The Lived Experiences of Community Health Nurses in a Home Visiting Program to High Risk Mothers and Children

By

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We would like to thank our families for their patience and support during the many hours we spent reading and analyzing the text. And our parents for teaching us to value and pursue educational opportunities.

I love this job, I mean I just love it!

I love knowing that we do have our common strengths as women,

that I see people grow and change...make phenomenal changes.

People say to me all the time, "Oh honey, how do you do what you're doing?

Gee whiz, this must be awful."

And I say, "Well, to each his own."

-Anonymous Community Health Nurse

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THESIS INTRODUCTION

This Master's Research Project is presented as a manuscript for a research journal. Within the manuscript are all the categories of the traditional thesis format. Following the manuscript are appendixes that include the proposal and the various methods of qualitative analysis. This analysis is provided to support our conclusions and give future researchers a groundwork to replicate or build on this study. We invite a continued discourse on the use of interpretive phenonmenonlogy in understanding nursing practice and on our understanding of the lived experience of our informants, community health nurses.

ABSTRACT

Todays community health nurses provide home visitation to families with overwhelming social problems. They enter the client's environment and assist with health care needs related to poverty, drug and alcohol abuse, domestic violence, neglect and mental illness. An interpretive phenomenological study was used to answer the following research questions: what is the lived experience of community health nurses providing home visitation to high risk mothers and children?, and how does this experience personally affect the nurses? Participants were seven baccalaureate prepared nurses employed by public health departments in the Pacific Northwest. They had a mean of seven years home visiting experience. The data were group interviews in which the nurses shared narrative accounts of exemplars from their practice, a questionnaire, and personal written expressions of practice submitted by the nurses. Analysis identified recurrent themes in the areas of: the background of nursing practice, the context for practice, the domains of community health nursing practice, the meaning of practice for the nurses, the ways nurses cope, and the effects on nurses lives. The most salient theme which emerged from the study was the meaning of this practice for the nurses.

RESEARCH ARTICLE

Community health nurses provide nursing care under very difficult circumstances. They visit in homes where clients are overwhelmed with problems caused by poverty, drug and alcohol abuse, domestic violence, child abuse, and mental illness. In these chaotic homes they are challenged to make difficult health care assessments, implement interventions, and provide intensive case management. Frequently they work with clients unmotivated to change their circumstances and in communities with inadequate social referral systems. In this difficult practice environment nurses must have realistic goals and expectations and learn to let go of problems they can not change. Frequently they feel they are only providing band-aid solutions and have limited opportunities to see successful outcome (Zerwekh, 1991).

The uniqueness of providing nursing care in the home also creates specific stressors for these nurses. They have the opportunity to directly observe and experience the complexity of their client's everyday life and to develop a long term relationship based on the trusting intimacies revealed in the home. But this intimate relationship can be emotionally taxing as nurses are repeatedly exposed to their client's sorrowful stories of abuse, violence, and adversity. Sometimes they vicariously experience these traumatic events themselves (Handy, 1991). This direct exposure to clients and their problems

often leads to hopelessness and burnout among community health nurses (McCann & Pearlman, 1990).

Review of the Literature

There is currently limited literature available on the experiences of community health nurses providing home visitation, but research describes the stress of practicing in similar settings. Numerous articles addressed the general stress of nursing practice (Baker, Menare, & John, 1989; Dewe, 1989; Foxall, Zimmerman, Standley, & Bene, 1990; Mallett, Jurs, Price, & Slenker, 1991; Plant, Plant, & Foster, 1992; Sullivan, 1993). British research of home health nurses visiting in environments similar to American nurses indicated nurses found their work with high-risk clients very demanding and valued emotional support from colleagues (Tyler, Carroll, & Cunningham, 1991; Fletcher, Jones, & McGregor-Cheers, 1991). Studies of community psychiatric nurses showed nurses had increased stress related to inadequate referral systems, clients with unpredictable behavior, visitation in unsafe areas, and feelings of responsibility for the overwhelming problems of an entire community (Carson & Bartlett, 1993; Handy, 1991). Research on health care professionals working with trauma victims revealed participants experienced symptoms of anxiety and disruption in their personal moral schema after hearing their clients traumatic stories (Alexanders, Chesnay, Marshall, Campbell, Johnson, & Wright, 1989; Lyon, 1993; McCann & Pearlman, 1990).

Only three studies were focused on the experiences and stressors of community health nurses. A survey of nurses practicing in a large Midwestern urban area indicated the heavy workload, caring for uncooperative families, unfamiliarity with handling situations in the field, inability to reach support resources, and concurrent personal situations were their major stressors (Walcott-Mcquigg & Ervin, 1992). A study of nurses in Texas completing a tool measuring job stress and satisfaction showed nurses perceived less stress with appropriate workloads and increased competence at providing care (Boswell, 1992). In the only qualitative study Zerwekh (1991) asked expert nurses in Washington State to share anecdotal stories describing how they made a difference in the lives of their high-risk client families. The stories disclosed nursing concerns of losing client families to alcohol and drug abuse, child abuse, physical violence, and the hardships of poverty. They also said they were unable to replenish themselves after caring for these clients, and one nurse said she worked with these families "at the expense of my soul" (p. 60). This researcher's unexpected findings prompted her to appeal for further research to learn more about the experiences of community health nurses and the self preservation strategies they use.

Research Questions

The purpose of this exploratory study was to address these research questions: 1) What is the lived experience of community health nurses

providing home visitation to high risk mothers and children? and 2) How does this experience personally affect the nurses providing this care? Additional lines of inquiry emerged during the study including exploration of the nurses' central concerns about their practice and ways they cope with difficult situations.

Methods

Research Design

The principles of interpretive phenomenology were used to guide this exploratory study. Phenomenology is a philosophically derived method of inquiry which allows for exploration and description of phenomena as they are actually experienced by humans (Benner, 1994). The goal of this research was to examine the lived experiences of community health nurses, interpret the meaning of their experiences, and uncover knowledge embedded in their practice.

Sample

Experienced community health nurses involved in home visitation programs to high risk maternal child clients were purposefully sampled. The administrators of two county health departments serving both urban and rural areas in the Pacific Northwest were contacted for assistance in identifying potential informants meeting the following study criteria:

*registered nurses with at least a baccalaureate education,

*a minimum of two years of home visiting experience with high risk mothers and children,

*presently working 20-40 hours per week in county health department programs.

We believed obtaining informants with this depth of practice background was essential to understand the lived experience. In each agency six or seven nurses met the study criteria. A somewhat homogenous group of 7 Caucasian, baccalaureate-prepared nurses participated in the study. Their ages ranged from 40 to 50 years. Three informants had from 10 to 15 years visitation experience, three had 5 to 9 years, and one reported visiting families for 3 years. They each had from 19 to 28 years of total nursing experience.

Data Collection

After receiving approval from the Oregon Health Sciences University Human Subjects' Review Committee we contacted potential informants regarding participation in the study. Those who demonstrated an interest and signed the consent form were asked to complete a questionnaire which asked about demographic information, length of time in practice, previous nursing experience, community health nurse role expectations, and self-care strategies. The responses were summarized (see Appendix B). The nurses in each health department were then scheduled to participate in two group

interviews several weeks apart, each lasting approximately two hours. Prior to the interviews informants were asked to think about experiential stories from their practice to share which exemplified the following: 1) characteristics of their client population, 2) how and why they were able or unable to make a difference in the clients' lives, and 3) how caring for the clients personally affected them.

We entered into the interviews from our own interpretive understanding of the phenomena, and then maintained an on-going openness to the messages unveiled in the informants' group discussion (Leonard, 1994). We utilized questions and responsive listening techniques in a relaxed setting to elicit specific narrative stories (Van Manen, 1990). We also organized our interviews in small groups of three or four informants, because this best simulated their work environment where dialogue and active listening with clients and colleagues are common (Fletcher et. al, 1991).

The nurses readily told their stories with such depth and sentiment that probing for more detail was rarely needed. Some pre-written probes were used to elicit detail and understand how the nurses thought and felt about specific client stories. Probes were also used to learn what the nurses found demanding, satisfying, and critical in their stories. If the focus strayed to generalities we subtly guided the group back to telling stories of lived experiences. During the session informants were encouraged to expand the

discourse among themselves through discussion, clarification, and comparing experiences. Informants were also invited to bring meaningful expressions of their experiences to share, such as special readings or personal writing (See Appendix E).

Analysis

The data analysis included the following:

*After each interview session we discussed our observational notes and initial impressions.

*The audiotapes of each interview session were transcribed verbatim, and the texts were read individually for meaning.

*We each prepared interpretive commentaries of specific nurse-client interactions. Our written commentaries were shared and discussed with each other and our research committee members. We also analyzed them for beginning themes.

*We repeatedly searched the texts to identify recurrent themes across the stories and various group interviews. A coding system was developed to tag thematic data within the text. The data were clustered and grouped into six broad categories, which are identified in the results (See Appendix D).

*Thick, rich sections of data were tagged, extracted, and interpreted to clarify and understand the emerging themes and issues. These parts were analyzed and compared for their commonalities and differences and their

relationship to the whole account.

*We wrote and rewrote interpretations of paradigm cases that we believed embodied the essence of the community health nursing practice (See Appendix C).

*We continued to discuss the meanings of the text among ourselves and with colleagues, informants, and our research committee. We frequently rewrote our interpretations based on these discussions.

Evaluation

Four useful approaches for evaluating interpretive accounts suggested by Packer and Addison (1989) were used in this study:

Examining Internal Evidence for Coherence: As we reviewed the texts, explored themes, and compared stories we looked for the plausibility or fittingness of our interpretations. We encouraged committee members to actively participate in expanding the interpretation. To better understand the text we also explored the meaning of disconfirming evidence and non-corroborative information that did not fit with the interpretation.

Examining External Evidence: Lines of inquiry for further clarification were developed from the transcripts of each groups first interview. Second interviews were purposefully held to elucidate and confirm that our early thematic analysis accurately represented the nurses' feelings about their experiences. We attempted to preserve the integrity of the nursing accounts

by skillfully reflecting the experiences in the text (Leonard, 1994). The text was also compared with accounts from the literature and information gleaned from the questionnaires completed by informants prior to the interviews. Several informants were contacted after the interview sessions and to validate the interpretations. Some nurses also contributed writings, and they were compared to the interview transcripts.

Seeking Consensus Among Various Groups: We used an on-going interactive process among the researchers and committee members to achieve consensus while remaining open to the possibility of new interpretations. We shared our analysis with community health nurses not participating in the study and other colleagues inviting either consensus or reasoned disagreement.

Practical Implications: During the research process we discussed the emerging findings for practical application to the every day world of nursing. The significance of those findings will be discussed throughout the remainder of this paper.

Results and Discussion

Our informants told many rich stories of their practice. Woven throughout the text were common themes of practice which we identified and organized into six broad categories: background of practice, including both life and nursing experiences and an intuitive grasp of clinical situations;

context for practice, including the very different culture of their clients, the impoverished circumstances of their client's lives, and the limited resources available in their lives; eight domains of practice, such as being present, establishing trust, advocating, and empowering; ways nurses cope, including setting strict practice boundaries, processing their experiences, and disengaging from the experience; and the personal effect on nurses lives, including fear for personal safety, symptoms of post traumatic stress, and threats to mental health. The final category, meaning of the nurses' practice, will be further discussed in the this article utilizing a paradigm case and exemplars from practice.

