and Robertson (2003) developed a model that focused on strengths and assets of community members within a socio environmental context
The consistent message, spoken by both PHNs and mothers in this study, was the overwhelming importance of developing supportive relationships that were non-judgmental, friendly, and fostered trust
I'm not going in there as an authority figure [. . .] and so it makes them feel more comfortable [. . .] so if I want to come back, they're more willing to have me back. Or if I'm going to introduce a program, they trust me enough that they're willing to go to the next step to do that program.
Our findings from the case in Ghana indicate that the CHPS model fosters trust that influences mothers' decision-making, and could lead to changes in health-related behaviors, particularly among marginalized populations.

We found that in the communities in which community nurses live and work, the nurses organize ante- and post-natal visits, hold peer educational sessions, home visits, health and nutrition discussions, durbars, and interventions targeting com- munities as a whole, including fathers, opinion leaders, etc. They actively engage and partner with mothers in their communities to address specific health challenges, including malnutrition as well as on non-health issues. Sometimes conversations centered on farm yields, the children's education, politics, etc. Outside of working hours, nurses are invited to attend social events in the commu- nities, all of which fostered deep relationships between mothers and nurses, which in turn engendered trust

This mother reported that her child was very healthy, was rarely sick and was meeting all his milestones, and she attributed the results to the nurses' advice. She also mentioned that she would not hesitate to follow the same advice with a subsequent child, as she was pregnant at the time of the interview.

Thus, the goodwill, competence, consistency, honesty, or openness of a CHPS nurse may provide the basis of trust

As our findings show, the trust and authority of nurses' ideas also partly emerged from mothers' observations about the success that such ideas had in improving the wellbeing of infants in their community, consistent with a skill-biased model of learning

Trust as driver of behavior in community models

Although we are unable to directly attribute trust building to CHPS nurses' training as we did not obtain detailed information on the training content (a limitation of our study), our findings suggest that community nurses who incorporated both traditional and scientific knowledge engaged more effectively with mothers and built relationships of trust through repeated instances of direct interpersonal contact with them (Granovetter, 1985). Through this holistic approach, mothers perceived nurses as showing commit- ment to their children's wellbeing and development, which made them receptive to health messages, and influenced feeding decision-making and behaviors.

Trust which in our paper refers to “confidence in the other's goodwill” (Ring and Van de Ven, 1992: 488) e has emerged as an important factor un- derlying relationships between nurses and their client

Noting tensions between trust in community members' traditions around feeding and community nurses' messages on feeding, we highlight the reflective trust exhibited by mothers in our case study.

Mothers overwhelmingly pointed out that during post-natal visits, community nurses pro- vided them with information about feeding, including nutritious foods for infants, and mothers “trusted” them regarding what to feed their infants.

“It’s a two-way kind of street. One asks a lot of private ques- tions and it’s a balance of power to be able to have information shared that way.”

Sharon (PHN) acknowledged that occasionally she struggled because, she explained, “You want to be doing everything for some of these moms, at least trying to help them out as much as you can. Your role only goes so far.” She found it difficult to keep that line straight between PHN and advocating as social worker, because “with some of these moms” she wanted to “offer them more resources, more tangible things” that extended beyond her “bounds as a PHN.”

The PHN had been addressing concerns that just as well could have been or should have been carried out by a friend or the mother's partner or family members. What culminated by this final stage were some LISMs seeking to fill a social support void causing PHNs to, again, revisit and redraw their professional boundaries.

'Welcome intrusions' characterizes the nature of TB nurses' relational work and its inherent tensions, which resists dichotomous interpretations.

Offers of food and drink were common in most visits, and there seemed to be an unspoken understanding that accepting these things was not a breach of 'professional boundary' rules. To accept such could be a formal gesture conveying acceptance of the client's efforts to welcome and/or a completely informal part of ordinary exchanges.

An obvious goal of surveillance is to physically observe the client. Yet once inside the home, only focusing on surveillance might create negative consequences in terms of gaining future access. All nurses experienced this phenomenon, speaking of it as ''getting through the door'' and ''what gets you through the door''. They were aware that how they entered the home held significance in terms of reinforcing the intrusion or diminishing it. Part of the goal of each visit therefore was to be invited back.

From clients' perspectives, deciding to open the door to the nurse seemed to be a way of maintaining their own

power in the situation.

'[If] you don't create that environment of friendship or, relationship . . . what I can say?, you are likely to get challenges, because I might even decide to harass you, might even, like, you come, you are knocking on the door, and I don't open. I feel like, 'oh god, she has again come'.''

''I think it's a trust thing. Because I'm going into their house, they're not coming to my office. I'm on their territory. What makes a relationship work is based on trust because once a patient trusts you, they take your advice ... I'm in their home and they're trusting me with being in their home. And also I'm trusting them being in their home.''

''. . . people say, 'well, why are you meeting this person in the parking lot?' And then you kind of tell little white lies. One client introduced me as a nurse he met in the hospital because they knew he'd been sick in hospital the year before, and that we had struck up a friendship... So then you kind of go with the flow... You have to be careful. People, wherever you're going, are identifying you as somebody regular.''

In short, getting through the door involves respect, trust, and sometimes, a kind of honest dishonesty, the necessary and inseparable dimensions of not intruding too much. Client privacy is central in order for nurses to be welcomed in the context of surveillance, and getting in the door leads to ''doing TB''.

The theme 'beyond a professional' addresses the ways nurses and clients get to know each other over the long course of treatment, and include subthemes of socializing- with-purpose, knowing the person-in-place, and cultural learning exchanges. According to clients, their nurses were ''beyond a nurse''; ''like a friend''.

