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BUILDING NURSE-STUDENT RELATIONSHIPS IN THE SCHOOL COMMUNITY: AFEMINIST PERSPECTIVE

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BUILDING NURSE-STUDENT RELATIONSHIPS IN THE SCHOOL COMMUNITY: A FEMINIST PERSPECTIVE

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by

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ABSTRACT

Background: With the release of the Community Health Nurses of Canada standards of practice (2003), the importance for nurses to establish empowering relationships within supportive environments is paramount. Moreover, it is important for nurses to recognize and understand how their position and the power it holds may influence relationships with clients in their practice.

Purpose: Guided by feminist inquiry, the major purpose of this research was to critically examine the relationships between Public Health Nurses (PHNs) and adolescent students in the school community. Specific questions included: How do PHNs describe their relationships with adolescent students within a school community? What broader contextual factors shape the formation and development of these relationships?

Methods: Using open-ended questions and a dialogic approach, 13 PHNs who work in secondary school nursing at one urban public health unit participated in one of three focus groups. Thematic analysis was conducted as described by Morse and Field (1995).

Findings: Study findings suggest that the formation and development of the PHN-student relationship is likened to that of building a school comprised of five interlocking "building blocks": visibility, trust, collaboration, continuity and power. Visibility was the PHN "gateway" for individual student contact. PHNs were considered trustworthy due to their outsider status to the school system. Collaboration was foundational to the relationship and involved negotiation, compromise and consultation. Continuity reinforced the need for time and consistency in public health programs and within the relationship. Power was found within hierarchical layers and reinforced by social relations of culture, gender and class.

Conclusion: In order to build empowering PHN-student relationships, PHNs must critically reflect on their individual nursing practice and policies, which influence relationship formation. Realizing the potential empowering and disempowering influences of gender, race, class, religion and other social determinants on health, PHNs are in a position to advocate for and promote the health and well-being of adolescent students. Further critical nursing research that incorporates the perspectives of students and others influential in the formation of the PHN-student relationship is needed.

Key Words: nurse-client relationship, Public Health Nurse, school nursing, adolescent students, relationship formation, feminist inquiry

CO-AUTHORSHIP

Kimberly J. Kempa Dias completed the following work under the supervision of Dr. Cathy Ward-Griffin and Yvette Laforêt-Fliesser. Dr. Ward-Griffin and Ms. Laforêt-Fliesser will be co-authors of the publication resulting from this work.

DEDICATION

To the Public Health Nurses who shared their stories:

May your roof never fall in
and your friends never fall out.

An Irish Proverb

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CHAPTER I

Background and Significance

In November 2002, the Commission on the Future of Health Care in Canada (CFHCC) released its final report outlining strategies to ensure the long-term sustainability of the health care system in Canada. One of these strategies included an increased emphasis on primary health care. Primary health care not only refers to equity in access to health and health care but also recognizes that health is determined primarily by social and environmental conditions that lie outside the traditional health care system and thus requires intersectoral cooperation to improve health status (MacDonald, 2002). As such, the CFHCC (2002) purports that primary health care offers tremendous benefits to the health care system and is therefore a priority. To that end, Public Health Nurses (PHNs) are now expected to practice in enhanced roles, incorporating principles of primary health care, such as collaboration, capacity building and health promotion. Further, the Community Health Nurses' Association of Canada (CHNAC) has recognized the importance of primary health care, and in response, has recently developed standards grounded in its principles to guide and evaluate community health nursing practice.

Community health nurses are registered nurses whose practice specialty promotes the health of individuals, families, communities, and populations (Community Health Nurses Association of Canada, 2003). Their values and beliefs include caring, primary health care, the integration of multiple types of knowledge, client/community partnership and empowerment. Community health nurses form relationships with individuals, families and communities based on these principles.

Public health nurses (PHNs) promote, protect and preserve healthy communities and systems that support and offer opportunities for health for individuals, families and communities (Community Health Nurses Association of Canada, 2003). With the demands and roles of public health nursing shifting to correspond with national strategies and priority areas (Allin, Mossialos, McKee & Holland, 2004; Falk Rafael, 1999), it becomes increasingly important to understand how nurse-client relationships are shaped by prevailing social, cultural, and ethical factors as well as economic, legal and technical trends (Hagerty & Patusky, 2003).

Valuing the importance of nurse-client relationships within community health nursing, CHNAC (2003) has incorporated the core expectation of building relationships as one of its five standards of practice. This standard recognizes the importance of establishing empowering relationships within supportive environments and promoting maximum participation of individuals, families, and communities to "preserve, protect and enhance human dignity" (CHNAC, 2003, p.14). Community health nurses are therefore held accountable to recognize and understand how their position and the power it holds may influence relationships with clients in their practice. In addition, community health nurses must also recognize the influence of socio-political-economic environments on the health of individuals, families and communities and on nursing practice.

The Registered Nurses Association of Ontario (RNAO) also recognizes the importance of the nurse-client relationship and has developed Best Practice Guidelines to address the "qualities and capacities of an effective therapeutic relationship, the state of knowledge, and the knowledge needed to be effective in a therapeutic relationship" (RNAO, 2002, p.11). Recommendations from this document include organizational and

policy changes. The RNAO recognizes that the "characteristics of organizations and agencies that provide health care will influence the development of a therapeutic relationship between the nurse and the client [and] have a responsibility to enable the client and the nurse to develop and maintain a relationship (RNAO, 2002, p.28)." With the many professional organizations and documents advocating for a stronger public health care system and for supportive environments and policies to establish relationships between and among individuals and communities, it is important to have a better understanding of relationships between nurses and clients in community health nursing, which is the focus of this study.

Literature Review

Nurse-Client Relationships

Throughout the years, many nurse researchers have investigated the formation and development of relationships between nurses and clients and their families in a variety of health care settings, from hospital care (Forchuk, et al., 2000; Henderson, 2003; Ramjan, 2004), community mental health (Horberg, Brunt & Axelsson, 2004; McCann & Baker, 2001; O'Brien, 2000), home visiting (Luker, Austin, Caress & Hallett, 2000; Ward-Griffin & McKeever, 2000), and public health nursing of vulnerable families (Knott & Latter, 1999; Vehvilainen-Julkunen, 1992).

Nursing research exploring the nurse-client relationship within health care settings has primarily focused on the characteristics of the individual nurse that may influence the formation and development of these relationships. When characteristics of listening, acceptance, trust, flexibility, openness and familiarity were evident (Chalmers & Luker, 1991; Coffman, 1997; Forchuk, et al, 2000; Moyle, 2003), a respectful working

relationship developed, which positively influenced the clinical progress and health and social gains for the client (Hostick & McClelland, 2002; McCann & Baker, 2001). However, behaviours such as lack of nursing support, unavailability of the nurse, avoidance, labeling, blaming and control (Forchuk, et al., 2000; Peckover, 2002; McCann & Clark, 2003; Ramjan, 2004) resulted in non-productive relationships of struggle and mistrust (Ramjan, 2004) as did feelings of powerlessness (McWilliam, Ward-Griffin, Sweetland, Sutherland & O'Halloran, 2001; Ward-Griffin, 2001).

School Health Nursing

School nursing has been defined as "a specialized practice of professional nursing that advances the well-being, academic success and life-long achievement of students" (National Association of School Nurses, 2002). Nurses who practice in school settings have the roles of health advisor, student confidante, and case manager. They enhance student health through: promoting health; facilitating the health and welfare of students, and intervening when problems are identified; promoting safety; and building student and family capacity (Lightfoot & Bines, 2000; National Association of School Nurses, 2002).

Nursing interventions within schools have been associated with decreased absenteeism (Kimel, 1996), better management of chronic diseases like asthma (Perry & Toole, 2000), decreased smoking rates (Cameron, et al., 1999), and decreased teen pregnancies (Fryer & Igoe, 1995). These American studies demonstrate how the school nurse has a multi-faceted role within the school setting, one that supports the physical, mental, emotional, and social health of students and their success in the learning process. The generalizability of these findings however, are of limited use in Canada where the role of the nurse is largely the implementation of health promotion programs as compared

to the roles of direct care and referral commonly found in the United States. In addition, since this research tends to be descriptive in nature it is not as useful for the development of evidence-based practice decisions and guidelines for nursing practice (Strohschein, Schaffer & Lia-Hoagberg, 1999).

In summary, much has been written about the ways in which nurse-client relationships are formed in hospitals and client homes. However, less is known about these relationships in the school community. Most researchers have described the characteristics of nurses that influence the formation of the nurse-client relationship. A closer exploration of the contextual factors on the formation and development of the nurse-client relationship has only recently begun to be explored in the nursing literature. Workload (Hostick & McClelland, 2002), time (Paavilainen & Astedt-Kurki, 1997), fiscal constraints (Aronson & Sinding, 2000; Ward-Griffin, 2001), power and authority (McWilliam, et al., 2001, Peckover, 2002) have all been identified in the research as influencing factors of the nurse-client relationship. This study addresses some of the gaps in the current nursing literature by examining the nurse-client relationship within school communities and how broader contextual factors may shape the formation and development of these relationships. With school nurses assuming an integral role in student health promotion, investigation into the formation and development of PHN-student relationships in the school community and influencing contextual factors is warranted.

Purpose

The purpose of this qualitative research was to critically examine the relationships between Public Health Nurses and adolescent students in the secondary school

community. Specifically, the research questions included: 1) How do PHNs describe their relationships with adolescent students within a school community? and 2) What broader contextual factors shape the formation and development of relationships between PHNs and adolescent students?

Feminist Perspective

The study was guided by feminist inquiry. This perspective provides the lens through which to recognize and interrogate the existence of ideological, interpersonal and structural conditions that oppress individuals (Hall & Stevens, 1991) while aiming to raise consciousness and promote new knowledge building (Hesse-Biber & Leckenby, 2004). Feminist inquiry therefore offers a way of challenging the status quo and hierarchical relationships, including the economic and social conditions that contribute to domination and oppression (Wuest, 1995).

A feminist perspective also provides methodological guidance when developing and implementing research. Since feminism recognizes that participants' experiences are inextricably linked to larger political, social and economic environments (Hall & Stevens, 1991), feminist inquiry ensures that the context and relationships of phenomena are considered in the designing, conducting and interpretation of the research (Campbell & Bunting, 1991). In addition, since rapport with participants achieves the depth and scope of data collection and analysis required to present credible descriptions of participant's experiences (Hall & Stevens, 1991) it is also important to reflect on how the powerful structural position of the researcher, compared to that of participants, may influence the collection, analysis, and reporting of data findings (Webb, 1993). Thus, feminist research helps to uncover and understand the oppression individuals have experienced in terms of

social relations (Hesse-Biber & Leckenby, 2004) while promoting personal and system change (Sigsworth, 1995).