We found meaning to be the most powerful finding because these nurses witness the stories and lives of such disenfranchised clients living in very impoverished circumstances and are still passionate about their practice. The nurses told stories of single mothers and children living in dark, barren, smoky motel rooms with large TV sets as their only stimulation. They described mothers with histories of neglect and abuse who self medicate their pain with drugs and alcohol, and they told of children who were unnaturally quiet traumatized by the world around them. They expressed concern about the safety of the children because their mothers were unable to parent them and frequently continued the cycle of neglect and abuse. And they told of frustration with a social system inadequate to meet the needs of the mothers

the mothers or to protect the children from harm.

Although they worked in this troublesome environment these nurses remained intensely devoted to their practice. After numerous years of experience in other nursing fields they described home visitation as "the best job I've ever had." Their many years in this practice, an average of eight, spoke to their dedication to this work. When they described their practice they told how it personally sustained them and used phrases including, "I love it, I mean I just love it" and "it's a transformation of my person to be doing this job." How was it these nurses avoided the burn-out that so commonly occurs in stressful practice environments?

One nurse's paradigm case described not an atypical situation that nurses face in their practice and showed how this nurse found meaning in her experience. In this story a nurse described an interaction where she visited an impoverished client's home to assess a newborn for growth and development. She found a sad but seemingly physically healthy infant living with alcoholic parents. The next day the infant died, and the nurse returned to the home to support and grieve with the mother. Later she attended the funeral and was the mother's sole support while they mourned the death of this newborn.

> Nurse: I was thinking earlier about intuition, which is really a big part of this job and thinking of a family where I saw that. I had seen her prenatally and once post partum and then she moved. I found her and

there were her two little girls in this dark little house sitting in front of this TV on the couch...half dressed and just a very sad, sad scenario. The mother was exhausted and an alcoholic, her husband was an alcoholic, and this little baby was just a pathetic little child...it was such a sad little baby. I remember on the mantel she only had one picture, a snapshot, that was taken in the hospital. You could barely even see the baby's face, just kind of this little dark face. That day after I'd been there the baby died but I didn't know it cause it was...like I'd seen her on a Thursday or something and this happened on a Friday. Then the week-end happened and it was published in the paper on Monday night. I picked up the paper and saw his name...and it was just devastating to realize that...that I'd been... I went to the home afterwards and talked to the mom and supported her. But the only picture she had of the baby at all was this one little snapshot taken in the hospital by the nursing staff...and the grief and the pain and the sadness and the unknown mystery...the mystery of it all.

When I looked at that baby, now looking back, I see lots of sad babies who survive, and this was not an underweight little baby, but sad. And I remember thinking sad, really deep mourning feelings towards this baby, but I thought at the time that it was more because it was in such a sad environment. But now when I look back on it I am not surprised that the baby died. I mean my intuition was deeper at the time than it sometimes is. I went to the funeral and she had me hold the baby, took it right out of the little casket and put it is my arms. It was a really bad painful case for me, that I just felt...I had tried...I kept trying to distance myself and just kept coming back to it. I would try to walk away from it emotionally and just be right back there. And I remember standing in front of the funeral home...it was pouring down rain and I was trying to leave, but I was with the mother. Rain and sleet were coming down and she was waiting to see if the husband would come to the funeral home, and they were trying to close up shop. And she said, "He's gonna come, I know he's gonna come. He's gonna come see his baby...he is. I know he is. I know he's drunk, but he's gonna come." She was chain smoking out in front of this home, and that was one of those moments that I'll never forget because the director came up and said, "We have to close, it's 5:30. We gotta..." And she just you know...tears in her eyes said, "Fine, go ahead, do it, close it up. I don't care." And he never showed up. You know, it's just one of those moments where looking back, I know my intuition was probably right on about the baby. Afterwards I really looked at myself a lot through that thinking, "Should I have done something..."

Int: What are your gut feelings when you think of that case?

> Nurse: Oh, it makes me just sick, you know, still just sick. I've cried a lot about it, grieved a lot about it, but it's still just...I mean I weighed and measured the baby, it was all right. It was nursing all right, but the parents were so sick...both alcoholics and both drinking. She was denying it but she reeked of it at the funeral so I know she'd never stopped probably, um...a terrible loss. Yet I do believe that was one of those cases where the baby did a u-turn...better now than later. And that was probably divine safety for them in the big picture because it wasn't a healthy place to be.

Although this was an extremely difficult and emotional encounter this nurse was able to find meaning in the experience and persevere in her practice. This home and family resembled many she had visited previously where there were sad infants, but her clinical grasp of the situation indicated this infant was not thriving. While her physical assessment did not indicate any problems her intuition cued to the distress of the infant's spirit. Ultimately she believed a divine intervention occurred which spiritually protected this infant from an unhealthy life...it was better the death happened now than later. When we probed her for a deeper meaning of this experience she clearly described a spiritual understanding of the encounter:

> Nurse: I believe death is a great mystery no matter how it comes, and I also believe that its' a coming home. So in that way I don't think of it as an end; I think of it as a beginning.

There was also meaning for the nurse in the paradigm case as she cultivated an intimate relationship with the mother throughout the experience. After the infant's death she returned to the mother, and a human bond was established as they grieved together. This human connection was

strongly evident when the mother had her hold the infant during the funeral. It was also apparent as they stood together in front of the funeral home in the sleet and rain waiting for the absent father. This nurse provided the support so profoundly absent in the mother's life when she was most vulnerable and alone.

Because of her experience with this client population she also knew this was probably a situation where she was powerless to intervene. Although she reviewed the case questioning her nursing interventions she was unable to identify any oversights in her care. She did recognize both parents were very sick with alcoholism, and their disease created an environment where this infant's survival was questionable. This understanding of negative outcomes was described by all the informants as necessary to persevere in the practice.

> Nurse: You have to realize that there are some people that will never be okay, that you can never fix, that you can never help, ever. And I think that is one of the hardest things about public health.

Along with accepting negative outcomes the nurses were able to understand their practice when they recognized a temporal component to change in their client's behavior. They learned to accept change as an evolving process and understood they may not see the results of their nursing interventions. They described their practice as planting seeds of

change while knowing they may not reap the rewards of their work.

> Nurse: It's a long-term, slow process, and I hold inside of myself maybe with these new moms we're planting seeds that we may never see germinate for five years down the line or something. But there is something positive I'm bringing to them, and I may never know the results and that's okay.

Throughout their stories the informants told of similar encounters with mothers and children, and meaning was also described in ways not exemplified in this paradigm case. The nurses felt personally enriched by interactions with their clients and were able to expand their understanding and acceptance of others because of their nursing experiences. There was a common belief their work made them less judgmental of others. Nurses taught their own families about their clients which gave their family members the opportunity to also benefit from their knowledge.

> Nurse: I try to say to my children, "This is a human being. This is a person who feels, has pain, and has joy.

They also felt privileged to serve their clients. Even though the clients were vulnerable they allowed the nurses to come into their homes and enter into intimate relationships. The nurses told of being privileged to share this relationship and to have the attention of their clients.

> Nurse: We do enter into very intimate relationships and that in itself is a great privilege. There's a lot of tenderness and love that occurs in the that time, and it is a privilege to serve somebody in this way.

The nurses recognized their clients as teachers. They believed the

educational component of their practice was a two way interaction, and they viewed their practice as an opportunity to learn about life from their clients. Client encounters also taught the nurses how to practice more effectively in the future.

> Nurse: I continue to learn, almost with every client. When I find myself getting really upset and angry and frustrated I do my best work when I stop and say, "What are they teaching me?"

They also told of stories where their clients had made positive changes in their lives because of their nursing interventions. When this occurred the nurses recognized how difficult this was for their clients because of their impoverished backgrounds and present circumstances. They described a feeling of shared celebration between the nurse and client when telling of these experiences.

> Nurse: I remember the other nurse said to her, "What would you really like for your life. What is your dream?" I remember thinking, "Boy that was quite a statement to say to somebody who's nodding off on a heroin high." And she said, "Well, I want what everybody wants. I want the house on the hill and the picket fence, a good man and my kids...isn't that what everybody wants?" And I just remember going "Yeah!" And it's so cute cause this spring she's clean and sober, she's got her kids, she's got a great boyfriend, and she's got a great house...and she painted her fence white!

In summary our findings reflect six broad categories of the lived experiences of community health nurses. The meaning of practice is described in detail because the results are so salient. This category reveals how the nurses make sense of the frequently disturbing experiences they

encounter while interacting with their clients. It also describs how the nurses continue to provide care to clients whose immediate futures suggest limited opportunities for change.

Summary and Implications

In our study more than sixty practice related stories were offered by the nurses providing a wealth of opportunity to describe and interpret the lived experience of community health nurses. Prior to beginning our research we identified only one qualitative study where community health nurses were asked how they knew they made a difference in their practice (Zerwekh, 1990). When compared to other nursing specialties there was little information about community health nursing in the literature. To elucidate this practice phenomenon we believed more qualitative accounts, which allow for in-depth inquiry and interpretation, were essential .

The findings of our research are broader than can possibly be explored within the context of one article. Therefore we chose to focus on the most salient category of findings, the meaning this practice holds for the nurses. Utilizing these findings we were able to illustrate the meaning and knowledge gained relating to our main inquiries, what are the lived experiences of community health nurses and how does their caring for high risk families affect them. The shared accounts of client encounters, such as the story of the nurse faced with emotionally supporting the alcoholic mother

after the death of her infant son and the meaning this experience held for the nurse, served as a window into the intimate nurse-client relationships unique to this practice.

In the qualitative study by Zerwekh (1990) nurses visiting a client population similar to our informants were found to suffer great emotional strain from their interactions. This was an unanticipated discovery for the author since she was attempting to describe how nurses make a difference with their clients. However we were surprised to hear our informants struggle with the challenges of poverty, substance abuse, and physical violence, and in spite of this adversity find personal meaning in their experiences. Many informants even described their work as the best opportunity they have ever had. The informants universally acknowledged satisfaction from working in partnership with the families and being able to at least offer the potential for positive life outcomes.

The informants did acknowledge that all clients would not be able to reach their goals, and they knew change was frequently described as an arduously slow process. Yet they all spoke of a temporal component to their client's change and of a hope for change resulting from their intervention which could occur "somewhere down the road." We do not mean to negate how difficult it is to gain this vision and reach this level of acceptance. The experienced informants described great difficulty detaching from their clients'

hardships and considerable role strain during the novice years of home visitation. This was viewed as the journey they travelled, not unlike their clients, to gain their present expertise. We believe this has significant relevance to both individuals and agencies in the practice setting. Utilizing findings on the ways nurses cope and how they find meaning in their practice can nurture less experienced nurses and sustain seasoned staff members.

Given the grim accounts in the literature and our preliminary perceptions of the bleakness of interactions with this client population we were encouraged by the community health nurses' optimism. We are inspired by their abilities to transcend the adversity of their practice and find opportunity for personal, family, and spiritual growth. Though many informants made reference to their own religious beliefs or practices we believe they experienced a spiritual growth in their practice which gives them a new sense of fit and meaning within the world. The nurses are actually enriched and uplifted by the meaning they derive from their practice.

Another central finding described by both informant groups was a human connection the nurses experience within the privileged moment of the client interactions. It allows the nurse to imbue the client with a sense of caring, dignity, and worth in the face of defeat or hopelessness. This was previously described as "being present" by Benner (1984), and the informants believe this is a primary requisite in establishing relationships that can create

change.