Although their role is to monitor TB treatment and connect clients to resources, as TB nurses become more personally involved with clients and their situations, they often take up other concerns which could be argued academically as not within their professional responsi- bility.
As nurses engage in better and worse situations with clients, in being too close and too distant, over-stepping and not stepping far enough into personal lives, they sort out the appropriate level of involvement in each relationship and situation over time.
Proximity, or how close nurses get to clients physically, emotionally, and morally (see Malone, 2003), is an important consideration in developing the skill of involve- ment as it draws attention to the fact that emotional engagement with clients as persons potentially has both effective and problematic aspects. The perils of proximity (Peter and Liaschenko, 2004) are such that by emotionally engaging with the person in particular locations and circumstances, the nurse opens herself up to her own anxieties.
Likewise positive emotions elicited in care-giving moments with likeable clients can pull nurses to being too close or too involved. Lack of recognition of this distancing or extreme closeness is problematic because either level of involve- ment may shift the center of concern away from the clients' needs toward the nurses'. It is in recognizing and reflecting on one's proximity, and through trial-and-error, that nurses learn and develop their skill of involvement.
Providing comfort also depends on discerning how to be
available without being intrusive (Benner et al., 1999, p. 273). This means recognizing when one is too close and respecting clients' indications of withdrawing or distan- cing themselves (Benner et al.). Yet, by law, TB clients cannot refuse treatment or isolation when the disease is active, and therefore cannot choose to withdraw. Providing comfort in this sense does not entirely address the surveillance reality of TB nursing practice.
Consequently, a phone call to arrange a time demonstrates the belief that the family requires respect in terms of negotiating a visit time, but also raises the probability of successful access to the home.
According to the PHNs in this study, the contradic-tion between confirming, supporting and creating atrusting relationship with the parents and at the sametime having a controlling function also represented achallenge
Care begins with the general assumption that the nurse is a guest in the client's place, whereas the hospital is often perceived, by both health professionals and clients, as the health profes- sional's place.

Yet once the nurse enters, the home's privacy is challenged and the client's ability to restrict public surveillance is compromised.
Likewise, the nurse's sense of a controlled workspace is altered, along with her/his sense of power, authority, and control.
She expands on the notion of proximity by suggesting that nurses choose how close to or distant from clients they will be.Their choices are based on who their clients are, their unique life circumstances, the specific health situation, and the geographical, sociopolitical, and cultural places in which nursing is carried out.The choices call for self-awareness, self-knowledge, an ability to set boundaries, and empathic understanding. Choices regarding proximity are part of nurses' obligation to continually re-examine their power as professional

Are we simply guests in clients' homes? How do we overtly and subtly exercise our authority as we make decisions in clients' homes? How do the places in which we find ourselves working affect our choices about how close we get to clients? Do our choices about proximity contribute to healing and well-being, or do they inadvertently reinforce clients' feelings of displacement?
Community child health nurses must gain entry to the house and to the family if they are to undertake the work of improving the family health and 'entry work' is the process which obtains access to the client and the home.

Luker and Chalmers (1990) identified women as the 'gatekeepers' to the family for health visit- ing services. They identified factors that either facilitated or blocked entry to the client and thereby the nurse's work.
The health visitors were aware their behaviour had an effect in determining their entry to the house, so they consciously presented in a non authoritarian manner respectful of the client's needs and their position as a guest in the client's home.
A high value was placed on respecting the rights, needs and explicit wishes of the client expressed as 'not imposing' (1991: 654)
Confirming and supporting the clients seemed to beimportant components in creating and maintainingrelationships. This corresponds with Severinsson's(2001) research, which shows that confirmation is a coreconcept of supervision.
One of the PHNs expressed: ÔMy problem is thatI am now so important to these parents that it is difficultto encourage them to act independentlyÕ
On the contrary, they found it challengingthat some clients became dependent on the PHNsÕ ser-vice and the PHN as a person as a result of the long-term nature of the relationship. Furthermore, when theclients had a poor social network or complex problems,then the relationship with the PHN became even moreimportant and the empowering process more compli-cated.
The PHNs reported that one central challenge wasthe contradiction related to, on the one hand, acting asan expert and, on the other, allowing the client to be theexpert.
Thus, sheshowed the parents that she believed in their ability tomake decisions and, although she was an expert andrecommended the vaccination, she nevertheless wantedthe parents themselves to decide
ÔThe mother leads the dialogue between us ,but I lead too. I had planned what to focus upon in thedialogue with this mother, but at the same time Iwanted the mother to feel that we focused on issues thatwere im portant to herÕ! This quotation also shows thePHNsÕ sensitivity and attentiveness to client concerns.
The PHNs stated that the aim of their supervision wasto contribute to strengthening the clientsÕ coping ability.
My job as a public health nurse is to preventdisease and to promote health. The point is how to. focus upon this, while at the same time supporting theclient, relating the topics in the dialogues to research-based knowledge and conducting a dialogue whichincludes reflecting wi th the client and not acting as anexpertÕ!

Thus, health chal- lenges can be explored openly and the PHN employs a cooperative partnership that evokes the family's ideas about health and emphasizes autonomy. As a result, either the family as a unit or individual family members can develop self-efficacy to initiate change

Our findings are congruent with the model developed by Hardina (2003). She specifically highlighted mutuality and reciprocity, social justice, focus on vulnerable populations, inclusion of personal and social levels, and organizational support for health professionals to foster empower- ing relations with communities.

Building trusting relationships, confidence, and skills was integral to the empowerment pro- cess.

A more prominent educational role was revealed in the nurses' use of process-focused meth- ods. This approach included asking questions, providing information, and discussing possible next steps as a way of building the client's decision-making capacity

hey sensed opportunities for more group ownership, and they stepped back from the process, giving space for clients to take the lead

The nurses identified confidence and skills as two key outcomes of building relationships with in- dividuals and groups, which then had the potential to lead to empowering citizen participation.

All the nurses repeatedly stated that building an individual's or group's capacity to take control over their health and the health of their community starts with a mutually trusting and respectful relationship between the client and the health care professiona

Building capacity for partnership and citizen control emerged as a meta-theme from descrip- tions of the nurses' practice with individuals, groups, and communities. Many of the nurses talked about the importance of making a difference in their clients' lives that focused on doing with rather than doing for, so the clients themselves felt empowered to take ownership of their health deci- sions.