Since relationships between clients and nurses may have empowering or disempowering influences on health (Hartrick, 2002), it is important to examine nurse-client relationships in the school community using a feminist perspective. A feminist lens illuminates possible inequitable power relations between students and PHNs that may not be possible with the use of a more positivist, objective perspective (Hesse-Biber & Yaiser, 2004). Many researchers have used the term "gender" as a biological attribute of individuals rather than as a social phenomenon that is produced and reproduced within relationships and social institutions (West & Zimmerman, 1987). The use of a feminist perspective offers a way to conceptualize, explore and critique the interactions between and among gender, race, class and other social constructs to better understand how intersecting vulnerabilities and social locations shape the PHN-student relationship within the school setting. Since individuals may only be aware of their own subjective experiences and have limited knowledge of ideologies and social structures and their effect on interactions (Webb, 1993), the use of a feminist perspective has the potential for personal empowerment through consciousness-raising (Wuest, 1995). Through the process of self-reflection and critique, both the researcher and participants will explore nurse-client relationships from diverse perspectives, thereby fostering new possibilities for individual and societal change.

Realizing the potential empowering and disempowering influences of gender, race, class, religion and other social determinants on health, PHNs are in a position to advocate for and promote the health and well-being of adolescent students. When

nursing consciousness is increased about the influence of social and economic determinants on the health of the student, nurses may become more attuned to spotting potential inequities in health promoting care within school settings, thereby changing school nursing practices and policies to ones that promote equity and social justice.

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CHAPTER II

BUILDING NURSE-STUDENT RELATIONSHIPS IN THE SCHOOL COMMUNITY: A FEMINIST PERSPECTIVE

With the release of its final report in November 2002, the Commission on the Future of Health Care in Canada (CFHCC), outlined strategies to ensure the long-term sustainability of the health care system in Canada through an increased focus on primary health care. To that end, Public Health Nurses (PHNs) in Canada are now expected to practice in enhanced roles, incorporating the principles of primary health care, such as collaboration, capacity building, and health promotion.

The role of the school nurse is well documented in the United States and Great Britain (Evans, 2000; Denehy, 2001; Robinson, 2002; Tapper Strawhacker, 2002), as are the outcomes on student health when a nurse is present in the school environment (Cameron, et al., 1999; Perry & Toole, 2000; Stock, Larter, Kieckehefer, Thronson & Maire, 2002). The National Association of School Nurses (NASN) of the United States advocates for school health nurses to: a) facilitate normal development and health of the student and to intervene when problems are identified; b) promote safety; c) provide case management; and d) build capacity of the student and family for adaptation, self management, self advocacy, and learning (2002).

However, the role of the school nurse in Canada is less defined and variability in this role can be seen across Canada. A study completed in Ontario of overall PHN perceptions of their roles and activities, highlights the role of the PHN as educator/consultant, social marketer, and facilitator/communicator/collaborator (Chambers, et al., 1994). Although broad in definition, the central feature for the PHN to

be effective in all these roles within schools is the ability to develop and form effective nurse-client relationships.

Valuing the importance of nurse-client relationships within community health nursing, the Community Health Nurses Association of Canada (CHNAC) has incorporated the core expectation of building relationships as one of its five standards of practice. This standard recognizes the importance of establishing empowering relationships within supportive environments and promoting maximum participation of individuals, families, and communities to "preserve, protect and enhance human dignity" (CHNAC, 2003, p.14). Building relationships within community health nursing often occurs within complex, changing and ambiguous environments. The structure and processes of organizations in which community health nurses are employed can also serve as enabling factors or may constrain the scope of community health nursing practice. As such, it is important for community health nurses to recognize and identify how nurse, client and organizational beliefs, attitudes, feelings, values and assumptions can impact relationships (CHNAC, 2003).

Previous nursing research exploring nurse-client relationships has investigated the characteristics of individual nurses which may "help" or "hinder" the formation and development of these relationships (Chalmers & Luker, 1991; Coffman, 1997; Forchuk et al., 2000; Henderson, 2003; Hostick & McClelland, 2002). This research has primarily been studied in the areas of hospital care, such as mental health and medical-surgical settings, and community health nursing, such as mental health, home health and more recently public health. Research investigating relationships between PHNs and clients has focused on work with vulnerable families and pregnant and/or parenting families,

rather than between nurse and students in school settings. A small number of investigators (Aronson & Sinding, 2000; Peckover, 2002) have begun to investigate how social context, particularly relations of culture, gender and class, may influence the formation and development of nurse-client relationships. However, our knowledge about the formation and development of nurse-client relationships in the school setting and of the influence of the broader social context is limited.

The purpose of this study therefore, was to critically examine the relationships between adolescent students and Public Health Nurses within a school community. Using a feminist perspective, the research questions were: 1) How do PHNs describe their relationships with adolescent students within a school community? and 2) What broader contextual factors shape the formation and development of relationships between PHNs and adolescents students?

Literature Review

A review of the literature was conducted to identify what is currently known about the formation and development of nurse-client relationships. The search strategy included reviewing CINAHL, MEDLINE, PsycINFO, SocialSciAbs, PubMed and Eric®PlusText databases for empirical literature, published within the last 15 years, using the key words and phrases of relationship, nurse-patient relations, relationship building, public health nurse and community health nurse.

Within the nursing literature, the nurse-client relationship has been described as central to nursing practice (Chalmers & Luker, 1991; Community Health Nurses Association of Canada, 2003; Hartrick, 2002). The Registered Nurses Association of Ontario (RNAO) asserts that regardless of the setting and clinical situation, this

relationship always needs to be established (2002a). Research to date of the nurse-client relationship falls within three general areas: relationships within hospital settings, relationships within community health nursing, and relationships within school health nursing.

Relationships within Hospital Settings

Within hospital settings, research on the formation of nurse-client relationships has focused on both nurse and client perceptions of the helping and hindering qualities of this relationship. In the medical, surgical and extended care literature, researchers have found that nurses perceive mutuality and unity (Ramos, 1992), participation in shared activities and the use of informal settings (Martin & Street, 2003), and the equalization of power imbalances (Henderson, 2003) as leading to a growing relationship because care was effortless, fun and unconscious (Ramos, 1992). Contrary, nursing behaviours of control (Henderson, 2003; Ramos, 1992); managing relationships based on the nurses' values, wishes and knowledge (Ramos, 1992); and blaming, labeling and stigmatizing of the client (Ramjan, 2004) led to non-productive relationships of struggle, mistrust and manipulation (Ramjan, 2004), and ill feelings and an impasse in the relationship when patients did not acquiesce control (Ramos, 1992).

Within the mental health literature, both client and nurse perspectives of building this relationship have been described. In a qualitative study of 10 newly formed nurse-patient dyads in a tertiary care psychiatric hospital, Forchuk, et al. (2000) described helping and hampering influences of the therapeutic relationship. In this study, nurses identified helping influences of consistency, pacing and listening, which led to comfortable, smooth, and co-operative relationships. Hampering factors to the

progression of the relationship were reported by nurses as inconsistency, unavailability, client factors related to trust, unrealistic client expectations, and a lack of self-awareness of the nurses' own feelings of discomfort, dislike of clients, fear and avoidance.

Turning to client perspectives of developing the nurse-client relationship, it has been reported that a climate of respect, neutrality and trust develops when nurses respond to clients' feelings, specifically in the early stages of a new relationship (Forchuk & Reynolds, 2001; Moyle, 2003). In her phenomenological study of clients hospitalized in a private psychiatric hospital for major depression, Moyle (2003) found the nurturing effects of listening, reassurance, and belief in patient ability by nurses had positive effects on the relationship. While privacy and consistency are important in the nurse-client relationship, characteristics of the nurse, such as being friendly and trusting, and the implementation of plans between therapeutic meetings, are also valued by the client (Forchuk & Reynolds, 2001).

Outcomes of hindering characteristics have led to descriptions of nurse-client relationships in the mental health setting. The unavailability of the nurse and feelings of not being treated as a person have been described by clients as leading to a painful experience and avoidance of the nurse (Forchuk & Reynolds, 2001). Moyle (2003) found that when nurses focused on the physical and ignored clients' emotions, patients felt marginalized as a diagnosis and powerless in the development and maintenance of their treatment plan.

Literature in the area of hospital-based nursing care provides valuable insight and descriptions of nursing behaviours that influence the formation and development of the nurse-client relationship. What these studies have failed to examine, however, is the

direct influence of contextual factors of the nurse, client and health care setting on these relationships.

Relationships within Community Health Nursing

Research of the formation of nurse-client relationships in community health nursing falls into three major areas: mental health, home health and public health nursing. Nurse-client relationships in community mental health nursing have been studied in an attempt to understand and create partnerships with clients. Examination of nurse and client perceptions revealed that there are several helping and hindering factors that may have potential outcomes for both the nurse and client and for the relationship (Horberg, Brunt & Axelsson, 2004; Hostick & McClelland, 2002; McCann & Baker, 2001; O'Brien, 2000). These authors have described helping characteristics to developing the relationship as showing compassion, concern and sincerity; understanding; honesty and flexibility; and increasing client control through self-disclosure of the nurse. These interpersonal characteristics are seen as having positive influences to the clinical progress and health and social gains of the client. Specifically, they have promoted care that is consistent with client needs (Hostick & McClelland, 2002; McCann & Baker, 2001), allowed clients to be seen as ordinary people (O'Brien, 2000), provided feelings of respect and understanding (Horberg, Brunt & Axelsson, 2004), and facilitated the transition for the client from patient in the community to person in the community (O'Brien, 2000).

In contrast, Hostick and McClelland (2002) noted in their co-operative inquiry, the hindering characteristics of nurse-client relationship, such as lack of respect and control, feelings of anger, frustration, resentment, betrayal, guilt and uncertainty are

experienced by both clients and nurses. Increasing workloads, external pressures and management styles and demands were also described by nurses in this study as having disabling influences on the relationship. Clients indicated that they want to be respected, feel understood and feel in control and take responsibility for their decisions (Horberg, Brunt & Axelsson, 2004). When clients perceive the nurse as having a superior attitude, as being tired or disengaged during home visits, or a lack of continuity exists, the clients' willingness to initiate contact with the nurse on subsequent occasions was compromised (Hostick & McClelland, 2002; McCann & Clark, 2003).

Trust, respect and acceptance of client values and wishes have been identified as key to developing strong trusting relationships (Trojan & Yonge, 1993) and lead to the acceptance of the nurse as an insider (Peircy & Woolley, 1999) within home health nursing. However, when home health nurses enter into a client or family home to provide home care services, this relationship is often marked by uncertainty, tension and power struggles (McWilliam, Ward-Griffin, Sweetland, Sutherland & O'Halloran, 2001; Piercy & Woolley, 1999; Trojan & Yonge, 1993; Ward-Griffin, 2001). In one study of home care nurses' experiences working with families of technology-dependent children, nurses described themselves as strangers and guests when they entered into a family's home (Coffman, 1997). When these nurses became acquainted with the family and their routines and preferences, a trustful working relationship developed. This working relationship was identified as blending with the family, defined by an openness and flexibility of the nurse, use of open communication, mutual respect, and identification with family.