While exploring the nurses' stories we were able to identify several spheres of practice the community health nurses commonly employ (See Appendix F). We labeled them the domains of community health nursing practice. The informants were pleased with the findings in this category. Some said they felt validated by having the nursing interventions they perform in the context of practice identified through sharing their stories. They said, "This makes total sense, it's exactly what we do." Some informants suggested there might be a sequence to the domains (being present, establishing trust, giving and sharing, rescuing, nurturing, teaching and counseling, advocating, and empowering). Further research is needed into the nature of the relationships among the domains.

Through this research we gained an understanding of the phenomenon which motivated our inquiry. We learned the nurses are affected in many ways by their practice experiences and use their experiences with clients to discover meaning in life and gain enrichment. In interpretive phenomenology we do not seek to find a single truth, but instead try to gain more understanding of the phenomenon. We encourage the continuation of this discourse among both nurses and researchers in their quest to elucidate new and deeper meaning embedded in the everyday world of community health nursing practice.

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APPENDIX A

Research Proposal

This appendix is the proposal as it was presented to and approved by our research committee and the Oregon Health Sciences University Human Subjects' Review Committee. It includes a statement of the problem, the research questions, an in-depth review of the literature, a description of the method, the sample requirements, the interview guidelines, a description of analysis, and the procedures for the protection of human subjects. There are also three appendixes which have copies of the research questions and probes, the informant questionnaire, and the informed consent.

Research Proposal

Introduction: Statement of the Problem

For over one hundred years public health nurses have assisted individuals and families to meet their significant health care needs. They have provided direct care or access to services for communicable disease control, family planning, well-child care, and nutritional counseling. They also have reached isolated individuals and eliminated barriers to health promotion and disease prevention by delivering care in clients' homes. While contemporary public health nurses continue to provide this nursing care, their ability to create positive outcomes is often in question as their client population has evolved to include individuals and families with overwhelming social problems (Zerwekh, 1991).

Today's client families have numerous needs related to poverty, drug and alcohol abuse, domestic violence, child abuse, and mental illness. Many adolescent and adult clients also demonstrate behaviors congruent with a post traumatic stress reaction to earlier life events (Kolk, 1989). In these chaotic homes community health nurses are challenged to make difficult health care assessments and interventions and to provide intensive case management. Increasingly they must also protect themselves from emotional and physical harm.

In this environment contemporary community health nurses mainly

provide secondary and tertiary preventive services to families who are at risk for further disintegration without intervention. While clients are referred for primary prevention and health promotion, these less complicated cases are usually trimmed from the nurses' caseload leaving only the most problematic clients in the home visitation program (Zerwekh, 1991). The remaining clientele not only have extreme problems, but they are often less motivated to work toward problem resolution. Nevertheless nurses usually identify these clients' difficult needs early and attempt to provide them with necessary interventions. However the lack of an adequate social referral system keeps clients from gaining timely access to critical services, such as alcohol and drug treatment facilities. Without the social support to solve underlying problems nurses frequently feel they are only providing band-aid solutions and have limited opportunities to see successful outcomes (Zerwekh, 1991).

This "band-aid" care presents a conflict for some nurses who entered the field of community health nursing believing they would provide preventive strategies to receptive clients. Expecting to provide health teaching in the community setting, some anticipated less stress than they had experienced while caring for acutely ill hospital patients (Handy, 1991). Instead nurses find themselves struggling with their client's enormous hardships and anguishing over whether their efforts make a difference

(Zerwekh, 1991).

The uniqueness of home visitation also creates specific stressors for community health nurses. These nurses have the opportunity to directly observe and experience the complexity of their client's everyday life and to develop a long term privileged nurse-client relationship based upon the trusting intimacies revealed in the home. Entering intimate relationships with clients to help them cope with the stressors associated with their responses to health problems has been described as the caring component of nursing (Benner & Wrubel, 1989). But this caring can be emotionally taxing as nurses hear numerous distressing accounts of painful life events from their clients. As caregivers are repeatedly exposed to the client's sorrowful stories of abuse, violence, and adversity they often feel like they vicariously experience the trauma themselves. When caring for these dysfunctional families nurses also have difficulty establishing realistic goals and expectations and letting go of those problems they can not change. The necessity for frequent contact with these clients and their problems can lead to hopelessness or burnout among community health nurses (McCann & Pearlman, 1990).

Research Question

Through this study we will attempt to answer the following question. What is the lived experience of community health nurses in a home

home visitation to high risk mothers and children and how does this experience affect them personally?

Review of Related Literature

A literature search was conducted to find relevant information on the lived experience of community health nurses providing home visitation to high risk clients. The researchers felt studies published during the past six years would yield the most significant findings related to the problem. It was also felt the client problems in home visitation have recently become more complex making findings of earlier studies nonapplicable to this research.

Numerous research articles were found in the literature on how nurses in general cope with the stressors of their professional experiences (Baker, Menare, & Johns, 1989; Dewe, 1989; Plant, Plant, & Foster, 1992; Sullivan, 1993). Two studies specifically looked at how intensive care nurses and hospice nurses are effected by caring for dying patients and their families (Foxall, Zimmerman, Standley, & Bene, 1990; Mallett, Jurs, Price, & Slenker, 1991). Research was found describing how other health care professionals are effected by home visitation. But little was published on how the frequent care of families with complex social problems specifically effects public health nurses. One study researched the occupational stressors and psychological well-being experienced by community nurse executive (Cohen, 1990). But this research fails to elucidate the lived experiences of community health

nurses who can perceive themselves to be "like the soldiers in the field getting shot up" (Zerwekh, 1991, p. 61).

Literature was found on the experience of home health nurses in England (Tyler, Carroll, & Cunningham, 1991; Fletcher, Jones, & McGregor-Cheers, 1991). Though one could argue these studies are not relevant for visiting nurses in the United States, the researchers discovered findings suggesting that English home health nurses working in similar environments experienced increased strain. Fletcher, et al. (1991) investigated the work stressors and psychological strains perceived by visiting nurses. They employed the use of group discussion and follow-up questionnaires with seventy nurses. They found 77% of the nurses felt they routinely needed to work overtime to achieve the standard requirements of the job, 63% felt high-risk clients made their work very demanding, 89% reported paperwork to be excessive and demanding, and 87% reported valuing support from colleagues. In using a self report depression scale, only one in ten scored high enough to be considered clinically depressed.

Two studies investigating the stressors of community psychiatric nurses providing home visitation were published. Carson and Bartlett (1993) found through a quantitative questionnaire that not having adequate and timely referrals, visiting families with a history of violence, visiting clients that behave unpredictably, and visiting in unsafe areas were within the top

ten identified stressors. The clients the community psychiatric nurses described visiting and the role expectation of supporting these clients through grief and tragedy seemed similar to those of community health nurses. In another study Handy (1991) compared the responses of hospital psychiatric nurses to those of community psychiatric nurses. The investigator reviewed diary entries, kardex log entries, and activity reports and shadowed nurses on their jobs. She found nurses transferred to community services believing the work would be less stressful, but instead found themselves responsible for the overwhelming problems of entire communities. Diary entries included, "I think we're a jack of all trades and master of none. I don't feel I'm expert enough to meet their needs, but any help is better than none. I've been listening to clients and I feel anxiety myself. A little voice tells me I must get out. This is different than the hospital ward; you can get away somehow there." (p. 827)

Only three studies were located that specifically researched the experiences and stressors of community health nurses. Walcott-McQuigg and Ervin (1992) used questionnaires to survey 67 community health nurses from three different non-profit agencies in a large Midwest metropolitan area. Major sources of stressors identified were the heavy workload, caring for uncooperative family members and clients, unfamiliarity with handling situations in the field, inability to reach physicians or other support resources,

and concurrent personal situations.

Boswell (1992) also conducted a quantitative study of 51 public health nurses in Texas. An instrument developed to measure job stress and satisfaction of in-patient settings was used because it was the only tool found that measured both of these concepts. Results of the survey indicated nurses' job satisfaction increased as they recognized improved quality, they perceived less stress when they had adequate time to complete required work, and their job stress decreased as they became more competent at providing care.

The only qualitative research found studied 30 experienced public health nurses in Washington State to learn the expert competencies of seasoned field nurses (Zerwekh, 1991). They were asked to tell how they knew they made a difference in the lives of their high risk maternal-child client families by sharing anecdotal stories from their work experience. While the nurses expressed a strong belief in their work the researcher was surprised to hear the frank accounts of social tragedies that prevailed in the more than ninety stories. The stories disclosed nursing concerns of losing the client families to alcohol and drug abuse, child abuse, physical violence, and the hardships of poverty. One nurse described her efforts with these families as "at the expense of my soul" (p. 60). She also felt there was not enough time to get replenished from caring for these high risk cases. Because of her unexpected findings Zerwekh advocates for further qualitative studies to

learn more about the hardships experienced by the nurses and to identify the self preservation strategies they use.

Three studies explored how the lives of health care professionals working with victims of traumatic life experiences are personally affected . McCann and Pearlmen (1990) described accounts collected from several therapists describing their reactions after following trauma patients. They all told of fearfulness, sleeplessness, nightmares, anger, and feeling of retaliation toward the perpetrators of the violence. They had also experienced disruption in their personal schemas related to the expected rightness and wrongness of life, and some were unable to disengage from the trauma of their clients' tales. McCann et al. (1990) maintain the potential for what was felt goes much further than a burnout syndrome. The exposure to the shocking images of horror and suffering characteristic of serious trauma could cause countertransference to the caregiver.

Another study in a hospital looked at the written responses of staff workers caring for patients who shared traumatic experiences with the staff (Lyon, 1993). The staff had difficulty maintaining their own feelings of wellness after hearing the violent accounts of victims of abuse and ritualism. Analysis of the written responses revealed three dominant themes: the toxic or contaminating quality of abuse descriptions, the feeling of staff isolation from other workers and personal friends, and questions about good and evil

and the disease of the spirit. The staff found themselves paralyzed by the bizarre stories shared by clients and unable to use their usual coping strategies. To address these problems the hospital developed a support system offering an open discussion of feelings, a time for staff recreation, and a time to share spiritual exploration.

The third study involved several nursing faculty who conducted a project reviewing 1215 rape case records to determine any demographic predictors of sexual assault (Alexanders, Chesnay, Marshall, Campbell, Johnson, & Wright, 1989). The records were often sketchy, and the nurses had no contact with the rape victims. Nevertheless the nurses began to experience significant feelings and behavioral changes in their personal lives. Aware of these changes they met to openly to discuss their feelings. In their discussions the researchers realized their feelings and behaviors paralleled reactions of rape victims and were evident of rape trauma syndrome. Since community health nurses, like the participants in these three studies, are exposed to stories of victimization they may also be at risk for secondary traumatization.

The literature review revealed limited research on how community health nurses are affected by caring for high risk clients in home visitation programs. Most of the research was done in other countries, studied other health care professionals, or quantitatively measured specific stressors. Only

one study used a qualitative descriptive approach to study the practice of public health nurses (Zerwekh, 1991). The unanticipated findings described by these nurses indicate the critical need to further understand the essence of the lived experience of community health nurses caring for high risk clients.