Falk-Rafael (2001), in her qualitative study of public health nurses, identified a client-centered approach that included a relationship of mutuality and trust as central to their practice and consistent with an empowerment process.

Public health nurses have more than a century-long legacy of addressing broad inequities in health and building capacity with people who are disadvantaged by their life circumstances (Reutter & Ford, 1998). Their practice focuses on vulnerable populations, issues of social justice, and em- powerment (Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic, & Chircop, 2006; Edwards & Davison, 2008)

Citizen participation is heralded as a critical element of community health programs that emphasize empowerment and health promotion strategies

It was I'm here to help you and make sure you're comfortable and that you feel comfortable as a mom and confident. And it was like they try and build the confidence for you to make sure that you know what you're doing. They give you the knowledge to have the confidence. And otherwise I wouldn't have had a lot of that. Like in the beginning, I was so shaky

The majority of PHNs spoke about how they recognized the perception of new mothers who may see them as a person in a position of authority who might judge them. Because of these potential feelings of discomfort or fear, most of the PHNs spoke about how they always attempted to shift the relation of power in the relationship and encourage the mothers to feel that they had more "control" and choice

In practice, meeting needs and build- ing capacity often occurred simultaneously; moreover, these activities often led to and in- formed political advocacy

We use the English term 'facil- itator' which means to help. In French we use the term 'animateur' which means bring something to life."

Basically we were saying to women, "You gals are the experts here and we want to help people be safer when they use and we need your advice." And so they both helped create a useful pamphlet that we could use in practice but the process of doing that made them feel as though they had something to contribute and that they had something to teach us

I think as soon as you start engaging in a relation- ship with somebody, my goal is to try to help them make that better and that's the trick. I'm not mak- ing it better. I'm helping them make it better I hope. And sometimes it is you making it better because they can't, for whatever reason, or aren't able to at the time.

I think a lot of times it's because we didn't . . . [in the] beginning check in to see what is it that these people or this person really, truly values and what is it that we value and what is it that we can do that will work with them rather than doing work that really has no place in that person's life or within that com- munity.

[In the] beginning one has a little window of op- portunity . . . And then just kind of quietly talking, . . . asking what the concerns are, how is that per- son, and then it just builds up from there. . . . [She describes a visit to a Mother and children who had
been referred to her and asked the Mom] "What are your concerns?"

Assessments often took place in the mo- ment. One participant recalled being part of an H1N1 immunization clinic when she was approached by a man who disclosed to her that he had AIDS, was facing surgery in 10 days of which he was fearful, and needed to talk. She remembered thinking, "Oh my good- ness! There's so much going on around me and this man needs to talk."

Client centeredness occurred within the context of mutuality and there were in- stances, such as with the Healthy Workplace initiative, where PHN expertise was clearly critical in planning the best course of action

The majority of PHNs believed having a set agenda created a relation- ship that was dominating and potentially oppressive for a mother. They told us that delivering a prescriptive agenda would contribute to a negative rela- tionship between themselves and the mothers. Therefore, the majority of PHNs preferred to follow a health discourse that was client-led

PHNs fully acknowledged the unique and changing needs of mothers and allowed the mothers to identify their own concerns and stressors and organize the visit around the mothers' understandings she showed me a lot of respect. I found she was very respectful and very . . . you know, especially of your privacy and things. Like she would say, you know, "If you're uncomfortable while you're breastfeeding, I can give you a blanket or I can give you something." And it seemed that she was always aware of how you're feeling

Full citizen participation attends to client values, interests, and concerns, with citizens having the right and duty to actively participate in and be in control of assessing, planning, implementing, and evaluating their health and health care both individually and collectively

Falk-Rafael (2001), in her qualitative study of public health nurses, identified a client-centered approach that included a relationship of mutuality and trust as central to their practice and consistent with an empowerment process.

With a focus on citizen participation and authentic partnerships, all nurses noted that they used strategies such as starting from the client's perspective, tuning into client readiness and implementing a holistic assessment

Much was realized through the interactional strategies, painting a new canvas, eliciting the client's agenda, and building capacity in terms of finding out who this LISM was and what she needed and wanted to fulfill her mothering responsibilities.

Painting a new canvas . The PHN moved from universal understanding of a lone parent in poverty to this particu- lar mother and person before her "like starting with a new slate.

The PHNs in this study tried to build a trusting and dy-namic relationship with their clients through confirmingand supporting them, sharing thoughts, experiences,reactions and knowledge, and respectfully approachingthe client at his/her own level.

Furthermore, the PHNs found it important to baseclient supervision on familiarity with the client and his/her concerns.

The findings showed that the PHNs regarded theclients, be they children, parents or young people ,as the subjects of client supervision. This indicatedthat the concerns addressed were based on what theclients themselves expressed or revealed in response tothe PHNsÕ questions, as illustrated by the followingquotation: ÔDuring the dialogue, the client herselfexpressed what she needed and what she thoughtabout it, I did not provide her with a solutionÕ.

Thus, the PHN s werewilling to support the clients, which the followingstatement also demonstrates: ÔThe mother wanted topostpone the vaccination and I found it important toback her up in this regard. I think it is best to meet theparentsÕ wishes as far as possibleÕ

The findings showed that, when performing clientsupervision, the PHN s often had to look beyond thecurrent situation in order to deal with the client at his/her own level and to identify needs and problems.

Furthermore, the PHNs stated that it was a challengewhen their personal values differed from those of theclient. One of the PHNs described the situation of amother who was worried because her baby's weightfailed to increase as expected. The mother wanted togive the baby formula milk, while the PHN thought thatit would be better to breastfeed more often, thusincreasing the milk production. The PHN commented:ÔWhat I think is imp ortant is that if the mother choosesnot to breastfeed the ba by any longer , then it is veryessential that the decision is based on know ledge andreflection, that it is a real choiceÕ.