The enactment of empowerment in the care partnership within home health care has also been explored (McWilliam, Ward-Griffin, Sweetland, Sutherland & O'Halloran, 2001). In this hermeneutic phenomenological study, in-depth interviews were conducted with clients, family caregivers and service providers. The authors concluded that the use of a hierarchical expert model of service delivery by care providers resulted in disempowerment of clients and family caregivers. Nurses undermined care partnerships when they used and expected to use their knowledge, status and authority to accomplish tasks and goals of the system and prescribed professional mandates.

When home care programs are faced with fiscal constraints, difficulties in developing the nurse-client relationship occurred. In a study by Aronson and Sinding (2000), nurse case managers were often faced with presenting news of budget cuts to clients. Consequently, clients expressed apprehension in relation to the case manager which resulted in mistrust and reluctance to open up to the nurse. Clients in this study also reported low spirits, decreased confidence and esteem, and developed a sense of hopelessness as a result of increased isolation and unstable home care services.

Similar to findings within home health nursing, researchers exploring nurse and client perspectives of forming their relationships in public health nursing identified trust, collaboration, confidence and a sense of togetherness (Chalmers & Luker, 1991; Paavilainen & Astedt-Kurki, 1997; Peckover, 2002) as the essence for the development of collaborative working relationships in the community that support individual coping. In a phenomenological-hermeneutic study of PHNs, Paavilainen and Astedt-Kurki (1997) found that once a collaborative relationship is promoted, it will become stronger and gain

depth as time goes on. In this study, the relationship gradually became reminiscent to friendship, however still required client confidence in PHN professionalism.

Most research exploring the nurse-client relationship within public health nursing has originated in the UK and has focused on the development of these relationships with single parents, vulnerable women, and child health issues within a home-visiting environment (Chalmers & Luker, 1991; De La Cuesta, 1994; Knott & Latter, 1991; Peckover, 2002). Similar to studies in community mental health and home health nursing, this body of literature also described the personal factors that can influence the relationship, such as trust (Chalmers & Luker, 1991; De La Cuesta, 1994), being non-judgmental (Knott & Latter, 1991) and using non-coercive techniques of asking questions, engaging in directive conversation, and talking and listening by the nurse (Peckover, 2002). As with other nursing research, investigators failed to thoroughly examine the impact of contextual factors, such as gender, race, and class of the nurse and client and their influence on the development of relationships.

Some studies (De La Cuesta, 1994; Knott & Latter, 1999; Peckover, 2002) described the impact of power, control and stigmatization on the development of these relationships. The power of earning client trust has been used by nurses to increase client comfort to share and volunteer personal matters of concern (De La Cuesta, 1994). Nurses have also been described as authority figures by mothers who had experienced domestic violence (Peckover, 2002) who were afraid of opening up during visits because of uncertainty about what was confidential during visits and the control nurses then had with that information. When clients feel they are treated differently or are being judged by the nurse, single, unsupported mothers have described feeling stigmatized (Knott & Latter,

1999). Since empowering and disempowering nurse behaviours may affect the health and well-being of the client (Hartrick, 2002), further investigation is warranted to determine how power and control shape the nurse-client relationship within public health nursing.

Relationships within School Health Nursing

When PHNs are present in schools, improvement in student health is seen. The presence of a nurse within the school has shown to positively influence the health of school-aged children with asthma (Perry & Toole, 2000; Telljohann, Price, Dake & Durgin, 2004); reduce smoking rates in high-risk schools (Cameron, et al., 1999); increase on-time graduation (Fryer & Igoe, 1995); decrease absenteeism rates (Fryer & Igoe, 1995; Kimel, 1996); and decrease teen pregnancies (Fryer & Igoe, 1995; Stock, Larter, Kieckehefer, Thronson & Maire, 2002). These studies all employed quantitative methods to determine effectiveness of health care services. In a study by Guttu, Keehner Engelke and Swanson (2004), schools with higher nurse to student ratios had increased services provided to children with diabetes and asthma; provided more counseling services to children for social conditions, such as depression and unintended pregnancy; and provided more follow-up care to children with school-related injuries and vision problems. Access to school health services also increased when full-time nurses are implemented in schools as opposed to part-time nurses (Telljohann, et al., 2004). Five-day/week nurses were 6 to 12 times more likely than part-time nurses (2-day/week) to be involved in health education, asthma visits, substance abuse visits, mental health counseling and menstrual/gynecological issues (Telljohann, et al., 2004). Although the positive health outcomes for students by having nursing presence in schools are well

documented, little is known about the formation and development of nurse-student relationships from the perspective of the nurse or how this relationship may affect student health.

In summary, investigation into the development of nurse-client relationships in the area of school health is lacking. Although much has been written about the ways in which relationships are formed in hospitals and client homes, the majority of these studies focused on adults rather than adolescents. There is limited research of how relationships are formed in the school community or how these relationships may influence health. Most researchers have explored the behaviours and characteristics which influence the formation of the nurse-client relationship, while neglecting the social context of these relationships. With the exception of a few (Peckover, 2002; Ward-Griffin & McKeever, 2000), researchers have failed to examine how broader contextual factors of the nurse or client may influence the formation and development of relationships. With the opportunities for school nurses in Canada to assume an integral role in student health promotion, investigation into the formation and development of PHN-student relationships in the school community and influencing contextual factors is warranted.

Methodology and Methods

Theoretical Framework

This study was guided by critical feminist inquiry. The use of feminist inquiry to guide and inform nursing research ensures that the context and relationships of phenomena are considered in the designing, conducting and interpretation of the research (Campbell & Bunting, 1991). Feminist researchers claim that knowledge is socially and historically constructed and that this knowledge does not exist outside the context in

which it was created. A feminist perspective recognizes that participants' experiences are inextricably linked to the larger political, social and economic environment (Hall & Stevens, 1991). Feminist research, therefore, helps to uncover and understand the lived experiences and viewpoints of those who have experienced oppression in terms of these contextual factors (Hesse-Biber & Leckenby, 2004) while attempting to effect social change (Hall & Stevens, 1991).

Since relationships between client and nurse may have empowering or disempowering influences on health (Hartrick, 2002), examining nurse-client relationships in the school community using a feminist perspective helps illuminate inequities and oppression that may not be captured with the use of a more positivist, objective perspective (Hesse-Biber & Yaiser, 2004). A feminist perspective offers a way to conceptualize and explore the interactions between and among gender, race, class and culture, thus enhancing understanding of how these social constructs shape PHN-student relationships within the school setting. Besides the potential for personal empowerment of participants through consciousness-raising, this approach to research is also directed at emancipation by challenging economic and social conditions that are oppressive (Wuest, 1995).

Sample and Sampling Strategy

Permission to carry out the research was obtained from the University of Western Ontario Research Ethics Board for Health Sciences Research involving Human Subjects (Appendix A). Using a critical feminist qualitative research design, focus groups were conducted with PHNs to understand the nurse-client relationship in the school community and the broader contextual factors that may influence their ability to form

these relationships. PHNs who worked in school nursing at one urban public health unit were invited to participate in one of four focus groups offered at the public health unit. To promote open discussion of the study's aims, the researcher attended two district school team meetings to introduce the study purpose and nature of the study. All potential participants were provided with an information sheet (Appendix B) and researcher contact information.

Nurses were eligible to participate if they were currently working in a secondary school setting or had worked in one within the last 3 years, consented to participate (Appendix C) and spoke English. Eight PHNs registered to participate in the study by using a sign-up sheet that was posted in a central location. Although anonymity may have been violated by this method, PHNs identified this as the easiest and convenient method to register for a focus group. Other nurses indicated their interest in participating in the study by phoning (n=1) or sending an e-mail (n=4).

Thirteen PHNs participated in a total of three focus groups. Although a fourth focus group was offered, it was cancelled due to a lack of registered participants. Three focus groups were adequate to obtain data adequacy, comprehensive descriptions and saturation (no new patterns emerge). Moreover, data from the third focus group was evaluated for new information and insights, and seeing none, the fourth focus group was not conducted (Morgan, 1997).

All participants were women and all had completed a Bachelor of Science in Nursing degree. Participants ranged from 27 to 61 years of age ($\overline{X}$ = 45.8 years). Cultural descents included Canadian, English, Irish, Chinese, Polish and Hungarian. Most participants worked full-time (n=8) with the remainder working part-time hours ($\overline{X}$

= 22 hours/week). Annual household income ranged from $40,000 to greater than $80,000. The average nursing work experience among participants was 21.7 years, ranging from 3 to 40 years. Public Health Nursing experience ranged from 3 to 34 years ($\overline{X}$ = 16.8 years) with an average of 13.5 years (range 6 months to 34 years) spent practicing within the school nursing program. On average, school PHNs spent 12 hours in individual counseling per month (range 0 to 40 hours) and 26 hours per month providing group teaching sessions (range 10 to 84 hours).

Data Collection and Analysis

Focus groups were the primary data collection method used in this study. Focus groups are beneficial to explore qualitative research questions and validate interpretations from analysis, as they provide a mode of communication that is closer to everyday social processes (Wilkinson, 2004). Inhibitions are often relaxed in group situations, resulting in increased candor by participants (Morgan & Krueger, 1993). This permits the researcher to explore unanticipated issues that is not always possible with more structured interviews. Through the inclusion of a method that is naturalistic with respect to communication and social processes, participants may experience an increased awareness of their participation in the oppression of individuals, which may lead to a greater sense of empowerment (Wilkinson, 2004).

In this study, focus groups were audio taped, lasted approximately ninety minutes, and used open-ended questions (e.g. What would you consider a successful relationship?) and a dialogic approach. The transactional nature of feminist inquiry requires a dialogue between researchers and participants so that lack of knowledge and misapprehensions are transformed into more informed consciousness (Guba & Lincoln, 1994).

Data collection and analysis occurred simultaneously. Immediately after each focus group interview, all interview and field note data were transcribed, reviewed and edited. All identifying information was removed from data transcripts and field notes. Field notes taken by the researcher and a research assistant were used as a supplement to focus group transcripts and helped to capture the physical setting, major points and key phrases, and nonverbal communication (Morse & Field, 1995). Along with a pre-established interview guide and probes (Appendix D), data from focus groups were also used to help inform subsequent focus groups by providing the researcher an opportunity to explore areas raised by previous participants. At the beginning of each focus group, participants signed a consent form and completed a short demographic questionnaire (Appendix E).

In order to establish credibility, and thus trustworthiness of the findings, all PHN study participants were invited to participate in a separate member checking group as follow-up to data collection and a component of analysis. Qualitative research findings are deemed credible when reconstructions of the inquiry "are approved by the constructors of the original multiple realities being studied" (Guba & Lincoln, 1985, p. 296). Three PHNs attended this focus group which assisted the researcher to further explore areas that came up during analysis (Morgan, 1988), validate and share interpretations with participants (Campbell & Bunting, 1991), provide participants with the opportunity to correct and challenge misinformation (Guba & Lincoln, 1985), and provide an opportunity for consciousness-raising to participants (Wilkinson, 2004). Acquiring knowledge has been described as consciousness-raising for participants (McCormack, 1989). Recognizing that naming and labeling of activities and experiences

establish and justify social worth (DeVault, 1990), participants were also given the opportunity at this focus group to add to the analysis, and to express their opinions about how well the emergent themes spoke of their experiences. Critical inquiry should also illuminate the role of power relations within society and lead to a means of transforming it to a more just world (Lather, 1991; Lincoln, 1995). Consciousness-raising involves the "recognition of social, political, economic and personal constraints on freedom, and provides the forum in which to take action to challenge these constraints" (Henderson, 1995, p.63). Participants were given the opportunity to discuss these constraints as well as to envision a more empowering workplace that would lead to strong PHN-student relationships.