Methods

This research will be guided by an interpretive phenomenological study. Interpretive phenomenology is the systematic descriptive and interpretive study of the essences of a lived experience to gain a deeper understanding of the phenomenon (Van Manen, 1990). The initial aim of this type of study is to capture the essence of the lived experience and transform it to a textual expression. Once in textual form an interpretive analysis is undertaken to identify the meaning embodied in the text (Van Manen, 1990). Rigorous reading of the text and reflection on the experiences is done to uncover commonalities and differences and to gain the essential meaning of the phenomenon (Benner, 1994). Interpretive phenomenology is appropriate for this research because its focus is understanding the lived experiences of community health nurses during home visitation.

It is also the appropriate framework because it reflects the state of science in this area. The few studies published on this phenomenon are generally quantitative focusing on the measurement of stress and coping of community health nurses (Boswell, 1992; Cohen, 1990; Fletcher,

Jones & McGregor-Cheers, 1991; Walcott-McQuigg & Ervin, 1992). The one qualitative study with the narrative approach failed to analyze the text for its essential meaning (Zerwekh, 1991). None of the studies have attempted to study this through interpretive phenomenology. By using this framework this research addresses the lack of essential theory building research on this phenomenon.

The qualitative strategy researchers will use to gather the textual information is informal interviews in a comfortable, nonwork setting. Participants will be asked to give narrative accounts of their lived experience as community health nurses. They will be guided by the researchers to engage in conversational language and storytelling of the events, situations, feelings, and interactions that occur during and after their home visitation with clients. Seeking narrative accounts through informal interviewing is a primary source of textual information in interpretive phenomenological research (Benner, 1994).

Sample

The sample in this research will be taken from expert community health nurses involved in home visiting programs to high risk mothers and children in Southern Oregon. Expert community health nurses will be defined as registered nurses presently employed part or full-time in a home visitation program with a minimum baccalaureate education and at least two

years home visitation experience. Researchers will only utilize experts as their depth of experience is necessary to clarify the lived experience. The home visitation programs sampled will be those sponsored by Josephine and Jackson County Health Departments. These programs provide home visitation and nursing services to mothers and children who have one or more of the following problems: teen-age pregnancy, low income, substance abuse, high-risk medical problems, low birth weight and/or premature infant, developmentally delayed child, and sexual or physical abuse. The number of nurses working at these health departments in home visitation are from eight to ten in each county.

The researchers will obtain the qualified research participants through purposeful sampling. The sample will be identified in conjunction with the nursing administration of the two health departments. Researchers will meet with the nurse administrators and determine the persons who meet the following criteria:

-21-65 years

-registered nurse

-employed at Jackson or Josephine County Health Department

-minimum baccalaureate education

-two or more years of home visitation experience

-twenty or more hours of home visitation per week.

Persons meeting the sample criteria will be sent a letter inviting them to participate in the study. The researchers will be available by phone to answer questions and will follow the letter with a phone call to confirm interest and set up an interview date.

The researchers will sample qualified participants until their analysis identifies reoccurring themes or April 1, 1995, which ever occurs first. The researchers anticipate a sample size of 5-10 participants.

Interview

The information gathering will be structured as two, informal, group interviews audiotaped for informational accuracy. The interviewing will be done in groups of three to four persons because groups provide a familiar communicative context where narrative is enriched through the active listening of several listeners and is a stimulus for other stories (Benner, 1994). Small groups are also appropriate for the nurse participants as they simulate the nurses' work environment where dialog with coworkers and actively listening to clients is common. The interviews will be informal and conversational in nature to allow the narrative to reflect the experiences. Questions and probes (see Appendix A) and active listening by the researchers, which elicit stories and experiences, will be broad, open, and responsive to the dialog (Van Manen, 1990). Participants will also be encouraged to expand the dialog by actively listening, questioning for

clarification, and adding stories to compare and contrast experiences. If discussion strays to generalities researchers will focus it back on "the stories" describing the lived experience.

Two interviews three to four weeks apart will be utilized to allow the researchers to review the tape prior to the next interview and to identify gaps or blind spots and areas where understanding requires clarification. This will also expand the text creating results with increased clarity, depth, and redundancy which are more plausible and reliable (Benner, 1994). Audiotaping and subsequent transcription of the interviews will be utilized to ensure the accuracy of the text.

In addition to the interviews the participants will be asked to complete a demographic tool prior to the interview (see Appendix B). They will also be encouraged to bring and share other expressions of their experiences, such as writing. If participants agree, a follow-up phone call may also be utilized for further clarification of the text.

Analysis

The analysis of the text will be on-going throughout the research process and will incorporate an iterative/cyclic process of identification of paradigm cases, analysis of themes, and selection of exemplars. The aim of interpretive phenomenology is to establish a dialog with the text and the usual point of entry is with paradigm cases. Paradigm cases are descriptions

of the essence of the lived experience developed from the text used to gain understanding early in the research process (Benner, 1994). Once paradigm cases are identified and contrasted thematic analysis begins. In thematic analysis the research moves between parts of the text and portions of the analysis attempting to identify commonalities and differences. This analysis is a cyclic process of comprehending, interpreting, and critiquing (Benner, 1994). Once the researcher identifies common themes exemplars are chosen from the text to illustrate the similarities or contrast differences.
The goal of this entire analysis is to develop exemplars which will allow the reader to understand the distinctions the researchers are
making about the practice of community health nurses (Benner, 1990).

There are threats to the interpretation of the phenomenology. The description may fail to clearly describe the lived experience but instead take some other form such as journalistic or biographic. The description may be directed at the lived experience but fail to illuminate the lived significance of the experience. The interpretation may elucidate something besides the lived experience, such as a conceptual clarification of the meaning (Van Manen, 1990).

To reduce these threats to interpretation of the lived experience four approaches to evaluation will be utilized. The interpretation will first be evaluated for internal character or coherence. This will be achieved by

identifying not only the reasonable interpretation, but also focusing on and developing the meaning of disconfirming evidence. The text will then be compared to external evidence by comparing the researchers' interpretation to the participants' interpretation of their experience. If they agree to a follow-up phone call, participants will be consulted on the validity of researchers' interpretation. The interpretation will also be compared to any written works offered by participants. Consensus among the researchers and the research committee on textual interpretation will also be sought. If feasible, the interpretation will also be presented to a graduate research seminar. Finally the practical application of the interpretation to nursing practice will be examined. The researchers will utilize the interpretation to assist nurses in obtaining therapeutic validation for their lived experiences and in acquiring organizational support for issues related to their community health nursing (Packer & Addison, 1989).

Protection of Human Subjects

Throughout this research and in the final publication the protection of the rights of the subjects will be systematically protected. The research proposal will be exempt from review by the Committee on Human Research at Oregon Health Sciences University under category #3. A written informed consent (see Appendix C) will be obtained from all participants prior to the interview. During the interview process strict confidentiality of dialog

revealed will be maintained among group members and researchers. Prior to analysis each participant will be given a code, and the tape transcription will only identify participants by their code. Participant codes, the tape transcription, and the original audiotapes will be stored in separate locked cabinets. The final publication will further protect the subjects by omitting personally identifying features.

The following time line will be followed during this study. The interviews will be done at the end of January and the middle of February. Text and thematic analysis will occur during February and March. Manuscript preparation, a report of the research of appropriate length and quality for submission to a journal, will be done during the remainder of April. The defense is planned for May 12, 1995.

Potential Utilization of Findings

Through this study the researchers intend to gain an in depth understanding of the lived experience of community health nurses to support their professional preservation. The results of the study should provide these nurses with therapeutic validation for their experiences. It may also help them get the organizational support they so desperately need. The findings could also render meaningful information for other home care providers as home visitation is becoming a common mode for delivery of client care.

Appendix A

Research Questions and Probes

1) What was the context of the incident (time of day, location, etc.)?
2) Give a detailed description of what happened including as much dialog as possible.
3) Why is the incident critical to you?
4) What were your concerns at the time?
5) What were you thinking about as it was taking place?
6) What were you feeling during and after the incident?
7) What, if anything, did you find most demanding about the situation?
8) What did you find most satisfying about the situation?

Appendix B

Questionnaire

Please complete the following demographic information:

Age:_____ Sex:_____ Total years in Nursing:_____

Degree in Nursing: BSN:____ MN:____ PhD:_____

Other Educational Degrees (please list): _____

Years in Public Health:____Years in Home Visitation Services:_____

Previous or Other Nursing Experience:_____

Please provide short answers to the following questions:

1) What motivated you to become a community health nurse?
2) How does you current nursing role fit the expectations you had prior to becoming a community health nurse?
3) What are the characteristics of your client population?
4) How do you feel you make a difference in your clients' lives?
5) How does caring for these clients affect you personally?
6) How do you balance the demands of your nursing job with your daily life?
7) How do you incorporate self care strategies in your personal life?

Appendix C

Informed Consent

Oregon Health Science University

Consent Form

Title: The Lived Experience of Community Health Nurses in a Home Visiting Program to High Risk Mothers and Children

Principle Investigators:
Jill Ayers. RN, BSN, graduate nursing student OHSU. (503) 488-0419
Beth Wilcox, RN, BSN, graduate nursing student OHSU. (503) 878-2230
Christine Tanner RN, PhD, OHSU Research Committee Advisor
(503) 494-3742

Study Purpose:
The purpose of this study is to learn about the ways in which public health nurses are affected by providing care to high risk mothers and children in home visitation programs.
To accomplish this, the investigators will be conducting in-depth interviews with the nurses providing these specific services. This study is part of a masters research project of graduate nursing students at Oregon Health Sciences University. The nurse investigators hope to publish the results of this study so that all nurses can benefit from the findings.

Procedures
Local health department administrative personnel will be contacted and requested to identify staff nurses who meet the study criteria. Potential participants will then be contacted, informed about the study, and given an opportunity to become involved.
If you agree to participate you will be involved in at least two group interviews with other public health nurses. You will be asked to answer questions and share stories to demonstrate experiences you have had with clients. You will be asked to share about the ways you feel your work with client families may have effected you. The sessions will be audiotaped and some notes may be taken by the investigators. You will be requested to complete a demographic data sheet at the beginning of the meeting. It is

likely that you may be receive a follow-up phone call for the purpose of further data gathering or clarification. The interviews will usually last between 2 hours, though participants may wish to discuss issues at greater length.

Confidentiality

You will not be named in any publications, and identifying data will not be linked to your responses from the demographic data sheet. The audiotapes and written notes will only be reviewed by the nurse investigators and the research committee members. The tapes will be transcribed with all the personal information deleted in the process.

Risks and Discomforts

Participation in this study will require a contribution of you own time. The investigators will attempt to schedule the appointments at convenient times and area locations. Some person might find that sharing their experiences could be emotionally upsetting. Others may find the process validating.

Benefits

You may or may not personally benefit from participating in this study. However, by serving as a subject you will be contributing new information that may benefit public health nurses and other caregivers in the future.

Costs

There is no charge for participating in this study. No reimbursement or compensation will be given to you as a result of your involvement in this study.

Liability

"The Oregon Health Sciences University, as an agency of the state, is covered by the State Liability Fund. If you suffer any injury from this research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, it's officers, or employees. If you have further questions please call the Medical Services Director at (503) 494-7887."

Participation

Participation in this study is purely voluntary. You may refuse to participate, or you may withdraw at any time, without effecting your relationship with or treatment at the Oregon Health Sciences University. If you have question about your rights as a research subject please contact the Oregon Health Sciences University Institutional Review Board at (503) 494-7887.

If you have any questions about your participation in this study please contact Jill Ayers at (503) 488-0419, or Beth Wilcox at (503) 878-2230. If you still have further questions you may also contact Dr. Christine Tanner, RN, Professor of Nursing (503) 494-3742.