A relationship based on trust is also fundamentalin the empowering process (Gibson 1991, Ryles 1999).Furthermore, building a trusting relationship is im-portant in client supervision, which is supported by thefindings of a study related to the values underlyingnursesÕ professional identity; which require interactionsaimed at recognizing the patient as a person, exploringhis/her perceptions of the situation and creating a senseof trust (Fagermoen 1997).

The PHNs reported that it was important to knowand understand the client and his/her concerns in orderto conduct client supervision.

The mothers in a study by Fager- skiol et al. (2003) wanted the nurse to be sensi- tive to their emotional needs, to take their voiced concerns seriously and to see things from their perspective. The nurs- es also consciously modified their speech and behaviour to suit the situation in an attempt to make themselves more acceptable to the client

If the health service in which the nurse is located is well known and accepted in the community this is noted as a pivotal means of gaining access to clients

Care in community health nursing is not restricted to the home but also occurs in places such as schools, community centres, and drop-in clinics. Unlike hospital and home-care nurses, community health nurses observe and engage with people in the broader community context of their daily lives This obligation is complicated by the need to navigate multiple places of care.

The infectious disease perspective calls to mind the work of present-day TB nurses, who provide care in a range of physical locations such as homes, workplaces, coffee shops, parks, and shelters.

Carolan et al. (2006) identify the nurse-client relationship as an important element in nursing geography in terms of the healing nature of places, questions of situated- ness, and nurses' social location in the context of gender and power.

So you have to go to your community, to the grassroots, to be able to get community support. So that means going to the women's groups, going to the men's groups, going to church groups, going to your community health boards, and the people who are the movers and shakers in your community.

Most public health nurses described their knowledge and ability to make connections happen for their clients as a significant skill

To accomplish this, many nurses indicated that it was important to know community needs, as well as available programs and services. For example, they had established relations with com- munity services and family resource centers.

Many nurses established collaborative relationships with the schools by getting to know the teachers and promoting themselves as resource people and partners at staff meetings.

You try lots of different ways to get that message out, and if it means being involved in community group things, for instance, on an advisory committee for the teen health centre and making it so that they don't call it a "teen clinic," they call it a teen health centre because we don't do any band-aid stuff [anymore

They noted that the empowering process is contingent on the attitudes of professionals toward local knowledge and experience, and the quality of com- munity involvement that the professional encourages

As reported earlier in CHPP II, relationships with clients were equated to PHN effective- ness. It was not surprising, therefore, that par- ticipants believed their effectiveness was lim- ited when changes rendered relationships no longer possible. Some whose practice had be- come more population-based saw a problem in being "based in an office and not out in the community."

One of the strengths that participants be- lieved they brought to individual client situa- tions was their knowledge of the community and its services and resources that might be useful to individual and family clients.

[S]he didn't talk to me for the longest time but I would see her and I would acknowledge her and say hello. . . . I knew she wasn't interested in talking to me. . . . [T]his went on for many, many months. And I would give her the odd cigarette and say something like, "Thanks a lot for cleaning up the parking lot. That really helps a lot." So we had a little bit of a relationship that wasn't based on much but just daily sight. And then one day she approached me and she said, "So you're some kind of nurse, right?" And I said, "Yes, I am." I thought I was going to get a tirade 'cause I was the enemy. . . . But she said, without looking at me still . . . . "Give Modicaid injections?" And I said, "Well sure, I can." And she says, "Would you give me one?"

I have size 10 feet and so I'd put on these little slip- pers and I remember this one family and that was the breakthrough moment! They were laughing at me and my big feet hanging over. . . . If people knew some of the things that we did to build re- lationships, whether it's eating pigs' hoof stew or other things that we do because that's how you gain the trust and how we're able to do our work with communities.

We have such a breadth of knowledge about com- munities and how they work and interact right from the grass roots level, from having the experi- ence of being in an individual's home and seeing what's going on and what the stresses are. . . . to the workings of different agencies and how they communicate with one another, . . . working with a municipality, looking at the broad picture, and then relating that to how . . . [it] impacts people throughout the life span.

"The advantage that public health nurses have is we're in the homes, we're in the community, and we see what's happening and we've got that knowledge base to move it up."

In a few instances where practice was more strongly characterized by a population-based approach, participants depended, initially, at least, on either relationships they had estab- lished in the community in previous PHN roles or the relationships they had established as citizens in the community.

Now I can't walk down the street without some- body that I don't even know yelling, "Hey, nurse!" . . . People that I'd never met come to me and say, "I've known you for years because I'm part of this community." . . . People know people I've helped and people watch how you relate to people. [They] will come back to you and say, "I remember when you did this and helped somebody" and you realize that really what you're doing is investing in a rela- tionship with a whole community that happens on a level you're not even aware of and it's crucial. . . . It's hard to articulate because it's largely invisible and intangible.

We found that in the communities in which community nurses live and work, the nurses organize ante- and post-natal visits, hold peer educational sessions, home visits, health and nutrition discussions, durbars, and interventions targeting com- munities as a whole, including fathers, opinion leaders, etc. They actively engage and partner with mothers in their communities to address specific health challenges, including malnutrition as well as on non-health issues. Sometimes conversations centered on farm yields, the children's education, politics, etc. Outside of working hours, nurses are invited to attend social events in the commu- nities, all of which fostered deep relationships between mothers and nurses, which in turn engendered trust

As our findings show, the trust and authority of nurses' ideas also partly emerged from mothers' observations about the success that such ideas had in improving the wellbeing of infants in their community, consistent with a skill-biased model of learning

As part of their reorientation, nurses live in these communities and strategically build relation- ships with the community members and leaders (chiefs, elders, opinion leaders) by organizing health and nutrition discussions, pre and post-natal visits, home visits, peer educational sessions, and educational durbars for the whole community, including fathers and opinion leaders (Phillips et al., 2006). CHPS nurses also work with volunteers within communities who help with mobilization and health promotion among community members

Community-based Health Planning and Services (CHPS) nurses in Ghana are community-based public health nurses who, have deliberately incorporated traditional approaches, such as social trust customs employed by traditional healers to facilitate relationship building, and have integrated an understanding of child feeding concerns and practices handed down from elders, into their practices (Binka et al., 2007; Nyonator et al., 2005).