During the process of analysis, the student researcher worked in collaboration with her thesis committee to review the data. This partnership ensured that themes were recognized and helped to add to the depth of the analysis and description of participants' stories. In addition, these peer debriefing sessions enhanced the credibility of the research process by providing opportunities among the team to develop next steps in the methodology; ensure that the researchers were aware of the role values played in the research process (Guba & Lincoln, 1985); and to discuss findings, conclusions and tentative analyses (Guba & Lincoln, 1989).

Coding for themes was based on the method described by Morse and Field (1995). This process involved reading and re-reading transcripts in their entirety and then reflecting on them as a whole. Extensive memos were written to summarize the entire interview. Once themes were identified, they became notable concepts, which linked substantial portions of the interviews together. Throughout the analysis, questions of

reflexivity and voice were asked as a part of the process of engaging and interpreting the data. As such, a reflexive journal was maintained by the student researcher during the research process. Reflexivity is the process where researchers recognize, examine, and understand how their social background, positionality, and assumptions affect the practice of research and by making these social locations and identities available to participants and the research audience (Hesse-Biber & Yaiser, 2004). Reflexive questioning also attended to the voices of the research committee and to the voices of the PHNs that are represented in their stories. Without a 'many voiced' account, analysis can be charged with self-indulgence and narcissism (Koch & Harrington, 1998). The process of data collection and analysis concluded when themes became saturated so that new data sources led to redundancy.

Findings

The goal of this study was to critically examine the relationships between PHNs and adolescent students in a school setting. Study findings suggest that PHN-student relationships are likened to that of building a school comprised of five major constructs or interlocking "building blocks": visibility, trust, collaboration, continuity and power. (see Figure 1). In addition, study findings revealed that other relationships between and

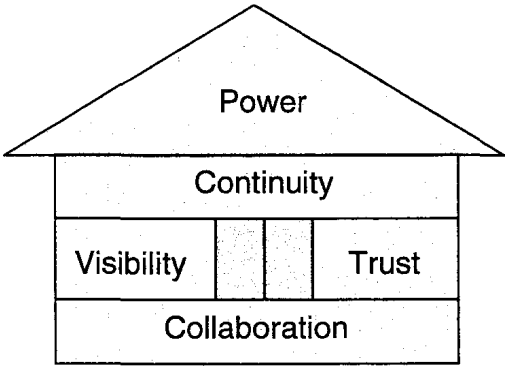

Figure 1. Building blocks of the PHN-student relationship in the school community.

among PHNs and staff members, such as principals and guidance counselors, helped or hindered the development of the PHN-student relationship. In this section, the "building blocks" and their importance and influence on forming and building relationships between students and PHNs within the context of a school community will be discussed.

Visibility: Becoming an insider

Becoming an insider was identified as the key to opening the doors to building the PHN-student relationship. Being an insider meant the PHN was visible within the school. This was accomplished through participation in developed student programs, student and staff presentations, and staff or school social events. Other visible locations, such as school hallways and accessible office locations were also important in obtaining insider status. When PHNs were not in these environments, staff and students forgot that PHNs were available to provide services and programs to students.

> *If you are not seen within that school, there is nothing there. You know what? They don't even know about school nurses a lot of the time because if you're not seen, they don't even know there is a school nurse.*

Being visible in classroom settings and participating in student groups facilitated building PHN-student relationships. These settings provided students with a supportive and safe environment in which to build rapport with the PHN and determine if she was approachable for possible future individual health consultations. These settings were considered "gateways" that facilitated individual involvement with students.

> *The actual classes that we're supposed to do in the classrooms really, really help to build up that rapport because you're there for seventy minutes. So they [students] can certainly assess whether they like you or do not like you. You just make it fun for them and they'll be at your door step for sure.*

In addition to class presentations to students, participation in student extra-curricular groups helped to facilitate the building of relationships between PHNs and students. These included groups such as student councils, peer leadership classes and graduation committees. The involvement of the PHN in these activities created visibility not only with students but with school staff who were also involved in these groups. Being involved in groups with students and teachers created opportunities for both to become acquainted with the PHN and to highlight their school roles and services. When PHNs were visible to staff, requests for participation in student groups and class discussions increased as did individual student counseling referrals. In addition, when staff invited the PHN to meetings and social functions, the PHN felt accepted as an insider to the school.

> *The more you're there, the more they're happy with you and the more services you get going and then they see more and more of your presence. You are doing worthwhile things there in the school so more people ask you to do stuff.*

Participants believed that services, such as staff presentations, increased their visibility, and if they were removed from their school PHN role, visibility for future involvement in other health programs would be impacted. When PHNs were unable to accommodate staff needs, these changes in services became barriers to visibility in student settings.

> *Like presentations on using the epi-pen or routine practices to the staff that we're not allowed to do. That is a huge barrier. Because they [staff] see that very much as our role of what we used to do and when we tell them we cannot do that anymore, there are hard feelings. It is a barrier of us getting in to do other things, like chronic disease prevention.*

Visibility of the PHN in other school locations such as the lobby, hallway and cafeteria also provided students with casual PHN interactions to ascertain the

trustworthiness of the PHN. Casual contacts with students provided students with opportunities to speak with the nurse about "safe" topics such as physical activity and healthy eating. PHNs also used their visibility in these locations to take advantage of opportunities for informal health teaching and marketing of PHN programs and services, especially when PHN visibility was limited in classrooms or group activities. Thus, informal interactions with students in these settings became gateways to individual involvement with students.

> *Sometimes I just go and sit in the front lobby, right before announcements. I'll just sit or stand in the front lobby and they'll come up and start talking to me. Just seeing you there lots of times, they get to know you.*

As well, the nursing office location within the school can facilitate or hinder the building of relationships. Office locations that were easily accessible and provided student privacy increased the likelihood of students contacting the PHN for issues concerning their health and well-being. When the nurse was located in an area which was "guarded" by a secretary, building relationships with students became difficult as confidentiality for the student became compromised. In addition, nurses who had no office or were not in a regular spot had decreased access to students.

> *You will find your location in the school is huge. The room at my high school got moved, so I'm by the front door. So during break, the kids can come and stick their head in and chat, or ask a question...When I was housed in guidance, it is like the guidance secretary is a gatekeeper...the kids see that as a barrier and you don't get that casual contact.*

Through opportunities such as presentations to students and staff, informal interactions and having a visible office location, PHNs had a better chance of becoming an insider at the school, which facilitated the opening of doors to build the PHN-student relationship. When the PHN was visible, more opportunities were created for

collaboration and for students to become acquainted with the PHN. This positively influenced the development of trust between PHN and student.

Trust: Communicating Safety

Trust is the next building block involved in the formation and development of the PHN-student relationship. PHN trust with both students and school staff is important as it must be present prior to being able to work together with students on needs and concerns impacting their health.

Students were more likely to trust a PHN who was known to keep student concerns and issues confidential. According to the participants, students were more receptive to persons who were "outsiders" to the school system, such as the PHN. They claimed that some students were less inclined to go to someone who was "close" such as the guidance counselor or a teacher. These staff members were seen by students as individuals who were less trustworthy as they were more likely to phone home and report issues divulged to them. Since PHNs were not employed by the School Board, they were able to maintain confidentiality within the limits of current legislation. As such, PHNs believed that students identified the PHN as someone who was safe and trustworthy with whom they could approach and discuss certain issues.

> *I usually say that 'I am not a Board employee' so they don't look at me as someone like a teacher that will phone home about stuff. It is good because you can talk to me about different things that you might not talk to someone else about.*

As this PHN describes, maintaining confidentiality and proving their "outsider" status often involved counseling students off school property, "*I know nurses, they meet at Tim Horton's so they could talk about an issue off school property since they're not supposed to talk about it on school property.*"

A non-judgmental approach to student ideas and choices was an additional PHN attribute, which increased their trustworthiness. A non-judgmental approach provided students with the emotional safety to know their ideas and concerns were recognized as legitimate. An open and responsive approach invited the student to continue talking with the PHN. When the PHN was not responsive to or did not value the students' ideas and choices, students would withdraw from the relationship.

> *I think that being non-judgmental, not only verbally but your whole approach – just taking them for the way they are presenting themselves. I think the body language indicates that as much as anything. When you are talking with them, it doesn't take long for a student to know whether or not you are the person they want to continue talking to or not.*

Establishing trust required the use of humour and other personalizing strategies that not only put the students at ease but also helped to decrease the power differentials during nurse-client interactions. Strategies such as dressing informally and calling students by name helped to decrease the power differential between nurses and students. These PHN behaviours assisted students to feel more at ease approaching the PHN when a need or concern arose.

> *You kind of bring it down to more of an equal level, even by the way that we dress, you dress accordingly. At [school], you would not wear a [fancy] dress because you would be so completely out there and not accepted. So a lot of the time it's going in there and meeting their needs at their level and really working within their comfort level.*

Finally, gaining the trust of school staff often required PHNs implementing non-mandated programs and services, and following established school rules and policies as this PHN explained, "*You have to kind of play by the rules, politics, and things, and if you don't, then you will not be successful.*"

Trustworthiness of the PHN was established through behaviors such as maintaining student confidentiality, being non-judgmental, and using humour and personalizing touches during PHN-student interactions. However, PHNs often risked their trust with students by not "playing by the rules" and counseling students off school property. The establishment of trust facilitated building collaborative relationships between PHNs and students, as well as between PHNs and school staff.

Collaboration: Laying the foundation

Collaboration was foundational to building strong PHN-student relationships. Similar to the function of a building's foundation, collaboration provided support to the other "building blocks" of the relationship.

> *I think one of the reasons that I've had good success at [my] school is because I have a really good relationship with the teachers and they're involved. They get involved with the extra curricular stuff at student council and stuff. So the students know that and they see us talking and we're trying to work together for their benefit.*

PHNs identified many persons who were significant participants in collaboration. Within the school setting, collaboration occurred between PHNs, students, and school staff, including teachers, principals, guidance counselors, and secretaries. In addition to internal school collaborators, external collaboration with community agencies, school boards, and programs within the public health department, were also essential.