I have read what is written above and agree to be part of this study.

_____ _____

Signature Witness Signature

_____

Date

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APPENDIX B

Questionnaire Results

These are the results of the questionnaire which is located in Appendix B of the research proposal. This questionnaire was given to the participants prior to the interviews. The results were used to describe the demographic characteristics of the participants. They were also used as external evidence to evaluate our interpretation of the text.

Questionnaire Results

Sample Size: Seven

Participant Characteristics:	Range	Mean
Age:	41-49	44.8
Years of Experience:		
Home Visitation	3-15 yrs.	7.77 yrs.
Public Health	5-15 yrs.	8.71 yrs.
Total Nursing	19-28 yrs.	21.71 yrs.

Gender: 100% female
Ethnicity 100% Caucasian
Education: 100% baccalaureate prepared RNs

Past Nursing Experience:
- Intensive Care
- Emergency Room
- Coronary Care
- NICU
- Medical-Surgical
- Pediatrics
- Home Health
- Stroke Rehab
- Clinic/Office

Motivating Factors for Community Health Nurse Employment:
- Opportunities to use teaching skills
- Autonomy
- Working with clients "on their terms"
- Holistic practice approaches
- Homogeneity of colleagues
- Preferable work schedule/hours
- Variety in work roles

Current Role Fit with Original Expectation:
- Thought it might be boring...it's not
- I'm working with clients in the ways expected
- It's actually more demanding and much more stressful
- Thought I would be appreciated more
- The job is always full of highs and lows

Characteristics of the Client Population:
- Low socio-economic status
- Drug/alcohol abuse
- Women and children
- Victims of abuse
- Absent fathers, frequent
- Involvement with social system/child protective services/corrections

Ways the Nurses Make a Difference:
- Prevention
- Educating families
- Empowering
- Advocacy
- Helping clients make positive changes
- Accessing treatment for alcohol/drug

Personal Affects:
- Greater appreciation of personal life
- Opportunities for learning
- Increased career experiences
- Some days feel sad, others good

Balancing Work with Daily Life:
- I don't always
- Quality time with family
- Professional counseling
- Sharing concerns with husband
- Turn it over to God/Higher Power
- Support groups/meetings
- Limit work to part time

Self Care Strategies Used:
- Meditation
- Music
- Travel
- Movies
- Nutrition
- Recovery programs
- Family/friends
- Leave work at the office
- Special purchases for self

APPENDIX C

Paradigm Cases

This appendix includes the analysis of ten paradigm cases, which were identified from the text because of their powerful representation of the community health nurses' experience. In our analysis of these salient stories we first summarized the content. Then we examined each story for themes which described the nurses' past experience, client interactions, ways of practicing and coping, and understanding of the experience. This analysis of paradigm cases and identification of themes was one of the initial steps in analysis.

Paradigm Cases

Nineteen year old mother IA-S6

A community health nurse (CHN) was dealing with an angry mother who was drug addicted and parent of a three week old female infant. The mother was not interested in talking about her baby and the CHN could not even engage her in conversation about feeding. The CHN was unable to assess if the babies intake was adequate. She felt frustrated in trying to establish a relationship with this mother and was worried about the infants well-being. No other support was available to baby in home; the grandmother was an alcoholic and the father was brutalizing.

The CHN felt the situation looked hopeless for the infant and that the infant communicated pleading looks at her to help get her out of the situation. The mother angry with infant for "kicking her leg", hollers at her to stop and slaps the baby's feet. The CHN feels helpless to stop the mother from hitting the baby again, because she realizes this mother herself was abused. The CHN discusses why she reports these cases to CSD....she does not have the power to change this herself, and she is frightened this baby might actually not make it in this environment. She states some of these babies turn around and go back for good reasons, and she is surprised that many survive. The mother is offered resources as nurse feels responsible to fix situation, but she refuses. Later she trusts the nurse and agrees to go for an alcohol and drug assessment. They determine she has problem with substances, but she does not enter the recovery program. Years later the nurse sees family at market. The baby has survived and is a sassy little thing. The nurse is struck by the resiliency of the child to survive a very compromising environment and believes her sassiness is her way of adapting.

One Tough Client IA-S8

A CHN was struck by the paradigm case which involved a tough woman who was addicted to heroin and about eight months pregnant. She had been scamming the system, including many agencies, for quite sometime. Representatives from the various agencies decided to band together and have an intervention with this woman. Their purpose was to let the woman know that she would have to make major changes, abandon her lifestyle, and quit using drugs. They had expected that she would go along with it in the face of the threat and power of the group, abandoning her ways because they said so. The representatives began to feel a loss of control when the woman would not even take a seat at the meeting. Instead she assumed a position of calmness standing idly in the door way, wearing her dark glasses, and holding an unlit cigarette. An agency representative tried to engage her about how

she was feeling in the moment of the interaction, but the client quickly turned things around by asking the representative how he might feel in a room full of drug addicts.

As the nurse reported the story she was amazed and awed by the way this woman assumed power and control putting the group almost at her mercy. The nurse realized this client was letting them know she was still in charge of her own life. It was an opportunity for the nurse to understand how little control she actually has in her clients' lives.

Infant Death IA-S15

In this story a CHN felt she had intuition about a baby who suddenly died the day after she had visited the family. The infant had appeared healthy, yet "pathetic and sad" to the nurse. The family was poor, both parents were alcoholic and they were exhausted. Other small children lived in the home. The CHN stated that she had sick, mournful feelings towards the infant during the visit, but originally attributed them to the baby's bleak environment.

The nurse was very affected by the infant's death and had a difficult time distancing herself emotionally. She was the mother's sole support at the funeral home, grieving along with her. The mother actually placed the dead baby into the nurses arms asking her to hold him for awhile. The Father never showed up at the funeral home, and the mother was very hurt. She believed him to be off drinking. The mother reeked of alcohol herself. The nurse questioned herself about her responsibility, and she wondered if there was perhaps something she should have known or done differently.

She was stricken by something in the soul of the infant that actually conveyed a desperate sadness, even though there were no objective findings that pointed to a concern for physical illness. The CHN described this as a terrible loss, yet felt it could also be a divine intervention for the baby who might have done a U-Turn... The nurse believed in this case the baby might actually be better off, and there was some higher power in control of this situation.

Intuition with a Fourteen Year Old Mom IB-S14

A nurse described her thoughts and feelings about an interaction with a fourteen year old mom and her thirty-six year old boyfriend. The nurse has her own ideas about the relationship that she brings to the situation. She does not believe there is anything right about this arrangement. She relates her own ideas of how life should be for fourteen year olds. In the context of the interaction the nurse feels frustrated and ineffective to engage the girl in any meaningful exchange. She keeps thinking about what she needs to find out about the baby and accomplish in her role as a community health nurse.

She continues to fell frustrated with her inability to make this happen. She describes intuition that she uses as a guide to direct her actions in letting go of all of her preconceived notions of what needed to be accomplished. The nurse has a difficult time in listening to her intuition, but when she does she encounters a meaningfulness realized in just being present for the young girl. She drops her focus on the "nursing" agenda she came with and finds that they can begin to establish a relationship when she just holds the baby while the girls mops the floor. The client realizes that nurse does understand her needs.

Resenting the Rich IB-S16

In this story the nurse finds herself resenting the financially rich persons in the community who appear to experience no hardships and lack an understanding of what her impoverished clients suffer. The nurse is called to see a pregnant woman who was released from jail. The woman has been having some bleeding, and the nurse drives her to the hospital believing that she is threatening a miscarriage. On the way to hospital the nurse is very aware of the contrast of the cultures she is traveling through. From the little cabin where she picked up this client to the large homes she passes with manicured lawns and covered swimming pools. She is angered by our societies inability to identify with her client's culture and needs. She is very empathetic to the adversity her client suffers, medicating the pain of her life with drugs and loosing all her children to the system or death. The woman verbalizes that she deeply desires to have her own child and vows to continue trying. The nurse later writes the following poem to capture the meaning of this experience.

-I Resent the Rich-

On Thomas Road
you are having a miscarriage.
Carnival glassware in
your living room.
A boyfriend named Luis
with silver teeth.
A sick father who cannot
raise his head.
Army blankets.

You still get dressed:
stretch pants, sandals, earrings,
even though you're bleeding

You have lost four children
to the Authorities. to Addiction.
"if my baby has a heartbeat,
will they take him?
if they take our babies,
we'll just have more."
You are crying

Out of jail last Friday,
Now we pass over the tracks
to the hospital where lawns
are trimmed and
swimming pools have covers.

where you will lose
your baby

Developmentally Delayed Couple IIA-S9

In this story the nurse described a developmentally delayed couple working to form their own family in the face of a father's controlling behavior toward their efforts at independence. The woman was pregnant and the nurse tried to teach her parenting skills while her father hovered over them and told them she couldn't change diapers or breast-feed the baby. The couple realized if they were going to have a successful marriage and raise their baby they needed to move to their own home. The nurse sensed their needs and talked with them privately to determine their goals. The couple told her they needed their own place in town so he can work and they can socialize with their network of friends. The nurse helped them get their own place in town and supported them with continuing services after the baby was born.

This story represented the positive effect a community health nurse's interaction can have on clients lives. Her intuition told her this couple would not survive together in their present situation. She established a trusting relationship by trying to teach the woman the parenting skills she wanted in the face of a disapproving parent. Her presence was affirming to the couples aspirations. She then advocated for the couple in the social system by helping them find their own home and empowered them to move from the home of her controlling father. After they had their baby she continued to teach and counsel them about baby care and parenting skills.

This case exemplifies the client characteristics which foster the human connection with the nurse and create positive outcomes. Although these were disabled clients they were positive people with goals and dreams. They

were also receptive to the nurse's efforts to help them realize their aspirations. These characteristics encouraged the nurse to establish a helping relationship which cultivated the human connection between the nurse and client. The couples positive outcomes after her interventions enriched the nurse's personal life.

The Father and Child Protective Services IIA-S10

This is a story of a father and the nurse battling with child protective services to get a child returned to the father's care. The story began with a couple seeking services on a Friday afternoon during the woman's pregnancy. While helping the couple prenatally the nurse felt they would not be able to care for the baby postnatally because the woman had psychiatric problems and the man had no parenting skills. She was also concerned because the man was a big, scary, "biker-type" who wanted a male baby. During the woman's labor he was at home drinking, which was "the manly thing to do" in his culture. The nurse feared for her physical safety when she went to the house to inform him it was a female baby, but he is okay with the news.

After the birth the nurse recommended they surrender the child temporarily to child protective services until they could acquire the needed parenting skills, and the parents agreed. The mother ran away from the situation but the father continued to work to get his baby back. The father and nurse realized the social workers were thwarting his efforts to regain custody, they even accused him of child molestation. The nurse decided the father was trying to be a good parent and was wrongly accused, and she actively helped him get his daughter back by confronting the agency and testifing for the father in court. He finally got his daughter back when she was 26 months old.

This story synthesized may aspects of the CHN's practice. This nurse used her personal social skills to interact with this couple during her pregnancy and develop a trusting relationship, even though there were times she feared for her personal safety. As she assessed their situation her past CHN experience cued her this couple was incapable of caring for a newborn. Because of their trusting relationship she was able to convince the couple to temporarily surrender the child. When the nurse realized the system was working against her client she empowered him by saying, "I will work with you". Her intuition told her the allegations of sexual abuse against her client were unfounded, and she actively advocated for his rights in the social system. Throughout their interaction she felt a human connection with this father. She was nonjudgemental of his lifestyle and way of being and empathetic towards his situation. The nurse continues to have personal contact with this client five years later and feels personally enriched by her experiences with him.