Mothers allow themselves to be influenced by nurses, who they perceive to be members of their communities (because of the relationships they develop with these nurses over time), as well as holders of "modern scientific knowl- edge" (Warren, 1989: 162), who provide advice that, over time, they find is effective in their communities.

A high value was placed on respecting the rights, needs and explicit wishes of the client expressed as 'not imposing' (1991: 654)

The health visitors were aware their behaviour had an effect in determining their entry to the house, so they consciously presented in a non authoritarian manner respectful of the client's needs and their position as a guest in the client's home.

These mothers preferred a professional demeanour which was not overly bureaucratic, and which respected the mother's confidentiality.

Are we simply guests in clients' homes? How do we overtly and subtly exercise our authority as we make decisions in clients' homes? How do the places in which we find ourselves working affect our choices about how close we get to clients? Do our choices about proximity contribute to healing and well-being, or do they inadvertently reinforce clients' feelings of displacement?

McGarry (2003) discusses the balancing of power between nurse and client, which can be partially understood by viewing the nurse as a guest in the client's home.

The PHNs in this study tried to build a trusting and dy-namic relationship with their clients through confirmingand supporting them, sharing thoughts, experiences,reactions and knowledge, and respectfully approachingthe client at his/her own level.

A fundamental differ- ence in home visiting is that the PHN is a guest in the family's home and should always respect the fact that families have their own internal commitments and self- determination.

A stance of watchfulness does not require always directly staring. It thereby can convey respect for the person's privacy even while under the surveillance of Public Health and diminish the sense of being scrutinized

Nurses may want to respect clients' signals of withdrawal, thereby comforting them, but the situation of surveillance in treatment adherence may demand that they remain present, keeping clients in view.

Being watched under surveillance, according to most participants, was infantilizing for clients and the nurses' awareness of such potential feelings was a key facet of their observation skills.
In short, getting through the door involves respect, trust, and sometimes, a kind of honest dishonesty, the necessary and inseparable dimensions of not intruding too much. Client privacy is central in order for nurses to be welcomed in the context of surveillance, and getting in the door leads to ''doing TB''.

Getting through the door then is a sign of some level of acceptance or welcome. Tangible incentives help with this (such as grocery vouchers and public transit tokens), yet it was the nurses' respectfulness, trustworthiness, and preservation of privacy that seemed to have a stronger influence.
Getting through the door involves respect for clients' homes by taking off shoes, waiting to be shown where to sit, and even continuing the visits under the distracting conditions of the house, such as cooking, telephones, and loud televisions. As clients feel respected, trust also develops as described by this nurse
The antecedents to empathic accuracy included the PHN's comprehension of the mother's multiple chal- lenges within her social environment. The antecedent to responding strategically was the PHN's respect.
They used several strategies in exercising a provider-as-partner role: engaging in respectful dialogue and active listening; believing in clients' capabilities and focusing on their strengths; and creating a safe, welcoming and accessible envi- ronment

All the nurses repeatedly stated that building an individual's or group's capacity to take control over their health and the health of their community starts with a mutually trusting and respectful relationship between the client and the health care professiona
For example, PHNs "asked permission" to help with breastfeeding.
she showed me a lot of respect. I found she was very respectful and very . . . you know, especially of your privacy and things. Like she would say, you know, "If you're uncomfortable while you're breastfeeding, I can give you a blanket or I can give you something." And it seemed that she was always aware of how you're feeling
Another important aspect of building effective relationships between PHNs and mothers was evident in many of the moth- ers' interviews as they spoke about how the PHN was very respectful to them, their babies, and family with many examples centered around breastfeeding.
Par- ticipants had different opinions about what the latter meant—some spoke of being care- ful not to power dress or dressing mindfully of socioeconomic differences but others be- lieved as long as respect was shown, dress did not matter:
It was really re- lating to him person-to-person, human-to-human, coming from very different lives and very different experiences. But it was an equal sharing in that experience and learning from one another.
Noting tensions between trust in community members' traditions around feeding and community nurses' messages on feeding, we highlight the reflective trust exhibited by mothers in our case study.

Tensions: trust in elders' traditions versus nurses' messages

The quote above points to conflict between old and new ideas about infant feeding, as well as some elders' mistrust of doctors.

Most people in my area, they're still a lot of people that don't know we're not coming in to put a band-aid on, and they really only understand nursing as that. And that, all by itself, is a bit of a barrier. Education isn't seen or valued, as the real value is to care, in caring for the sick as opposed to helping people learn how to keep themselves well. So education on all levels: from population to the government.

'Welcome intrusions' characterizes the nature of TB nurses' relational work and its inherent tensions, which resists dichotomous interpretations.

'[If] you don't create that environment of friendship or, relationship . . . what I can say?, you are likely to get challenges, because I might even decide to harass you, might even, like, you come, you are knocking on the door, and I don't open. I feel like, 'oh god, she has again come'.''

Being watched under surveillance, according to most participants, was infantilizing for clients and the nurses' awareness of such potential feelings was a key facet of their observation skills.

Notably, engagement may be required with clients considered noncompliant or difficult, which means withstanding emotions (one's own and the client's) such as frustration, impatience, or anger, and staying open to the cues they offer for alternative perspectives in understanding.