Collaboration occurred with the aim of promoting and attaining student health and well-being. This was accomplished through the processes of negotiation, compromise and consultation. Negotiation and compromise occurred between the PHN and school when organizing programs for students. Often the services offered by the health department were not congruent with the perceived needs of school staff. As such, PHNs

would acquiesce to the school's expressed needs by carrying out a service which was outside of their mandatory programs in order to meet students' health needs. By doing so, the PHN strengthened the trust of the school staff. As a result, negotiation between the PHN and the Public Health Department for time and resources to provide these "non-mandatory" services also frequently occurred.

> *So a lot of us will do something that they [school] want, and then we've got them [school] on our side, and then swing into – well would you mind, we would like to do this and then it's okay.*

Negotiating between the school board and the public health systems was also essential for laying the foundation of relationship-building between PHNs and students. When discussion and compromise regarding programs did not occur, student programs overlapped and gaps in student services were not addressed. This lack of collaboration between systems created frustration for both school staff and PHNs.

> *The principals don't have a venue to give their input as far as their assessment for their school's needs and issues. We [public health] come up with this is what fits with our mandatory program, so this is our agenda. But there is no avenue or venue for the two [public health and school board] to kind of discuss... Some [of the programs] are very much overlapping, so they [schools] feel just like a victim, I think because we re-invent ourselves every other year! There is no dialogue.*

Consultation with the student and other professionals occurred to determine how best to support the student with their concerns about health-related matters (i.e. bullying, healthy eating, and pregnancy). This process recognized the individuality of the student as well as the specialties of the professional supports in place.

> *It's when you consult as well as decide if you were talking with an individual student. Like in what way could the social worker help or the guidance person, or you. You might sit together with someone, a guidance person or someone, so you can plan together how the students' needs can be met.*

In situations where PHNs did not support student decisions but instead attempted to influence student ideas and opinions, avoidance of the PHN by the student occurred. On the other hand, as one nurse explained, "*.... if they feel valued and respected, that is empowering.*"

Collaboration is the foundation to building PHN-student relationships as it may be influential in supporting other "building blocks" of the relationship. In addition, since collaboration was identified as contributing to student empowerment, this building block became the key in facilitating students to create ownership of their health and well-being.

Continuity: Structuring in Time

Building relationships within schools is a slow process which can take several years to develop. Continuity in PHN presence and role facilitated this process by enabling PHNs to schedule the time to focus on these relationships while developing the trust of those within the environment. Continuity in the relationship was facilitated in three ways: continuity in PHN presence within "feeder schools", continuity in the relationship between PHN and student while on waiting-lists for community services, and continuity in public health services.

PHN presence within elementary schools that "feed" into assigned high schools ("feeder schools") facilitated the development of PHN-student relationships. PHN presence in feeder schools increased the time available for the students to become familiar with the PHN. Feeder schools provided opportunities for students to interact with the PHN during class presentations and participation in student groups. It is through these groups that the "gateway" to individual student interactions was created and the trustworthiness of the PHN established. As one PHN described, "*When I have been*

going to the same school for a long time, or also feeder elementary schools and you have kids there you may have known for eight years. They'll come to you when they need you."

Maintaining continuity in the relationship between PHN and student was important while a student had been placed on a wait-list for services in the community. Depending on the health assessment of the PHN, long-term relationships were not always necessary. For instance, a student who required more appropriate services within the community usually had only a short-term relationship with the PHN. PHNs also described being directed to minimize individual counseling and to refer students to the community for long-term follow-up. During this waiting time for services, maintaining the relationship ensured that student needs were addressed. Periodic contact while service was in place further enhanced and developed this relationship.

> *But as much as you say don't build long-term relationships because we are hearing from above that we're supposed to minimize individual counseling, I have had kids waiting six months for counseling. So I'm not going to just abandon them...I find the continuity really helps.*

If continuity in public health services and the PHN role within schools changed, the development of relationships with students became affected. All "building blocks" in the structure of the relationship were affected. The foundation of collaboration was impacted between the PHN and school staff and between the PHN and public health department when continuity was disrupted in service delivery. Collaboration was affected because the negotiations that used to occur regarding programs once offered in the school, no longer occurred. When PHNs were unable to negotiate programs and services, school staff failed to request PHN presence within their schools as they were

unsure of what the PHN role consisted. As such, the lack of continuity of the PHN role and services diminished PHN visibility in the school.

> *Give me those five minutes [for the presentation] and then I'll get your active recess in and then I'll get your active classrooms in and I'll get your peer support groups. But I need those five minutes to meet this need to get this person to let me in the door.*

Thus, continuity in the PHN role and services provided structure to all the "building blocks" necessary to develop strong PHN-student relationships.

Power: Exerting Social Control

In addition to visibility, trust, collaboration, and continuity, the final building block of the PHN-student relationship is power. The roof of a building protects the rest of the structure. As such, the power building block is depicted as the roof of the school as it depicts "power over" all of the other blocks thereby, demonstrating its dominant role in shaping PHN-student relationships. For example, when the roof is raised properly with the appropriate "power with" tools of advocacy, empowerment, and ownership, the relationship is strong. If too much weight comes from above, collapse of the "building" (relationship) may occur. Not unlike a roof that is composed of many layers of shingles, so too is the power within the PHN-student relationship. These layers of social control are not only made up by hierarchal structures within the public health or school systems, but they are also reinforced by the social relations of power, such as culture, gender, and class.

The first layer of control was the health department. This layer is composed of administrators, such as the Medical Officers of Health, directors, and program managers. Public health programs and services are designed and implemented to meet the Mandatory Health Program and Services Guidelines established by the Ministry of

Health and Long-Term Care. These guidelines leave little room for collaboration between schools and PHNs to implement services which would meet the school's immediate needs, but were outside the parameters of mandated programs. In addition to controlling the type of programs offered to schools, the health department also determined the type, frequency and duration of resources and time devoted to this programming.

> *Even if it is on the guide, like a peer support group, you have to say you're doing it in a high risk school, versus a low needs school. But you're not allowed to apparently, even though it is advertised for everybody.*

Public Health Nurses attempted to reverse the control of the health department. PHNs strived to gain control and autonomy over their practice by expressing with one another their frustrations and disrespect for health department policies, implementing services for schools that did not meet mandatory programs and utilizing documentation practices that were broad in scope rather than reflective of Ministry requirements. This PHN described how she attempted to gain control over her practice, *"I wouldn't go and cancel my stuff for something like operational planning, I will tell you that much. It has to work into a schedule that does not interfere with my schools."*

Control within the school was the next layer on the roof, as illustrated by the gate keeping tactics of staff members, primarily the secretary and principal. Secretaries were influential in affecting PHN-student relationships as they could create or hinder the visibility of the PHN. Secretaries granted access to the PHN to see the principal to determine services and permitted students the access to see the PHN if the nursing office location was in the main office area.

Principals exerted the most control within the school. To some extent, they controlled which services would be brought into their school, thus enhancing or limiting visibility of the PHN. A trusting, working relationship between the PHN and principal increased the prospect that other staff members would invite the PHN into their classrooms or extra-curricular activities, such as anti-tobacco initiatives. If the relationship between PHN and principal was not collegial, PHNs felt disrespected, did not get student referrals, and were unable to implement required health promotion programs. As this PHN explained, "*I mean, it's not my choice, it's not my school. The principal is the head honcho. They are the boss. They do what they want in their little kingdom.*"

Another dimension of control was noted by the use of PHN controlling behaviours over the student, including refusing to see students when they were deemed to have become "too dependent" on the nurse and calling the school or referring staff member to ensure that students followed up with PHN advice. As this PHN illustrates, nurses would exert power by setting boundaries for students, "*So I just say, I'm only available at lunch time or I'm only available at the break just to see how urgently they want to see me...I thought that I had to set some boundaries.*"

Students had the least amount of power within the school. They were controlled from all others above them, from the type of help offered to them, and when they could see the PHN. The limited control they had was deciding who they would approach to discuss issues related to their health and well-being. As previously mentioned, this decision was influenced by whom they perceived to be trustworthy, safe, and

confidential. In addition, study findings revealed that the power relations of culture, gender, and class influenced the formation of PHN-student relationships.

The cultural factors that influenced building relationships between PHNs and students included religion and race. Schools that included the teachings of specific religious beliefs were more directive about the services and presentations that the PHN could provide. PHNs stated that they were not permitted to teach or counsel about pregnancy, safe sexual practices, and homosexuality within the Catholic school system. Often the teacher was in the back of the classroom watching and listening during sexuality classes and indicated when the PHN was permitted to answer a question on one of the topics noted above. PHNs discussed having to meet students off site to counsel them about their pregnancy options.

When PHNs were not permitted to be open or to discuss student concerns within the school environment, PHNs indicated their visibility and trustworthiness were affected. PHNs felt that students were less likely to approach the PHN on these concerns as they may be viewed as being uncomfortable or ill-informed with the topic.

> *Well in the Catholic schools, when we go in to talk to teach sexual health, we're only allowed to teach about STD's. We're not allowed to talk about pregnancy prevention. They [students] don't see me necessarily as a source of information on pregnancy prevention or maybe if they are concerned that they are pregnant, maybe they wouldn't think of coming to me because I don't talk about that....I don't know whether the students are thinking, 'Well, she's not talking about it because she doesn't feel comfortable; she's not well informed.*

Race was also influential in building nurse-student relationships. Race is an "invisible" contextual factor - blinded by privilege, the dominant group creates for a system of social ranking based on race (Hesse-Biber & Yaiser, 2004). This ranking is then used to control socially valuable resources (Weber, 2004). Twelve of the thirteen

study participants were white. The ranking of white versus non-white as a social dichotomy places the power with those individuals who are white (Hesse-Biber & Yaiser, 2004). Many refugees who are new to the Canadian health care system do not have the past experiences of being able to access health care. One PHN indicated that for many refugees to Canada, receiving free health care and support was considered a privilege as access to this resource was controlled by others in their home countries. Thus, refugees may not have accessed the PHN for services such as counseling or referral because these were not only foreign concepts but also because of the social conditions which had been procured between a dominant versus non-dominant group. As such, the PHN was often viewed by these refugee students as a health care authority figure that controlled access to services, "*A lot of them are nervous about meeting 'the nurse!' You know a health care authority figure perhaps for them. It is just developing a kind, warm, non-judgmental relationship with these people.*"

Beliefs about gender, gender differences and the differential power that it bestows also shaped the building of PHN-student relationships. Adolescent girls were depicted as being more forthcoming and open when requesting PHN assistance. Since all PHNs in this study were women, this finding is suggestive that girls are expected to be more comfortable in relationships with other women. PHNs spoke of utilizing examples from their personal experiences of being a mother to help female students understand the parental side of decision-making. These experiences helped the PHN to be able to relate to the students' experiences at home and facilitated building empowering relationships.

> *I have two daughters and often times, if I'm talking to a girl, I will say, 'well, you know what? I have two daughters who have been through their teenage years' and so I can sort of relate to them.*

PHNs also felt that being a woman and mother facilitated girls coming to speak with the PHN about women's issues such as pregnancy. It was thought that girls were often less likely to feel comfortable speaking with a male teacher or guidance counselor.