The HIV Couple IIA-S12

In this story a CHN interacted with a young family as both parents discover they have HIV and learn to deal with the changes created by their devastating diagnosis. Initially she interacted with the couple when the woman was pregnant. They were leery of the nurse because they were alternative people and she represented the establishment. During the woman's pregnancy she tested negative for HIV. When the baby was five months old they came to her because the father, who had a history of high risk behavior, looked sick, and they want him HIV tested. When the test came back positive they came to her for help but she was pulled away for an emergency at one of the schools. While at the school she kept thinking about the mother's potential for infection and the potential exposure to her breast feeding baby. She made contact with the couple again that day and told the mother she must stop breast feeding and got her formula.

Two days later she returned to the house to check on the family. She found the father coping with his grief by resorting to his old behaviors of drinking and smoking and endangering the baby by carrying and occasionally dropping her. The nurse talked to the mother alone and told her she must make a plan to leave as he was endangering her's and the child's safety. She empowered the mother to leave. The next morning the nurse returned to find the mother and child gone and a very angry father. She confronted him about his behavior and how detrimental it was to his and his family's health. She counseled him to keep himself together for the sake of himself and his family.

The nurse continued to follow them and was able to get services for the sick man. Even in this desperate situation she felt there was a strong sense of affection within this family. They still lived apart, but he was getting medical attention, was living a health lifestyle, and spending most days with his family. The nurse felt her interventions weren't heroic, just the normal things CHN's do when clients are in the throes of a crisis and can't care for themselves. However she was personally touched by the experience because each time she visited the sick man he made the effort to dig a plant from the garden, pot it , and present it to her as a gift.

This story encompassed all aspects of the CHN practice. Initially she gained trust from clients suspicious of her motives. The clients portrayed the trusting relationship when they turned to her for help in a crisis. Her experience guided her from the knowledge of the father's positive test to the knowing that the breast-feeding baby was at risk for infection. She rescued the infant by bringing formula and teaching the mother the risk of HIV transmission with breast-feeding. She then empowered the mother to leave the unsafe situation. Her past CHN experience gave her the ability to confront the father about his detrimental behavior and taught him how to

improve his health in the face of this devastating disease. Throughout this experience her intuition told her there were strong roots of affection in this family, and through her interventions she nurtured their familial bonds. She also continually had a sense of presence or being with the family.

During the telling of the story she made comments that show she gained great meaning from this experience and felt personally enriched by what she had done for them and how they responded to her. She recognized a human connection as she says, "I felt compassion for his wife and kids, but I also felt it for him". She also recognized the client as a teacher when she stated, "I think the human condition is very fragile, and we don't know how lucky we are. And this experience makes me value and appreciate all those things in my life more". She also described the privilege of serving these clients when she said, "We're real lucky that we have an opportunity to view things from another side, that we have that vision". She coped with this emotionally laden experience by sharing it with co-workers and expressed emotions by crying while telling it in the interview.

Three Generations of Women IIB-S2

In this story the nurse described three generations of women living in the same home. There was the grandmother, the young mother, and the little baby. They were all sitting around the kitchen table at 11:00 in the morning while the mother cared for her child and the grandmother had a wine cooler. The grandmother raised her children in a car, but this young mother had been able to provide a real house for her child. Although she was on welfare, the young mother believed how she was raising her child was a big improvement over her upbringing. She talked about going to school but couldn't quite finish the application and access that system. The nurse commented that maybe the infant will be the one to get into school. But she also acknowledged that this uphill climb is a "slippery slope."

This story described many aspects of the client characteristics and culture. They were a family living on the fringes of society trying hard to work their way in. Although she raised her family in a car, somehow the grandmother instilled in her daughter the desire and abilities to get a real house. The daughter was able to use resources available in the social system to realize her mother's dream. She was continuing the process by implanting the same hope in the next generation through her dreams of having an education. Even though she may not attend school herself, her child may realize that dream. This illustrates the slow process of change typical of CHN clients.

The nurse was able to find more meaning in her practice by recognizing this temporality of change. She recognized each generation is a step along the path of change. Although the young mother made progress it

will be difficult for her to totally ascend from her past. But seeing this young woman's progress gave her hope for the future. She also knows from past experience with clients this is a "slippery path" and may of her clients are never able to make changes in their lives.

The Drug Addicted Family IIB-S3

This story described a family destroyed by drug addiction. Initially the nurse was working with the mother, her boyfriend, and their new baby. The mother had two "darling" girls who were in a foster home because of her previous drugs problems. The mother and her boyfriend really wanted the two girls back, and they were making improvements in their lives to show child protective services they could provide a good home for these girls. The children were returned to the home, and the nurse closed the case and no longer had contact with them. Over the next two years she read about them in the paper. First there was a report of domestic violence. Then he died of a drug overdose. Next she discovered the mother was in drug rehab and the children were back in a foster home. And finally the mother was arrested for some kind of domestic violence.

This story exemplified the self defeating cycle that drugs and alcohol cause in many clients' lives. Initially the nurse was working with the family and they had made significant progress. But then they relapsed and their lives fell apart again. She commented that many of her clients can't get past the drugs and alcohol in their lives, and she frequently sees this cycle of improvement followed by relapse. She described an acceptance that many times the outcomes with this client population are not successful because of their inability to surmount their problems.

The nurse also described the limitations of her interaction with this family because of organizational constraints. She was only allowed to visit them for a specified amount of time while the girls were reintegrated into the family. After she stopped visiting them the family disintegrated. She said she tries to refer families like this on to other agencies, but because of her overwhelming caseload she can't continue to visit every family with drug and alcohol problems. She says she deals with this by establishing boundaries of what she can and cannot do for each family, while realizing that some families may not make it.

APPENDIX D

Code Definitions/ Exemplars /Quotes

This appendix comprises the bulk of the analysis. The themes identified in the initial readings of the text were organized into six broad categories: background of practice, context for practice, domains of practice, meaning of practice, ways nurses cope, and personal effect on nurses lives. Each theme was then defined and used to code the text. This process verified the accuracy of our codes and their definitions. The most illustrative quotes and exemplars were taken from the text and used here to support our code definitions.

Code Definitions/ Exemplars /Quotes

I Background of Nursing Practice

Life Experience: The nurses' specific past and present life experiences that they bring to this arena of practice including socioeconomic status, relationship histories, family histories, nurturance, loss, social supports, addictions, and recovery.

As a child I was taught not to bring up sadness. ..."Cry somewhere else," my mother would say. But I'm not afraid to express my feelings or even grieve anymore. I find it very helpful. I've had many things to grieve about myself... I've learned it from my own life process, my pain, loss, and recovery. But I've also learned about grieving in my job...from the clients.

My parents were staunch Republicans...believed that these impoverished people choose their life situations and will not change. This is an opportunity that I might have missed to learn that what my family believed was just not true. I feel lucky to pass this new understanding to my children instead. I hope it will make a difference.

...And I have also done my time with food stamps, unemployment and dysfunctional relationships too. I've suffered as a single mother, not always being able to pay all of my bills. I'm recovering from addictions myself. I think that we have all experienced pain and abuse in some ways. I remember what that was like and I try to mirror for the clients that they also have the same possibilities and hope for change. I think that my own experiences guide me in my work with others...

Sometimes when I think about it I'm not so sure that my life is all that much more together than the client's lives. I mean, I've had difficulties in my life...Don't we all? And my children...we sometimes have problems at our house too.

We've naturally all had experiences with grief and pain. But we probably are able to go a different way in the end than they do because there was somebody or someone who was loving, supportive in our lives. Some of us have had intensive

counseling for our issues. But even if we didn't there was some person who really loved us.

It was my own mother, not nursing school, who taught me to accept others as they are and not to be judgmental. She was really great at that. The best person I have ever seen! She was a nurse too, worked in clinics for many years. But I can't say that all of my siblings got that from my mom. One of my sisters is like that. She has had some hardships like me. But everyone in my family is not like that...can't understand others different that themselves.

Personal Attributes: The nurses' specific abilities they employ to achieve desired outcomes with clients.

After you do this job for awhile you see that there are probably some nurses who will never be able to really connect with clients...I think it is probably more their personal styles than anything else.

I always work to find the positives or strengths in people and validate them. Sometimes it can be really tough. It's hard to imagine but it is really difficult with some people. I can usually find the positives and affirm them.

I have seen that generally the nurses can accept others even when no one else can. It's like we love them unconditionally. Yes, we love them unconditionally.

I think that you just have to be, you know, really comfortable with your self. Otherwise you will not be able to be really honest with other people you visit. You have to learn to be confrontive. It is not always the easiest thing to do when you're in their home. Sometimes the families are just wanting someone to do that. They already know what is wrong but need someone else to be right out front about the issues. But others can be very angry, sometimes threatening. It really comes from a caring place. When nurses migrate and end up in public health they have to be comfortable with this...

You have to be really skilled at diffusing situations. I had to go to the hospital and counsel a father that what he was doing really was

not such a cool thing to do. He was threatening to shoot everyone there he was unhappy with. I knew he was actually worried about his baby.

I see all of the sad things that have happened to them, hear their sad stories. Sometimes I just have to wonder why it is them it's all happened to and why not me? I mean why do they deserve this and why do I not?

Probably at least around fifty percent of the time they may tell you just what you want to hear. Or they may just tell you a flat out lie. You have to be real discerning...

Personal Belief System and Values: The nurses' expressions of personal, spiritual, professional, and political beliefs. Also what the nurses describe as being important to them.

No matter what your specialty is here you have to learn to take very good care of yourself. Otherwise this work will make you ill. We have to find those things that strengthen us and enrich us. I don't want to just get hard-hearted. I believe it's very important to feel what they are feeling. That is why I let myself really experience their pain. But I work a tight recovery and self-care program.

There are many injustices in life and I get very angry about it. We see it all of the time. But I believe my anger directs me in a certain way. It actually inspires me to make changes, so I am glad for my anger.

I believe that God is actually in charge of my client's lives, not me. And so I do not write the script for them. I just try to focus on what I am responsible for.

I love an old Jewish saying because it describes what it is that I believe we actually do:
"It is not within our power to place the divine teachings directly into someone's heart. All that we can do is place them on the surface of the heart, so that when the heart breaks, they will drop in".
That quote tells me that it is not actually up to me to make the change in a person, I can't. But as a nurse, I do need to be there

when another is in pain.

I don't believe that we are in these nursing positions by chance. We are all working some things out here, the clients and us as well. I believe we are in these positions for an important reason.

You know it's all really a mystery...their sad pathetic eyes, and yet lots of those babies survive...I do believe there are those cases where the baby does a "U-Turn," someone just decides that maybe it's better now that later on.

Nursing Education: The nurses' reflective statements of what they learned or experienced during their formal nursing education, and how they perceive the educational process affects their ability to work with clients.

I think the problem with our nursing background is that we were taught in school that successful situations have to always be a tangible something you can measure. We feel ineffective to just be with the patient, like it is not enough. That is not something that we were ever taught it was okay to do.

I think the training that we get in all of the communication courses really helped. Helps me a lot in interacting with clients now. Helps me know how to suggest changes without being too offensive.