Indeed nurses' power in ensuring adher- ence can contribute to a feeling of intrusion for clients. Furthermore, the PHNs stated that it was a challengewhen their personal values differed from those of theclient. One of the PHNs described the situation of amother who was worried because her baby's weightfailed to increase as expected. The mother wanted togive the baby formula milk, while the PHN thought thatit would be better to breastfeed more often, thusincreasing the milk production. The PHN commented:ÔWhat I think is imp ortant is that if the mother choosesnot to breastfeed the ba by any longer , then it is veryessential that the decision is based on know ledge andreflection, that it is a real choiceÕ.

Sometimes the PHNs experienced that the client'sdecisions differed from recommendations set out inNorwegian White Papers or from what they as profes-sionals considered a qualitatively good choice. To haveknowledge, but not act as a Ôknow-allÕ thus representeda challenge.

The fact that the PHNs followed up the clients over along period of time represented a challenge in itself,because it was difficult to be aware of one's ownassumptions or prejudices when meeting the clients.However, some of the PHNs stated that, when follow-ing up the clients over a long period of time, theylearned to know and understand them and achievedcontinuity with regard to the children's growth anddevelopment.

On the contrary, they found it challengingthat some clients became dependent on the PHNsÕ ser-vice and the PHN as a person as a result of the long-term nature of the relationship. Furthermore, when theclients had a poor social network or complex problems,then the relationship with the PHN became even moreimportant and the empowering process more compli-cated.

comments/ notes

trust as key to behaviour change

Power and the equal aspect of power in community setting

sharing information as a way to share power

being aware of the power dynamic relationships and working with clients in order to collaborate based on strengths; avoiding a prescripitive approach

<--- key point/theme: sharing power

<--tactics to shift the power

<--- tactics to shift the poiwer

being aware of the power dynamic relationships and working with clients in order to collaborate based on strengths; avoiding a prescripitive approach

Power and the equal aspect of power in community setting

therapeutic friendliness as a tool to lessen the power dynamic; foster trust

power dynamics, egalitarianism, client cemteredesss

partnership

strategies to encourage client ownership

power-trust-caring

lack of understanding of the public health role --> thinking of nurses as power mongerers, threatening authority figures

power can be perceived in multiple ways, with nurses occupying multiple roles "bad guy"/"good guy", nurses recognize the importance of striking a friendly and helping relationship to offset the reality of their power

clients are in their own homes and for the most part attending to their daily care needs independently in the public health setting. This may point to an initially smaller degree of professional intimacy during the beginning stages of the relationship as nurses are not physically caring or admnistering medication or treatments in a way that in physically proximal to patients.
power, nursing care requirements such as observation, and the desire to build trust are all competing priorities of a TR in the PHS

power, nursing care requirements such as observation, and the desire to build trust are all competing priorities of a TR in the PHS
public health nurses are aware of the ethical complexities of exercising and holding power in a therapeutic relationship within the public health setting

challenges related to power dynamics (contradiciting priorities such as being the expert while also being a source of validation and support)

nurses "place" in the relationship is unique in the public health setting
the importance of the place in the relationship should not be ignored
"nurse as guest"

although sharing of power is inherent in the public health TR, there is still unequal power with the nurses holding the ability

complexity of power and boundary navigation within the public health setting

position as guest in clients home

not imposing, maintaining a position of less power? Less overt expression of power (nurses)

conflicting power dynamics

power dynamics, persuation

potential for therapeutic relationships to be stagnant if not enough trust is developed***

there is a certain amount of "testing" that the mothers may do in order to see if the nurses are trust worthy….

trust as foundation precursor to understanding clients needs

nurses are entering the patients domain and therefore have to build trust as the nurse risks being viewed as an intruder if this trust is missing

trust can take the edge offf of the more "power heavy" functions of public health nursing

nursing objectives to maintain their professional status/ power while developing trust is a challenge

vulnerable clients may be more prone to feeling stigmatized and alientated and special care on the part of the nurses' hadndling of proximty, professional intimacy and boundaries helps to foster feelings of trust

trust can be developed through the nurses' ability to embody and provide a comforting presence

boundaries, trust power,]--> interdependent nature at the beginning stages of the relationship

nurse as a guest, the "place" of the nursing therapeutic interaction has an influence on how to develop trust

<--- strategies for how to "get through the door, develop trust"

pivotal moment of introduction

public health nurses adapt an advanced social skill set which helps them to navigate these compciated discourses with patients

litmus test -- trust as a graudual process that takes time. Time and continuity of relationship in the public health setting allowed the potential for these deeper interactions to develop between nurses and clients

<-- vulnerable clients

<-- vulnerable clients

the importance of visible and active demonstration of "caring"

"laid back" and friendly

length of relationships

strengths based appraoch, capacity building

capacity building is not limited to individuals in the public health nurse-client interaction but also takes place at the systems level,

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trust is gained through client's seeing observable evidence of the nurse's expertise ---> this is different than the hospital environment **HOW?**

trust is gained through client's seeing observable evidence of the nurse's expertise ---> this is different than the hospital environment **HOW?**

a mixture of approaches yields more effective trust building process (traditional and scientific knowledge) --> this implies that nurses in the community may incorporate high levels of cultural competence in order to build trust within commmunities and individuals

the nurse as the information giver, the cliient as the information reciever and therefore the client is also the decider of what to do with this information. (hints at persuasive nature of TR in PHS)

role of the therapeutic relationship can sometimes be broad and reflects the highly personal nature of the exchange that PHNs share with their clients. PHNs may become aware of a higher number of personal, social, familial or financial problem and this nurse indicates that she has a hard time defning what is responsibility as PHN

<--- the crucial demension of boundaries and the need of PHNs to repeatedly draw the boundaries

in the community there exists a distinct understanding of what may constitute a breach of boundaries compared to hospital environments where the autonomy of patients may be more limited
Nurses in PHS are looking to get "invited back", indicating that they are aware of their position as guest in a client's home

power, boundaries, decision making is in the place of the client]]]---> this is a unique feature of ETR in the PHS

the friendship/ relationship component is crucial in order for the exchange to progress and for goals of care to met/ addressed
nurse as guest

nurses must have understanding of how not to intrude, how to handle the privacy of clients while being a guest in their home

PHN role defnition, professional responsbility,

time is an interesting element of the ETR relationship in PHS and allows nurses time to "feel out" the relationship and gain an understanding of the appropriate boundaries

self awareness = key component of navigating boundaries

the balance of boundaries in the PHNs' role as a supporter and role as "controller"/authority figure

nurse as guest

<-- does this make client's more likely to protect their personal space and less receptive to nurses visits?