> *I think that sometimes, especially if a girl is pregnant or has questions about sexual health, often a female student feels more comfortable speaking to a female staff or female nurse. I have had situations where female students are afraid of men and afraid of talking, for whatever reason. But they actually do not feel comfortable speaking to male guidance counselors or male staff. Being female helps in some situations.*

In direct contrast, boys were depicted as being less trusting of and open with the PHN. PHNs felt this was because boys have been socialized to believe that they can not ask for help, or that it is not acceptable to speak freely. Masculinity focuses on expressing differences from and superiority over anything considered feminine (Hesse-Biber & Yaiser, 2004). As such, when a male student approached the PHN, it was usually for a physical concern, such as a cut, rather than for a psychosocial issue.

> *And it is always a little more difficult with the male student. The girls seem to be a lot more forthcoming. The boys will be very guarded about a lot of things. Sometimes I will get referrals and I will have a little bit of a background on why the student is being referred. But when I try to get them to talk, they really clam up and it can be difficult.*

Gender relations also influenced the referral process between PHNs and school staff. Girls were thought to be referred more often than boys by teachers and guidance counselors who were usually male. PHNs were unsure if this was because girls were more likely to approach someone for help, or because the student tended to be the same gender as that of the referral source or the same gender of the PHN. One PHN explained,

"The male guidance counselors tend to refer males and the female guidance counselors seem to refer females."

Finally, class also shaped the formation and development of nurse-student relationships. Since dominant groups within the social system have the power to influence the allocation of many types of resources, such as finances (Weber, 2004), study participants indicated that most PHN resources were allocated to schools which were labeled "high-risk". These schools had smaller student enrollments, required extra support services, extra social work services, and had lower school readiness evaluations for students entering kindergarten. In addition, the students who attended these "high-risk" schools came from lower socioeconomic families where English was often not the first language. PHNs spent most of their time within these locations as this is where it was deemed by administration that their services were most needed. PHN school assignments were determined based on the number of "high-risk" and "low-risk" schools they carried. A re-shuffling of school assignments would often take place to ensure that each PHN was carrying the right quantity for their case load. This re-shuffling of assignments would mean losing schools in which relationships were established and picking up new schools where no prior relationships existed. Thus class-based assumptions directly affected the allocation of public health nursing services within "high risk" and "low risk" schools.

Perceptions of PHNs also reflected these class-based assumptions. They reported that it was easier to build relationships with students who attended "high-risk" schools. This was in part because PHNs felt these students had flexible personal boundaries compared with those students in "low-risk" schools. Students at "high-risk" schools were

described as being extremely open and trusting of the PHN compared with students in "low risk" schools who felt it was socially unacceptable to speak about their problems.

> *They're ['high-risk' students] so open it's not funny. They talk about their sexuality, the STD that are lately acquired: 'Oh Miss. I cured this one but I have another one for you now!'...They don't have the same kind of boundaries.*

However, study participants noted their visibility was greater in "high-risk" schools due to the smaller class enrollments. Consequently, PHNs were able to spend more time getting to know students individually, therefore making it easier to build relationships with the "high-risk" students. As this PHN explained, *"You develop the type of relationships where I find that in the big schools, is impossible...The smaller the school – vocational schools are usually very small. So you really get to know them."*

Discussion

This study highlighted several findings about the formation and development of relationships between PHNs and students. These include: the existence of five interlocking building blocks required in the development of PHN-student relationships, the ethical dilemma faced by PHNs as both an 'insider' and an 'outsider', and the influence of "invisible" social relations during the formation and development of PHN-student relationships and their control in the distribution of resources.

Study findings illuminated the presence of five building blocks involved in the formation and development of PHN-student relationships: visibility, trust, collaboration, continuity and power. Previous authors have written about the influences of trust (De La Cuesta, 1994; Forchuk, et al., 2000; Moyle, 2003) and collaboration (Hostick & McClelland, 2002; Martin & Street, 2003; McCann & Baker, 2001; Paavilainen & Astedt-Kurki, 1997) on the development of relationships between nurses and clients.

However, few researchers have explored the influences of visibility (Coffman, 1997; Piercy & Woolley, 1999); continuity (Forchuk, et al., 2000) and power relations (Aronson & Sinding, 2000; Henderson, 2003; Hostick & McClelland, 2002; Ramos, 1992) on the development of the nurse-client relationship. This study not only builds on previous research of these constructs and their influences on nurse-client relationships but illuminates the importance of the provision of client-centred care in the context of building PHN-student relationships.

The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline (2002b) for the provision of client-centred care identifies individual nursing practices which can facilitate the achievement of client-centred outcomes through creating client empowerment, improving client satisfaction, and enhancing quality of care and work life. Client-centred care is defined as involving "advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making" (RNAO, 2002b, p.12). Organizations are also seen as having an enabling influence in the provision of quality nursing care when supportive practice environments are maintained (2002b).

These values and beliefs of client-centred care were expressed by PHNs as required for collaboration with students and school staff and maintaining student trust. PHNs indicated that when care was not provided based on expressed student needs, difficulties in establishing the relationship developed. For example, when PHNs did not collaborate with students and schools around health concerns that mattered to them because of confusion of the PHN role, students and school staff often mistrusted the PHN, which then restricted the visibility of the PHN.

With client-centred care having a central role in the formation and development of PHN-student relationships and presumed resulting effects on student health, PHNs and nursing organizations have the responsibility to ensure that client-centred care does not remain a philosophy but instead becomes the norm for nursing practice within schools. As such, more resources must be dedicated to the continuous professional development of PHNs and the orientation of new PHNs. These values must not only be practiced (RNAO, 2002b) but also mentored to nursing students as part of their core curriculum in basic nursing education.

Further, nursing organizations have the responsibility to provide models of care delivery that support continuous, uninterrupted and meaningful relationships with students and schools (RNAO, 2002b). PHNs need to challenge organizational policies that support allocation of resources based on middle-class gender, class, and cultural ideologies rather than on values and principles of client-centred care delivery. This includes working together with students and schools to recognize and understand how their values and beliefs (e.g. religion) may influence the provision of client-centred care. Finally, the role of client-centred care in the formation and development of PHN-student relationships must also be explored further.

Perhaps one of the most unique study findings is that of the ambiguous position of the PHN as both 'insider' and 'outsider' within the school and the ethics of trust that students and school staff demand from these roles. This position was demonstrated through PHN-student activities which took place off school property, such as pregnancy counseling. Within home health nursing research, nurses have also been identified as insiders (Piercy & Woolley, 1999), strangers and guests (Coffman, 1997). Acceptance of

the nurse as an insider occurred when the nurse became acquainted with family members and client routines and preferences (Coffman, 1997) and when the nurse was consistent, conformed to existing values and provided care routines to the wishes of the client (Peircy & Woolley, 1999). These findings are similar to those of the current study which revealed that PHNs gained student trust when they provided confidential services consistent with student health needs. While these authors demonstrated how an insider perspective granted by clients may exert powerful influences on relationship development, the current study highlights the ethical dilemma of trust faced by PHNs of being caught between being an 'insider' to the school and an 'outsider' to students.

Trust is earned by nurses not only through their identifiable disciplinary positions but also through their personal moral character (de Raeve, 2002; Tarlier, 2004). Although trust creates vulnerability of the student and can therefore become a source of potential power for the nurse, the importance of trust in the development of relationships continues to be highlighted in the research (De La Cuesta, 1994; Forchuk, et al., 2000; Moyle, 2003). Having the trust of the student in the present study was seen by PHNs as one of the requirements for building PHN-student relationships. Trusting relationships in effect, were seen as the means to health promoting outcomes for students. The conceiving of relationships as a "means to an end" (Hartrick, 2002) underscores the significant value of the health promoting effects of relational experiences. PHNs need to understand and recognize the potential that "being in relation" has for the health of students, so that their ability to become more health promoting in their practice will be fostered (Hartrick, 2002).

Although the broader social contexts of culture, gender and class were hidden within hierarchical layers of control, they were central in the formation and development of PHN-student relationships in the school community, particularly in relation to the allocation of resources. These findings add to the existing body of literature of nurse-client relationships that demonstrates hindering influences on the development of relationships when nurses manage relationships based on: their own values and beliefs (Ramos, 1992); external pressures, increased workloads, and management demands; (Hostick & McClelland, 2002) and fiscal constraints (Aronson & Sinding, 2000). However, while PHNs discussed the influence of gender, class and culture of the student on PHN-student relationships, they did not recognize how their status of a white, middle-class health care professional influenced the relationships they developed with students. This lack of awareness therefore contributed to the decisions of who gets what services and why. Each person's behaviour and experience with broader economic, political, cultural and organizational factors in society inform, produce and reproduce the other (Eakin, Robertson, Poland, Coburn & Edwards, 1996). Until PHNs recognize and understand this 'dialectical' nature of the PHN-student relationship, health problems of students may continue to be explored at the individual level rather than in relation to their broader social, political and economic contexts (Eakin, et al., 1996).

In the present study, culture, gender, and class, provided an invisible system of power and privilege defining who exerted more power over whom (Weber, 2004) because of another's presumed cultural or other "biological" characteristics (Anderson & Hill Collins, 2001). PHNs indicated that multicultural clients did not always feel

comfortable approaching the PHN, partially in fact that the PHN was viewed as a health care authority figure.

The perception of a student's ability and competence, as well as that of the PHNs, was shaped by gender. Girls were seen as more forthcoming and able to speak about their concerns while boys were portrayed as having more difficulty opening up. This portrayal of difference between boys and girls is consistent with the gendered role expectations of masculinity (strength, independence, unemotional) versus femininity (helplessness, dependence, submissiveness (Falk Rafael, 1996). Participants also spoke of how being a woman, and more specifically, how their experiences of being a mother had helping effects when building the PHN-student relationship. Women are often assumed in society to be more competent in terms of empathetic understanding then are men, due in large part to society's restrictions on women's personal and occupational development (Davis & Proctor, 1989). As such, PHNs felt that male teachers and guidance counselors had the tendency to refer students to them more frequently than the female teachers because of the social construction of femininity which prepares women to care (Falk Rafael, 1996). The practices of referrals and programming based on gender are problematic within the school environment as they not only favour one gender over another for access to services but they also reify the gendered assumptions of femininity and masculinity within a powerful educational system.

The presence of inequities based on class difference was also affirmed in the present study. Labels were assigned by the public health department to schools and students as "high-risk" or "low-risk" to justify resource allocation. The provision of more resources to "high-risk" students served to reinforce social class ideologies as needs

for these resources were frequently not identified by the students or schools. Students may see their socioeconomic status as lower to that of the nurse because of such policy decisions with consequent feelings of having little to contribute to the relationship and heavy reliance on the nurse. Lower-income individuals who are not reliant on the nurse but instead are more assertive may be viewed as rude or non-compliant (Davis & Proctor, 1989). Additionally, nurses who see their status as high may overplay their role as helpers.