They said in nursing school that you should not be judgmental of patients. Do you learn it there? I'm not really sure. I might have intellectualized about it. But I see all kinds of nurses who all went to school and they are still judgmental.

I don't think they prepare you to work out in the community. They didn't really say much about what was not black and white. There is mostly a lot of gray in working with these families. No easy or fast answers. If they taught this in school than I must have been absent on those days.

I believe it is really integral to our education and training that we have learned to view all individuals in a holistic way: spiritual, emotional, and physical beings. That is a strength of nursing.

When we got out of school we thought we were not doing it right if we weren't able to make big changes. We expected to make great changes in many things. Now we see the reality for most people, if I can generalize, is probably that if anything changes it will be in small, slow ways.

Past Nursing Experience: The nurses' descriptions of events, actions, behaviors, moods, and thoughts which took place within the context of their practice prior to public health.

I worked in the ICU for many years...spent fifteen years there just taking the brunt of things. I was nearly suicidal. I caused my patients great pain but always had to lie to them. "This will only take a second, won't hurt," passing tubes and doing invasive treatments. You have no right to be there emotionally, there is no chance for processing. You do your job, cause pain, try to save some lives, then go home at the end of the day. It is a very abusive environment for human beings on both sides. I think that the nurses suffer more than the patients...the stress and level of perfection always required. It was like being in the trenches of a war, like Viet Nam. I lived in that arena of nursing for a long time and knew I just couldn't do it anymore. I'm not going to do that to myself or anyone else. I'm not going to kill anyone in this job, or hurt them... In this job I can focus on healing the patients and myself.

I worked in home health visiting the elderly and shut-ins. There were honestly times I know that if I didn't come along visiting when I did, that some people would not have made it.

In the hospital the patients are really powerless and others are in control of everything. I really didn't like practicing that way, towering over vulnerable people who aren't even allowed to wear their own clothes, stripped of everything essential to them. That is powerless...I really prefer to work at their level.

I had to leave hospital nursing. I couldn't bear to see individuals molded into a false sense of self, a hospital mold that's directed by others. You were judged there by how well you complied with the treatment plan, or carried it out as the nurse. We just controlled the patients too much. We took away their belongings, their dignity, their life as they knew it outside of those walls. Whatever

the doctor or nurses said became the law there. If they didn't want to go along with it you just write a nasty note about them...bad patient, goes down in their chart.

Community Health Nursing Experience: The nurses' descriptions of events, actions, behaviors, feelings, moods, and thoughts which they attribute to their experiences as community nurses.

I learned that it did not work to tell the clients what to do. Instead, I learned from experience to offer suggestions. First I'd find out what their goals were, instead of telling them how they should accomplish what I thought they would want to, or needed to. I had to learn to offer alternatives to what they were unhappy about.

There is just a certain kind of chemistry, feelings between the client and the nurse that keep you invested in them...

I had to learn new roles, new skills. I tried at first to function in the old mode. I had a hard time making the transition and yet I really liked this kind of nursing. Had to learn to trust myself. I would try to memorize things I could say to clients, wanted to have the correct response. I tried to find answers in protocols, but they didn't usually help these kinds of situations. That's why being a new nurse is so hard. It was confusing that everyone around me seemed to know what they were doing. They looked calm. In the beginning I think I was checking out things often with them. As time passed I started feeling better about my work. I realized that most things in public health are not black and white. I think I am the one who has to go to bed at night and be able to sleep after what I have done that day, no one else. I trust my heart to tell me what is okay to do, and I really don't worry what is okay in someone's protocol. I've learned what works now and it is about connecting with people, that's what matters.

Intuition: The nurses way of knowing, gained from past experiences, what will likely occur next, such as recognizing early cues, discerning the essential time and methods for intervention, and sensing subtle messages communicated in interactions.

I realize that intuition is really a very big part of this job. I use it all of the time. I remember when I felt like I didn't have it in this

job, and yet I know it was there...maybe didn't really listen to it back then. A more experienced nurse, a good friend of ours here really helped me out with that. I would come back from visits and share the sick abusive situations I would see, I felt safe to let her know how I felt about all of that. She would validate that it was horrible things I was seeing, experiencing She said it was a normal response, seeing unhealthy things with healthy eyes. When I told her what I felt during the interactions and how I intervened with the clients she affirmed that I was getting it...reading the situations correctly. She was actually very instrumental in helping me to put it all together.

It takes considerable growth in public health nursing before you can recognize the essential time to challenge or confront someone. Sometimes it is really risky. You have to really be in touch with what is going on there.

The poor baby just looked at me, you know...we made eye contact. And it was just as if the baby had said "Help get me out of here!"

When I start trying to go by the book, telling myself what I should be doing, what the client should be doing, I start doing all of that crazy stuff in the clients presence. My intuition usually comes through and says "just be gentle, be loving with her"...when I feel anxious because the client seems shut-down, unresponsive I probably have the hardest time tuning in.

I have to just trust it. When other people think we should do an intervention and my gut tells me already it won't work that way. I mean there is a baby and a mother at stake here. I have to listen to my own intuition which I have learned to trust after doing this job for many years. It has grown in me from a place that I wasn't sure of to something that guides me.

I made a decision before I walked in the families door that I would trust my intuition and just relax from the beginning. I left all of the stuff I usually brought in the car.

There is a very vivid and clear energy that will tell you what to do next in that moment. It is a spiritual energy. I first learned about it from another nurse.

I knew it was the right time to ask, and she agreed to go into alcohol and drug treatment. She is clean and sober today. It was a wonderful moment...some are not so wonderful.

I remember thinking really sad and mournful thoughts toward the baby. But I thought at the time that it was because it was such a sad environment for a baby to be in. I was not really surprised at all to learn that the baby died, even though I could find nothing physically wrong on the visit. My intuition was even deeper at that time than it sometimes is...I was not surprised to read it in the paper.

I've been a woman on this planet for forty-four years. I can trust my intuition to guide me about safety on home visits.

You can't always predict what the clients are going to do...but I do think you get a sense of vibrations with these people.

II Context for Practice

Client Culture: The way that nurses describe the characteristics, behaviors, beliefs, and lifestyles of their client population.

We work with lots of people thought to be at the lower end of the spectrum, at least in terms of socio-economic status. They are often involved with the police, or have been in jail, maybe a few times. Sometimes I find that those people who are truly at the bottom reaching up are emotionally needy and ready to try a new approach.

I visited a mom who was about two weeks post partum. They lived in one of those horrible motels right down town. The baby was not really thriving, had lost a lot of weight. The mom was not paying any attention to the baby. The mom was curled up into a fetal position on the bed. The poor baby with bluish hands, cold and listless.

She had already lost three other babies before this and was bleeding now. She had just gotten out of jail. The father with tattoos and stainless steel teeth. I took her to the hospital and she said if they lost this baby they would just have more...

She was angry, belittling, and shut down. The nineteen year old mother of a three-week old infant. The father was brutalizing, the grandmother tipsy on valium...

The father of a baby worked all day long picking rocks out of wood piles. He got fired from his job for taking time off to be at his babies birth. They now lacked any income, a safe place to live, had no transportation. The baby needed to see a doctor right away.

The mother was developmentally delayed. She wanted desperately to breast-feed and do everything right for her baby. The baby's grandfather would stand right behind the mother and destroy all of her confidence. "You don't know what you are doing, you can't do that right, why even try?" Then he would even say to me, "You are just wasting your time with her." He was just very controlling, very vocal. He has his very own church out in the boonies and is very controlling of his wife too. Someone gave this guy a daughter that has trouble learning and so it just gave him another area to take control over too.

She was in her sixth month of pregnancy and was still not able to get into prenatal care. She had been turned down by a doctor, missed an appointment, I think. She had no phone and no transportation. Her boyfriend was serving time in the county jail.

Client Environment: The nurses' colorful descriptions of the communities, homes, jails, motels, and living environments they visit.

They live in dark depressing places. Never have any flowers or even magazines around. I worry about how it affects the children. There is so little stimulation, maybe TV which is always on.

I remember looking around this room and thinking, "this is just hopeless. I mean this room where these people are trying to live is a craphole."

One motel visit I had was in this awful place...no where to keep food cold or cook food for the children. Nothing inside but broken down old motel furniture. It was really cold inside there. I sat on

the floor, sometimes the seats are wet.

She had actually received an eviction notice, but was waiting until the imminent day when they would come and remove her physically, and in the meantime the place was trashed. I don't usually get too wrapped up in how orderly the home is, it's not why I'm really there. But this was absolutely a health hazard on several accounts. The cat litter box had mold growing on the feces, and their was a scrawny cat actually trying to paw at food from the toddler. There was garbage strewn throughout the home and I thought, "I cannot allow this two-year old to live like that." I told the mother it had to change today.

One home visit I had was way in the boonies at the other end of the county. They live way out there, not around anyone else. And you drive past a sign that says "Do not enter or you will be shot, and awhile later another one says..."You are in my sights." I'm still driving up this mountain side kind of ducking along in the car, because we had this appointment and I am going to show up.

It's like their entire world turns just outside their motel windows. I was on a visit and they got all excited and asked me to come look out their window and see what was happening. Then they pointed out all of the places where the police had been in the past few days. Just normal midweek activities there. They know what all of the neighbors got busted for, when they are getting out, and they depend on each other to help with childcare.

Client Characteristics Associated with Success: From their experiences the nurses identify inherent or acquired characteristics possessed by individuals capable of personal growth and successful outcomes.

I believe it really makes a difference if they have even one positive role model or support person in their life. If they are connected to a person with good outcomes they believe it can happen for them too. When a person has no hope, why should they even try?

I think what makes a difference is actually an inherent personality trait, when you look at families and see that some siblings survive their horrible upbringings but all of them don't...

Some of them have an inner strength that comes from their beliefs, Just like we do. Some may be financially destitute, but have a spiritual strength, or can find it somehow...they have hope for recovery from their abuse. Some are simply survivors.

I think that I can sometimes tell when a client has what it takes to make positive changes...if there is some glimmer of interest, some goals they already have for themselves. Just wanting for things to be better, I can see a ray of hope for those clients and will invest my energy there.

When it seems like people are unwilling or uninterested to change I have to ask myself if it is because I really wanted them to achieve my goals or if the goals really belonged to them to begin with. I mean they may be just patronizing me. Why shouldn't they, I mean we actually go into their homes with agendas, the clients have to value a change themselves.

The people I often see change and follow our advice are the ones that might just lack information, have a knowledge deficit. They are capable people who just get confused with a barrage of information. Like maybe they watch some television show that warns about the dangers of immunizing their children and they are afraid it will harm them. We are able to calm their fears and provide them with information to make better choices. I think we have lots of success in these areas.

Sometimes the motivators for change seem ugly. People have to be threatened sometimes. Child protective services threatens to remove their children and they are forced to make changes. Some times it does seem to last, when the whole family turns around.

It's kind of weird if you think about it, like you can actually feel a difference in the families who will be successful. I can tell when I go out in a home that if people are sincerely unhappy with their life they will verbalize it. " I really want to get off these services, hate this feeling. I never thought we would be this bad off." They are basically very unhappy and want to make change. It is not our doing really. They already have goals, some desires. That is a big difference compared to other families who have been on welfare for three generations and are comfortable with the status quo. There are only a few of those that you can really pull out, just a

few. That is what they expect of life.