<-- nursing self awareness

<-- nursing self awareness

first stage of the therapeutic relationship is described as "entry work"

In the first stage of the TR, the PHNs in this study present themeselves as a non authority figure in order to gain entry

cultivating and expressing respect

confrimation, validation, and support

nurse desires to empower and not enable helplessness

empowerment as a complicated process, length of relationship as a major facet of the TR in PHS

nurses recgognize the complexity and contraditions within their role as PHN

"not acting as an expert" while holding and expressing "expert" knoweldge = tricky

empowerment =key feature of TR in PHS
building the client's decision making cpacity is part of empowerment

nurses "giving space" = therapeutic action

confidence,, skills, = empowerment

empowerment happens after the first stage, the building of trust, has been accompished

doing WITH rather than doing FOR = connected to empowerment,

client empowerment as an ingredient in health promotion

<-- confidence building, client empowerment = therapeutic actions that are invisible but very important in order for subsequent health promotion and health education activities to be successful
nurses tendency to try and "shift" the power in order
Empower mother

actively acknowledging the clients as experts of their own lives and situations

actively acknowledging the clients as experts of their own lives and situations

first stafe of the therapeutic relationship, described as a "window"

client led health discourse -->

nurses converying respect, being aware of feelings

tuning into readiness is part of this PHNs begnnning phase of the therapeutic relationship

client centeredness --- > many public health nurses have mentinoed this aspect of client care.

priority conflict: medical recommendations vs status of a successful, supportive relationship

nurse as the educator and the nurse is the one to initiate these discussions and reflections related to health care decisions so that clients can make an informed choice

empathy

KKEY POINT Public health nursing often takes place in the broader community context of the clients' daily lives, which changes the nature of the ETR

relationships with individuals BUT ALSO groups, the borader context of the community

additional skillsets of PHNs when it comes to "making connections"
community needs, programs, services, are part of the required knowledge base of the PHN in order to practise effectively and therapeutically
the nurses are getting out there in the community at times when there is no identified, acute health need or problem. The nurse is getting to know frontline people in the community in order to engage with them and make connections which might not be named "therapeutic" in the traditional sense but crucial in order to build trust with community leaders

client relationships effectiveness = public health nurse effectiveness

trust is deepened through nurses presence within the community at large

formalized traditional approaches to relationship building
encorporates the nurses into these communities

Clients expressly indicate that they do not want to be
imposed upon by nurses

nurse as guest in the beginning stage of the relationship

nurse as guest in the beginning stage of the relationship

strongest influences in being able to get rhough the door
and successfully complete the first stage of the relationship
= resepctfullness, trustowrthiness, professional intimacy and
preservation of privacy

empathy

respect

nurses may face difficulties in developing trust as clients navigate multiple sites of information for health choices

not all communities/ individuals trust healthcare

educating the client about the role of the nurse may in fact be a crucial component of the TR as clients may traditionally think of nurses as belonging in hospitals

observation represents a tricky requirement of the TR in the PHS because in runs the risk of seeming disprespectful to clients
differences in opinion hetween client and nurse (not necessarily specific to the PHS)

PHS ETR = longer time commitment

PHS ETR = longer time commitment

implication	research question 1,2,3, or 4
nurses need to be aware of how to create these equal relationship	RQ1
	RQ2
	RQ1
	RQ1
	RQ3
	RQ3

nurses are aware of the overwhelming importance of managing power dynamics within the public health setting. Perhaps extra attention could be devvoted to the strengths based approach nursing style	
a key feature of the therapeutic relationship in public health settings is power, its negotation, and the emotional labour involved in manoueving the power dynamics so tha the client is empowered and reinforce the clients position as expert	RQ2
trust is a central feature of healing the power imblanace with marginalized or oppressed populaitons	RQ4
this ppoint indicates a shift in the literature, which has up until this point acknowedged only the sharing of power. This point emphasizes that at times there are "rules" and authoritarianism that can take place within the public health setting.	RQ1
navigating power and trust in the beginning phases of the realtionsihp will look different in the PHS as the client, the owner of the home in this case, is a person who holds significantly more power and control over their boundaries than a person who is institutionalized.	RQ1
	RQ1

	RQ1
roles and responsbilities of nurses:	RQ3
mulriple roles and responsbilities of the public health nurse	RQ3
	RQ1 and 2
	RQ2
How does the nurse occupy the role of guest while navigating the requirements inherent in establishing a therapeutic relationship? What actions do nurses fulfill to show themselves as respectful or "good" guests?	RQ3
	RQ2
	RQ2
	RQ2

<---power is central to the relationship, existing in the forms of patient empowerment, unconditional respect, all while preaching a certain health agenda or "correct way" of carrying out child health activities

<--what does this imply for our practise? How do nurses navigate the testing period and how should they react if they realize they are being tested?