The student voice should be central to public health understanding of client need, appropriate care and intervention (Niven & Scott, 2003). Unfortunately, power sustains the organizational hierarchies in which PHNs build relationships with students and in which power is vested in certain positions and legitimized as authority over PHNs (Falk Rafael, 1996). As such, PHNs must engage in self-reflective practice to understand how they may reinforce the oppressive nature of social ideologies when building PHN-student relationships. PHNs have the responsibility to challenge and change the profound effects of ideologies that oppress and dominate in the interests of the oppressor by advocating for empowering relational practices and policies that promote student health. PHNs therefore need to listen and work with students and school staff to develop ways of sharing power and collaborating around health and well-being needs of students. This knowledge will assist PHNs to become politically active in advocating with students and schools at the levels of provincial and institutional priority-setting and resource allocation (Kurtz & Wang, 1991). Therefore, PHNs need to realize the importance of becoming actively involved in decision-making opportunities, such as operational planning sessions, rather than seeing these activities as barriers to their visibility in schools.

Limitations

While the research highlighted several important findings in the formation and development of relationships between PHNs and students, the study was limited by the exclusion of the perspectives of students, school staff, and health department administrators. Future research which includes the student perspective is imperative in understanding how student oppression from hierarchies and socially defined characteristics of culture, gender and class may influence their relationships with PHNs. In addition, PHNs in the current study perceived the PHN-student relationship as having empowering outcomes for student health and well-being. These included increased student self-confidence and self-esteem; becoming advocates for the health of friends and family; taking ownership of their health; and making informed choices for themselves. Although these findings are similar to those of Falk Rafael (2001), only PHN descriptions were obtained in the present study and were not supported by client narratives. Therefore, since the students' perspectives are missing of how an empowering PHN-student relationship may affect their health and well-being, this is an area that needs to be explored in the future. Finally, further exploration of the perspectives of school staff and health department administrators would increase our understanding of the "building blocks" of the PHN-student relationship and of the influence of social relations on the formation of these relationships from the perspectives of those who control social situations and resources.

Conclusion

Study findings revealed that five interlocking "building blocks" of visibility, trust, collaboration, continuity and power are necessary for the formation and development of

PHN-student relationships. Moreover this relationship was shaped by culture, gender and class. Through an understanding of these social power relations and their resulting inequities, PHNs can begin to see, critique and potentially change a system of domination that might otherwise be imperious when developing PHN-student relationships (Hesse-Biber & Yaiser, 2004). Ultimately, PHNs along with students and school staff have the potential to challenge and transform the status quo towards a more equitable, client-centred, health promoting environment, one in which all students benefit.

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CHAPTER III

General Summary and Conclusions

The purpose of this study was to critically examine the relationships between Public Health Nurses (PHNs) and adolescent students in a secondary school community. The formation and development of the nurse-student relationship was likened to that of building a school comprised of five interlocking "building blocks": visibility, trust, collaboration, continuity, and power. Visibility in settings such as classrooms, student groups and school hallways were identified by nurses as "gateways" to having individual involvement with students. Trust was initially acquired because students identified the PHN as an outsider to the school system to whom it was safe to talk and disclose information. Collaboration between individuals and systems was identified as foundational to building the PHN-student relationship. Continuity reinforced the need for time and consistency in public health programs and within the relationship. Power was found within hierarchical layers and reinforced by social relations of culture, gender and class.

The findings of this research have significant implications for the nursing practice of Public Health Nurses working within schools and for policy makers at the local and provincial levels. Further, these findings suggest several important areas that might be addressed by future research.

Implications for Nursing Practice

Students are central within the building blocks of the PHN-student relationship. PHNs in this study indicated that resources must be allocated based on expressed student needs. Difficulties in establishing the relationship developed when care was not client-

centred. For example, when PHNs did not collaborate with students and schools around health concerns that mattered to them because of confusion of the PHN role, students often mistrusted the PHN as did the school, which then restricted the visibility of the PHN. These study findings illuminate the importance of the provision of client-centred care in the context of building PHN-student relationships.

The Registered Nurses Association of Ontario (2002) Best Practice Guidelines (BPGs) for the provision of client-centred care identifies practices that facilitate the achievement of client-centred outcomes through creating client empowerment, improving client satisfaction, and enhancing quality of care and work life. Organizations that provide supportive practice environments are also seen as enabling the provision of quality nursing care. The current study further supports the importance of nursing interactions and organizations which minimize client vulnerability and maximize client control and respect (RNAO, 2002), by highlighting the influence of client-centred care on the establishment of relationships.

If PHNs and other nurses are to understand the scope of influence client-centred care has in the development of nurse-client relationships, further nursing research must be conducted. In the meantime, the RNAO's BPGs offer a starting point for recommendations, which can help PHNs and management incorporate client-centred values and beliefs into practice and policy. PHNs need to ensure that client-centred care does not remain a philosophy but instead becomes the norm for nursing practice within schools. This requires support from the public health organization for professional development workshops and training during orientation for new PHNs (RNAO, 2002). In addition, these values and beliefs not only need to be incorporated into the core

curriculum of basic nursing education but also modeled by school PHN preceptors in student practicum placements. As such, resources for ongoing PHN professional development in this area must be advocated for by PHNs and nurse managers.

As shown in this study, the culture, administrative style, and model of care delivery, can have profound effects on the development and formation of relationships between PHNs and students. PHNs need to advocate for models of care delivery that support continuous, uninterrupted, and meaningful relationships with students and schools (RNAO, 2002), and challenge organizational policies which support allocation of resources based on social ideologies. In addition, PHNs need to work together with schools to recognize and understand how their values and beliefs (e.g. religion) may influence the provision of client-centred care.

Trust has been defined in the literature as a "willingness to place oneself in a relationship that establishes or increases vulnerability with reliance upon someone or something to perform as expected" (Johns, 1996, p. 81). Trust creates vulnerability of the student and therefore becomes a source of potential power for the nurse. When power differences are diminished, individuals experience less vulnerability when trusting. As such, PHNs have the responsibility to morally evaluate trust relationships with students to reveal the potential for the abuse of power (Peter & Morgan, 2001).

Developing trusting relationships is not only important in the relationships nurses have with students but also for relationships with colleagues in the public health and school systems in order to collaborate effectively as a team. Difficulties with trust in relationships such as these have been identified as the result of power imbalances, financial constraints, organizational politics, and restrictive policies that exist in a broader

network of trust (Peter & Morgan, 2001). This network of trust, originally described by Annette Baier, conceptualizes the circles of relationships which exist and interconnect all persons from friends, partners and family, to neighbours and co-workers, to politicians, researchers, and members of professional regulatory bodies (Peter & Morgan, 2001). These circles help to politically situate PHN-student relationships and to address issues of domination as trusting relationships may not occur on a one-to-one basis if either person is oppressed by others in the network (Peter & Morgan, 2001). For example, when an institution such as public health is managed by oppressive practices such as the allocation of resources based on class ideologies, many PHNs and their relationships with students, teachers, principals, and others are affected in this network. When the intricacies of the network are understood by PHNs, they can begin to recognize and address the impact of oppression on trusting relationships of the less visible and less powerful, namely the student.

Counseling students off school property demonstrated the ambiguous position of PHNs and the ethical dilemma they faced in developing trusting relationships with both students and the school. For PHNs to gain the visibility to access students, they must be an "insider" within the school. However, they also used their "outsider" status with students to gain their trust. When PHNs address individual student needs off site, not only are they at legal risk but their credibility may also be affected as PHNs risk losing their visibility within schools if discovered by the gatekeepers. Their outsider status is also at stake if they can not go to a confidential location, as the PHN risks losing student trust when these topics are not considered safe to discuss within the school. PHNs must therefore recognize the power they hold as both the "insider" and "outsider" and change

practices which potentially manipulate the trust of both students and school staff. This involves becoming reflective of how professional and personal values influence individual practice and decisions through case discussion at team meetings. Management support for case discussion is crucial so that PHNs have the freedom to express their viewpoints, ideas, values and experiences without risk of punishment (Peter, Lerch Lunardi & Macfarlane, 2004). In addition, open conversations with both students and staff about this compromising position need to take place to produce a collaborative resolution of how best to support the student within the policies of the school.

Study findings strongly suggest the existence of "invisible" social relations during the formation and development of PHN-student relationships and a resulting influence in resource allocation. These social relations of culture, gender, and class, must be recognized and understood so that empowering health promoting relationships may be created. Through an understanding of these social constructions and their resulting inequities, nurses can begin to see, critique and potentially change a system of domination that might otherwise be imperious when developing PHN-student relationships (Hesse-Biber & Yaiser, 2004).

The presence of culture, including race and religion, as a social construct was identified during relationship formation and development between PHNs and students. Both race and religion shape everyday social relations by providing a system of power and privilege whereby a group or person is controlled or exploited because of these presumed cultural or "biological characteristics" (Anderson & Hill Collins, 2001). Race not only affects the assumptions drawn but also the comfort levels experienced in interpersonal relationships (Weber, 2004). Findings of this study suggested that

multicultural students, particularly refugees, may not always feel comfortable building a relationship with the PHN. PHNs attributed this finding to their status of a health care authority figure for these students. It could be argued that these difficulties for the formation of relationships are not only a result of the nurse being viewed as an authority figure but can be attributed to the invisible system of racial privilege rooted in society's structure (Davis & Proctor, 1989).

There is often an incomplete conceptualization of the nature of cultural competence within nursing (Campinha-Bacote, 1999) resulting in public health programming and services that do not work effectively within the cultural context of a client. PHNs, health department administrators and school staff need to recognize the influence of culturally competent policies and procedures for the formation and development of PHN-student relationships and challenge and change those which allocate resources based on discriminatory constructs. The process of cultural competence requires PHNs to see themselves as becoming culturally competent rather than being culturally competent (Doutrich & Stoney, 2004). Campinha-Bacote (1999) describes this process as: cultural awareness through self-reflection, cultural knowledge through educational opportunities, cultural skill through understanding and challenging barriers to care based on race, cultural encounters through practice and experience and cultural desire through working with ethnically diverse populations.

Perceptions of another person's gender often trigger certain assumptions, expectations and interpersonal responses (Pillow, 2002). Because "gender" is often considered a biological attribute of individuals within society rather than a social phenomenon (West & Zimmerman, 1987), it is not surprising that in this present study,

gender served as an indication of a person's ability and competence. Boys were seen by PHNs as having difficulty "opening up" due to societal stereotypes of male expectations to be powerful, aggressive, and rational. Seeking help for males is equated with weakness and thus male students may not make extensive use of counseling, as long as help seeking is seen as a reflection of weakness (Davis & Proctor, 1989). Conversely, girl students were identified by PHNs as more forthcoming and able to speak about their concerns. Asking for help, displaying emotion and expressing distress are consistent with gendered role expectations of women. Women are assumed to be submissive, tender, and nurturing (Falk Rafael, 1996) with their problems frequently dismissed as emotional, dependent, or unreasonable. To minimize the dominating effects of gender in relationships, public health programs and the relationships that PHNs build with students' in schools, must provide supportive environments and programs which foster independence, caring, nurturing, autonomy, and enhance the decision-making abilities of both boys and girls. Discussions with teachers and other staff about the stereotypical assumptions that guide the referral process must also be addressed.

Social class is a pattern of domination which indicates how people and social institutions construct and alter their relations with one another (Grabb, 1997; Ng, 1991) and determines the allocation of group access to material resources, including economic, political and social resources (Anderson & Hill Collins, 2001). In this study, the power of class difference was affirmed when schools and students, through the middle- to high-class opinions of the public health department, were assigned "high" or "low" risk labels, often to justify resource allocation. The provision of more resources to "high" risk students served to reinforce social class ideologies as needs for these resources were

often not identified by the students or schools. It is important to understand how these ascribed statuses have the potential to accentuate the PHN-client power status differential. Clients who see their socioeconomic status as lower to that of the nurse may feel they have little to contribute to the relationship and thus may rely heavily on the nurse. In general, lower-income individuals are expected to behave less assertively and competently in their interactions with higher-income individuals. When they do not behave in this manner they may be viewed as rude or non-compliant (Davis & Proctor, 1989). Thus, nurses who see their status as higher may overplay their role as helpers.

One way to reduce class biases in the PHN-student relationship is to understand that behaviour is purposive and does not reflect poor judgment, lack of wisdom or inappropriate values (Davis & Proctor, 1989). Misunderstandings occur when PHNs, students, public health and school board administrators, share different social realities and do not understand the purposiveness of each other's actions. In order to increase understanding and effect subsequent change, an evaluation of current programs and practice should be done to recognize the need for diverse programming based on student and school needs. Namely this includes recognizing that one type of interaction will not remedy all student health needs or socioeconomic problems. PHNs have the responsibility to become advocates for the unique needs of the student and school and to ensure that gender, culture and class and their interconnections, are considered when developing relationships and implementing programs.

Implications for Nursing Policy

As previously stated, the student voice should be central to public health understanding of client need, appropriate care and intervention (Niven & Scott, 2003).

Unfortunately, power sustains the organizational hierarchies in which PHNs provide care and in which power is vested in certain positions and legitimized as authority over PHNs (Falk Rafael, 1996). PHNs in this study articulated frustration with a public health system that allocated resources based on mandatory programs rather than to time and programs that would meet expressed student and school needs. As such, difficulty resulted in building PHN-student relationships because of the existence of power hierarchies which hindered PHNs from obtaining visibility, trust, collaboration, continuity and power within schools. In order to understand student needs, it is necessary for PHNs to spend time observing, interacting with and talking with students and school staff to be more equipped to collaborate around health and well-being needs of students and staff within school communities.

Since building health public policy has been identified as a way of promoting health (World Health Organization, Canadian Public Health Association & Health and Welfare Canada, 1986) and relationships can have empowering or disempowering effects on health (Hartrick, 2002), PHNs have the ability and the responsibility to become more politically active against behaviours which reinforce oppression based on social relations within the formation and development of PHN-student relationships. With Community Health Nursing now a recognized specialty nursing practice in Canada, it is crucial that, at a local level, PHNs receive and utilize institutional support and acknowledgement to express their viewpoints, ideas, values and experiences. In addition, PHNs could benefit from developing negotiation and political action skills through membership and participation in professional nursing groups that are active in the policy making process at both provincial and national levels.

Implications for Nursing Research

While the research highlighted several important findings in the formation and development of relationships between PHNs and students, a significant limitation of this study was the exclusion of the perspectives of students, school staff, and health department administrators. Inclusion of the student perspective is important for two reasons. Firstly, the findings suggest that students experience control from not only those who command resources in the hierarchy above them but also experience domination based on socially defined characteristics of culture, gender and class. In order to better understand empowering relationships between PHNs and students, an exploration of student perspectives of how these social relations influence their relationships with PHNs is important. Furthermore studying nurse-student dyads may provide insights about the processes involved in developing empowering PHN-student relationships.

Secondly, the inclusion of the student perspective is important so that the effects of the PHN-student relationship on the health and well-being of the student is captured. In the current study, PHNs described the PHN-student relationship as having empowering outcomes on student health and well-being. These outcomes included increased self-confidence and self-esteem, becoming advocates for the health of friends and family, taking ownership of their health and making informed choices for themselves. These findings are similar to those found in a qualitative exploratory study by Falk Rafael (2001) in which PHNs identified three categories of outcomes of empowerment which were supported by client narratives: changes in self, changes in relationships with others and changes in behaviours. In the present study however, the students' perspective of how a relationship with a PHN may affect their health and well-being was not included

due to the lengthy ethics process of the local school boards to grant access to students. As such, this is an area that should not be ignored as an area of future nursing research.

Finally, further exploration of the perspectives of school staff and health department administrators would enhance our understanding of the "building blocks" of the PHN-student relationship. These perspectives would increase our understanding of the influence of socially defined characteristics such as class, race, age, ethnicity, gender or religion on the formation and development of these relationships from the perspectives of those who control social situations and resources.

Conclusion

PHNs form a critical group who can challenge the status quo for a more equitable society. They are able to exercise power as health care providers, however they seldom reflect on the ways in which they work in a network of power relations defined by society (Holmes & Gastaldo, 2002). In order to effect change and create conditions that empower students, PHNs, along with school staff and public health administrators, need to be aware of and challenge the social structures and relations of domination that influence the formation and development of relationships between PHNs and students. The findings from this study provide many opportunities for PHNs to use the knowledge gained to challenge and change oppressive and inequitable nursing practice and policies of social privilege. Ultimately, it is an empowering PHN-student relationship that will have positive effects on the health and well-being of the student.

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Appendix A

Ethics Approval

Office of Research Ethics

The University of Western Ontario
Room 00045 Dental Sciences Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. C. Ward-Griffin
Review Number: 11045E
Revision Number:
Protocol Title: Building Relationships With Adolescent Students in the School Community: A Feminist Perspective
Department and Institution: Nursing, University of Western Ontario
Sponsor:
Approval Date: 22-Nov-04
End Date: 31-Dec-05
Documents Reviewed and Approved: UWO Protocol, Letter of Information, Consent
Documents Received for Information:

This is to notify you that the University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has received and granted expedited approval to the above named research study on the date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

This approval shall remain valid until end date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:
a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interset, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Paul Harding

Karen Kueneman, BA (Hons), Ethics Officer HSREB (Expedited)
E-mail: kueneman@uwo.ca

Faxed: Y/N
Date:_____

Appendix B

Letter of Information

Building relationships with adolescent students in the school community: A feminist perspective

Introduction

Have you ever thought about what impact your relationships with adolescent students in the school community have on student health and well-being? Little is known about the ways in which relationships are formed outside of the health care setting or family home, such as the school community and what influence this may have on student health.

The purpose of this study is to examine the relationships between adolescent students and Public Health Nurses within a school community. You are being asked to participate in focus groups to understand their relationships with adolescent students, the contextual factors (eg. gender, race, class) that may influence their ability to form and develop these relationships and what impact these relationships may have on student health and well-being.

Who can participate in the study?

You may participate in this study if you are a PHN currently working in a secondary school setting or have worked in a secondary school setting within the last 3 years.

What you will be asked to do

In the focus group interview, the researcher will ask questions to the group and the individuals in the group will discuss the questions. Participants within these groups are able to refuse to answer questions or may leave the group at any time. Focus groups will last approximately 1-1 1/2 hours and will be audio taped. Focus groups will be conducted at the health unit during the day, at lunch, or after work hours.

Possible Benefits

Those participating in this study may become empowered through the process of reflection and sharing of their experiences with the researcher and with other participants. No foreseeable risks to participants have been identified.

Confidentiality

Participants have the right to refuse any question. Taking part in this study is voluntary and you may withdraw from the study at any time. All transcripts, audiotapes, and field notes will be kept in a locked cupboard only accessible by the research team. After the study is completed, audiotapes will be destroyed. Anonymity will be used in transcribed data, as well as in the presentation and publication of results. If quotes are used in publication, pseudonyms will be

employed and the institution or individual being referred to will not be used. In addition, every effort will be made to ensure interview rooms are private to help ensure confidentiality.

Compensation

PHNs will receive compensation for mileage at a rate of $0.36/km, where required. Food and beverages will be available for all participants during the focus group.

Follow-up after study

This letter is yours to keep. Participants who wish to receive a written summary of the study findings may indicate this on their consent form by providing their name and mailing address.

Problems or Concerns

In the event that you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact the Director, Office of Research Ethics, University of Western Ontario, (519) 661-3036 or e-mail: ethics@uwo.ca.

We thank-you for taking the time to consider participating in this research study.

Sincerely,

Kim Kempa Dias, RN, BScN
Graduate Student

Dr. Catherine Ward-Griffin, RN, PhD
Associate Professor
Faculty of Health Sciences, School of Nursing
University of Western Ontario

Appendix C

Consent

Building relationships with adolescent students in the school community: A feminist perspective

Consent to Participate

I have read the Letter of Information, have had the details of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Witness	Date

Please forward a summary of the study findings to:

Name: _____

Mailing Address: _____

_____

Appendix D

Focus Group Interview Guide

Focus Group Interview Guide

1. Describe the work you do with students in schools.

    a. Probe: Why do students come to see you?
    b. Probe: Describe these relationships.

2. Describe a successful relationship you have established with a student in your practice.

    a. Probe: What would you consider a successful relationship?
    b. Probe: What do you think contributed to its success?
    c. Probe: What skills or approach did you use in that situation?
    d. Probe: What was the goal of that particular working relationship?
    e. Probe: What was the impact?

3. Describe a situation that resulted in a difficult relationship with a student.
    a. Probe: What would you consider a difficult relationship?
    b. Probe: What do you think contributed to its difficulty?
    c. Probe: What skills or approach did you use in that situation?
    d. Probe: What was the goal of that particular working relationship?
    e. Probe: What was the impact?

4. What factors influence the development of relationships with students in a high school setting?
    a. Probe: Intra-personal factors?
    b. Probe: Inter-personal factors?
    c. Probe: Extra-personal factors?

5. Of all the areas we discussed about relationships with students, what do you find is the most important to you?

Appendix E

Demographic Questionnaire

Building relationships with adolescent students in the school community: A feminist perspective

Demographic Questionnaire

Code Number:

1. Birth date (year/month/day) _____
2. Are you male or female? (circle one) Male Female
3. What is your cultural descent? _____
4. Languages spoken: _____
5. What is your highest level of nursing education ?(circle one)

   Baccalaureate Masters PhD

6. How long have you practiced nursing? _____
7. How long have you worked for Public Health? _____
8. How long have you worked in schools as a PHN? _____
9. On average, how much time per month do you spend in individual counseling? _____
10. On average, how much time per month do you spend in group/teaching sessions?_____
11. Are you **presently** working full-time or part-time? FT PT
    (_____hours/week)
12. What is your annual household income?

    a. $0 - 19,999
    b. $20,000 – 39,900
    c. $40,000 – 59,000
    d. $60,000 – 79,000
    e. greater than $80,000