RQ2

RQ2

RQ2, RQ3

RQ3

RQ4

<-- development of trust

<-- development of trust RQ2

how do nurses develop trust when "invading" the client's space? RQ2

RQ2

<-- how do nurses ensure a successful first encounter given the complicated nature of invading a client's personal space RQ

RQ2

interdepedence between time, trust, continuity of care, boundaries RQ2

RQ4

RQ4

RQ4

how do nurses show they care? RQ3

RQ3

	RQ2
empowerment is a key eafture of therapeutic relationships in public health setting	RQ
<--- therapuetic relationships in public health setting develop over a longer period of time	RQ2
<--- this is a unique facet of the TR in PHS	RQ1
<---unique feature of TR in PHS	RQ1
	RQ1
	RQ1
	RQ4

RQ1

RQ2

RQ2

RQ2

RQ3

RQ3

RQ3

are there adequate guidelines for nurses working in these settings where boundaries might become more blurred

RQ1

RQ2

RQ2

RQ1

RQ3

RQ2

RQ1

RQ1

How do nurses decide what is too close or too far emotionally in TR in the PHS? RQ2

do nurses have adequate time and space in their practices to reflect on their roles and boundaries in developing relationships in the PHS? What would be helpful to nurses in these situations? RQ3

RQ

nurse as guest --? What are the impliactions of this influence on the ETR? How does this influence trust, power, professional intimacy, and all the elements of the ETR ? RQ1

RQ2

RQ3

	RQ3
what are the listed first stage of ETR in RNAO TR BPG => do they correspond or would an aletered model of the first stage be a more accurate represetnation of the PHNs	RQ1 and 2
	RQ1
	RQ1
<--- what is a broad term for these sorts of actions? (actions of affirmation)	RQ1
	RQ3
	RQ1
	RQ1
	RQ3

is there a greater deal of patient autonomy in the PHS? How might this greater deal of autonomy influence the TR?	RQ1
	RQ1
	RQ1
how do nurses know when to give space? What are nurses feelings and thoughts about giving patients space and autonomy	RQ1
	RQ1
	RQ2
	RQ1
	RQ4
	RQ1
	RQ1 2
empwerment as key therapeutic trategy used by PHNs	RQ1

RQ3

RQ3

RQ1

RQ4

what are the requirements for a successful client led health discourse? When is this appropriate and when is this less appropriate?

implications for further research

RQ1

<--- is this in any way related to stages of change or motivational interviewing?	RQ2, 3
	RQ4
is client centeredness more easily expressed or prevalent in TR in the PHS? Why might this be?	RQ1
what are nurses responsiblities in these instances? How do we handle the complexity of these priorities?	RQ3
	RQ1

RQ1

RQ1

RQ3

RQ3

are nurses given adequate time and acknowledgement for this part of their job? RQ3

what is thereapeutic knoweldge in the public health setting? RQ1

RQ4

RQ2

RQ2

what makes clients feel imposition? How can health care units train their nurses to avoid this possible dynamic?	RQ3
	RQ3
	RQ1
	RQ1, 3
	RQ3
	RQ3

RQ3

RQ2

RQ2

RQ2

RQ2

RQ2

RQ2

RQ2

RQ4

is trust developed by nurses through showing their expertise, being friendly, or a delicate combination between the two?	RQ3
what are the current practices of nurses who encounter these barriers? Do they terminate the relationship in the early stages or are they able to gain access in other ways?	RQ3
barrier: misundersatnding the role of the PHN	RQ3
	RQ2
	RQ3
	RQ3
what are the mplications of a longer time in the ETR? (A longer working phase?)	RQ1

RQ1

research question 4
What are some strategies that public health staff can adopt to establish relationships with vulnerable clients (homelessness, mental illness)

It was really re- lating to him person-to-person, human-to-human, coming from very different lives and very different experiences. But it was an equal sharing in that experience and learning from one another.

Painting a new canvas. The PHN moved from universal understanding of a lone parent in poverty to this particu- lar mother and person before her "like starting with a new slate.

Our findings from the case in Ghana indicate that the CHPS model fosters trust that influences mothers' decision-making, and could lead to changes in health-related behaviors, particularly among marginalized populations.

In the context of public health, being contagious is part of the suffering experienced by clients. Providing comfort therefore is particularly important for diminishing feelings of stigma and alienation. Contagiousness also implies the need for sensitivity with regard to physical closeness and distance. With this in mind, choice about one's proximity in client meetings is an important aspect of comforting. As seen in this study, getting up close to infectious clients, offering a quick greeting before masking, or sitting next to them, goes far in sustaining a sense of trust and being cared
for.

Mothers like Diane, who as children were taken out of their family home and placed in foster care, learned that the world was not a safe place, and if people in their nuclear family and in systems of authority were unpre- dictable and undependable, who could be trusted? In response, mothers "watch," explained a social worker: "They will read you as soon as you walk in the door; that is, where you are, where you have come from, what you do, whatever." LISMs wanted to ensure that the PHN could be trusted not to render judgment.

To trust or mistrust. Mothers shared that they learned to mistrust human service workers, agency personnel, and police officers when they were young. Diane (LISM) remembered being told as a child to "be scared of social workers or cops and stuff like that." When the PHN
showed up at her door on a routine postpartum visit, Diane was fearful: "I was really, really nervous. I thought she was there to try and take my baby or see if I was a bad mom."

Among mother participants was a predominant propen- sity for mistrust, and thus it took more than smiles and verbal praise to assuage the mother's fears and to convince the LISM that the PHN could be trusted.

To trust or mistrust. Mothers shared that they learned to mistrust human service workers, agency personnel, and police officers when they were young. Diane (LISM) remembered being told as a child to "be scared of social workers or cops and stuff like that." When the PHN
showed up at her door on a routine postpartum visit, Diane was fearful: "I was really, really nervous. I thought she was there to try and take my baby or see if I was a bad mom."

code respect	
respect, trust, client centeredness trust	
trust	being sensitive to te realities of stigmatized population e.g. being mindful of how close the nurse decides to sit to a population
trust	these populations may have traumatic or unfortunate experiences with authority figures, and therefore trust needs to not only be built but potentially *rebuilt*
trust	these populations may have traumatic or unfortunate experiences with authority figures, and therefore trust needs to not only be built but potentially *rebuilt*
	these populations may hold a higher propensity for mistrust
trust, power	