I say to the one's who want to change that I will help them with things I can do. And I know that five years later those peoples will be gone and out of the social system. It's real different than those who stay in the system forever. It is so hard to break that barrier down. They are not comfortable with any other model. It's like they would have to walk away from everything they have ever known, and it's just too difficult.

The families who are entrenched in drug use can not make any lasting changes unless they are really in recovery. Otherwise they end up taking steps backward. Some of them are really trying hard but they have no control. They're working hard at being a family, getting their life together and then you read in the paper their arrested for domestic violence or rape or something. The mother is in and out of treatment program, the kids in and out of foster care. Such a sad life. And then I read in the paper that the father was found dead in a parking lot one night.

Client Interaction with Social System: Nurses describe the ways that their clients interact with various social agencies and groups including contacting agencies to acquire basic needs or responding to an agencies specific concerns.

It seemed like for some reason the child protective services had not been fair to this woman. They did not even tell her that they planned to take her baby at the birth because of who she was living with. The father of her baby had actually physically abused their previous child when they were very young, five years earlier. They were not offered counseling, parenting, or rehab. I was involved and working with her during that pregnancy. She was very young, just signed the baby over to them to put into foster care. She had now grown into her twenties, gone to some parenting classes to prepare, got a decent job. She wanted this baby more than anything and I am certain if she had been told she would have changed her situation. They did not tell her anything until she was ready to deliver, and as the public health nurse I had no clue. They did take the baby but we eventually got a hearing, fought for that mother and her baby. She was a daycare provider at a gym in town.

A family who had a baby removed was very upset. The system was really not user-friendly, no one explained the expectations. They wanted to see their baby but they felt they had no allies at child protective services to arrange it. They were being criticized for not visiting but could not make out the process. I called them up told them to call up the agency and demand visits every day.

One pregnant mom was dropped by a care provider for missing an appointment, and not calling ahead to say she'd had car trouble. It was two months before we could get her reassigned and in to another doctor. Lot's of paperwork and phone calls the client and nursing staff.

We held an intervention with a heroin addict and a group of multi-disciplinary professionals who had interest in how she was doing, being addicted and pregnant. There must have been about twenty professionals in the room. She was scamming the system big time. She was on methadone and using other drugs as well. She was using other people's urine for drug screens. She was one large, tuff woman. It is a paradigm case for me because she taught me a lot. We were all going to tell her exactly what she had to do and this is how it is, you know. She came in, stood in the door way, and held an un-lit cigarette. She was wearing a black leather jacket, her black hair falling down her back, about eight months pregnant then. She just stood in the doorway the whole time wearing her sunglasses. Finally a man from the methadone program asked her how she was feeling right then. She walked toward him and said, "How would you feel in a room full of drug addicts?" I was struck by the way she reversed the situation.

Nursing Interaction with Social System: The nurses' interactions with various individuals and groups within the social system to support the needs of their clients.

Sometimes I find that this interaction is really fun! Cause I can get out there and rattle some really big cages. I can raise some hell you know about the injustices, get a great result for a client and it feels really great.

We can call up agencies and get things rolling in a positive way for our families. We can call up and find out what the delays are, link the woman to what she needs.

We write support letters and get children into headstart and early intervention. Sometimes we can help get clients into alcohol and drug treatment rather than going into state penitentiaries. There is power and clout in being connected to people in the community.

We tend to know the clients better, more personally, after visiting their homes than other agencies do. If you think about it, child protective services are about the only other agency that make home visits and that is not always on the best of terms. These families are sometimes only numbers to other agencies. Or they might be just a problem they are involved with...but to us they are real people we have seen in their environments. We can sometimes help by sharing information with agencies that help provide a missing piece to the puzzle. And often that helps the family obtain what they need.

Client-Nursing Interaction: The nurses' shared narrative accounts of the client encounters in which they participate. They consist primarily of face-to-face home visits.

I told them I would work with them to get their baby back. I spent a lot of time teaching them, getting them into parenting, and getting them to trust me. It was not an easy chore after all they'd been through. But they were willing to do the work.

I have a client that drank throughout her pregnancies. Has a little child that looks just like fetal alcohol syndrome to me. I took her to an AA meeting last week. She wants to get clean and sober now. She is in denial about that little girl and has had several miscarriages because of the drinking. It was painful to see that little fetal alcohol face. The mother says, "I drank in my pregnancy, but she's just fine. She is just doing wonderful." I'm feeling like this mother is ready to hear what I need to say and I asked her, "Do you think your drinking had anything to do with your miscarriages?" "Yes, I think I killed my babies." She started to cry and I cried with her. "Do you think your drinking could have hurt Nicole in any way?" "Yes", she said. We both cried. I could feel her guilt and pain. When I left I was still crying and just thought about how long this woman had suffered.

There was a teenage client I had done many visits with prenatally and I actually went to her birth and helped her have the baby.

People in the schools, the hospital, and other agencies were unhappy with her because it seemed that she did not follow through on things. She was actually a little shy, would not go out of her way to reach them. But in some way we really connected. It was like that chemistry I guess, and I thought she was a sweet kid. That has been a few years ago and the other day she came walking into the health department and asked for me up front. She was confused about immunization schedules, needed to clarify what her child needed, and how she could access them. It made me feel really good that she came downtown and sought me out for help. If we hadn't had the good connections in our interactions previously it wouldn't have happened.

I had several visits with a couple and their baby. the man was HIV positive. At one point the mother thought she might be also. He had used IV drugs in his younger years but had long since made many positive life changes. As time went on he became more and more ill and I arranged for disability services to help this family out. They had their emotional and relational ups and downs throughout the time I came. The man made himself get up and go outside during our visits and would dig up a beautiful plant for me each time I visited. And I thought "I don't know if I could be facing a horrible death and go out and do something like that for someone else."

Nursing Organizational Environment: The nurses' explanations of the structure, expectations, work environment, finances, support, and restrictions of their organization which effects their practice.

I don't know about the other nurses but sometimes it feels so hard to deal with all of the tough client issues that it is difficult to find humor in the work, I miss that.

After hearing the stories of abused women all day long I returned to my office crying and she gave me a hug. The people I work with are really what keep me going in this job.

I'm not sure administration would approve of all of the kinds of encounters we have with our clients, they might not always follow protocols, but maybe we need to rewrite the books.

I think I am having more job stress these days from our

organizational concerns, than over clients. It's around the staff, and the politics, and the constant lack of resources...

We need much better funding to be able to continue this work, and do it well.

I have been very concerned about the mental health status of my coworkers. This is a very stressful environment. There have been injuries, breakdowns, and nurses that become cases just to be around. It does not seem that the staff receive proper intervention,

III Domains of Practice

Being Present: The nurses listen and acknowledge clients in a way that lets them feel that another human being genuinely cares, understands and supports them, regardless of what they have ever done. The clients feel that in the moment of the interaction the nurse is truly present for them.

When I am with a woman I attempt to uncover some dignity. They have not had the chances to feel a little proud of things they have done like we have, or even feel cared about. If there are little things that I can do whenever I am with them to show some human respect, than that in itself is a good thing.

I have gotten my work down to a fairly fine science. It's all around being present to the issue and being able to constantly realize while I am sitting there, what the issues really mean for that woman who is experiencing them. I am fine tuned to what she is saying and I listen to the client closer than I listen to anybody, more than my kids or my husband. I really am one with them, at that point, actually feeling what it is that she is telling me. I am upholding her in that moment.

And I went to the funeral and I remember standing out in front with the mother in the pouring rain after. The director there wanted to close up at the end of the day. We were still standing out waiting for the father to show. It was sleeting and cold. She just kept saying, "He's gonna come, I know he's gonna come. He's gonna come. He will come to see his baby. I know he is getting drunk, but he will come." It was a moment I will never forget. The director finally came to her about 5:30 and said

he was really sorry but that they would need to close up. She was tearful and in great pain.

...I was trying to look at her lovingly and uphold her personhood and connect with her spirit, which is something I always do even with babies...

Establishing Trust and Building Relationships: The nurses demonstrate that it is safe to be truthful and vulnerable about their life circumstances. The nurses use self-disclosure, confidentiality, honesty, and trustworthiness with their clients.

When a client offers something, like a drink of juice or coffee, it has always been my policy to accept. It's the exact opposite of what we were all probably taught, but it's relationship building--like wampum, smoking the pipe together. "I'm accepting something from you and you're accepting something from me," like a meeting place and it has worked many times for me.

It's interesting you know...the clients do not usually ask about your life. You can be in their home and be interviewing the day lights out of them. They rarely say, "Do you have kids...are you married?" Maybe only twice in my career here. But if they do give me a little interview, or ask, I do meet them honestly. They sometimes see us as wealthy, or all knowledgeable, having it all together. I will offer them information about my hardships.

I am respectful of their territory, whatever it is... unless it is dangerous or unsafe. Sometimes they kind of test the waters. Like the woman who placed the boa constrictor on my lap. I know that other nurses would not have gone along with it, but that is just me, and it did help make in-roads with this particular client. After that she would tell me that her boyfriend was abusive, the kids there were all his, and that she emotionally had to get out of there.

When I sense that the woman is unhappy I may disclose something about myself that helps her know it's really okay to talk to me like, " I was very upset in early pregnancy, what is it like for you?"

I think that we kind of set the stage for allowing them to be

vulnerable when we meet with these people face to face. We help them learn to be open in a one to one situation. And I think it's because we do it in such a way that is not punitive, not degrading, we don't put them on the defensive about their lives, we make it comfortable for them.

Giving and Sharing: The nurses create opportunities during the interactions to offer simple gifts of hope, dignity, and respect. The clients share understanding of their personal life experiences with the nurses who translate them to personal and professional knowledge.

There is some kind of compassionate part that wants it to be easier or richer, or find ways to allow them to have some dignity or integrity in their life. It is missing in their life...but maybe fate has brought us together and I can do that, I can give them that.

I learn just as much from my clients as I have ever taught them. There is no question about that, but it is not something I had really expected in this job.

I struggled with this one client to develop a nursing plan to reach her issues. I was not getting anywhere, been through a lot of issues there with her already. It finally occurred to me to ask her just what it was that she needed just then. I said, "What can I do for you, want me to watch the baby for a few minutes while you take a breather?"

I've thought a lot about it and it is really establishing the relationship that makes the difference. Those women are so isolated and if we can just have a good meeting of the mind together. They hear you, and there is some respect there and then they might be able to make changes, you know...

And at first I struggled with myself...didn't think I should, didn't really feel that I had the time. But I finally told her I could take the baby for a few minutes and she went to take a bath. She took a long bath because she unwound and got straight, and was prepared to come back in and assume the caretaking. She knew the baby was safe and could just relax a little bit. It didn't seem like nursing, and it was a real dilemma in my mind...but you know I realized that it probably kept them from beating up the kids.

Rescuing-Fixing: The nurses sometimes intervene when the clients are unable to recognize harmful outcomes . Also, reflections of the experienced nurses upon the early "novice" phase of practice when they attempted to "fix" the client adversities themselves.

The preliminaries looked like she would be HIV positive. She was still breast-feeding so I went out that day, told her she would need to quit and brought her infant formula.

They did not even have the basic food and home supplies, not even a toothbrush to brush their teeth. She had just been released from jail and I really wanted them to have a chance. I went and purchased a months supply of groceries, and left them on their doorstep. There were bags and bags of groceries and diapers. That was years ago, and I learned even though you care about them it is not a good thing to do.

It was my day off. I baked some fresh bread and took it by their place. I had to know that she was okay, not off using drugs. Now I know that you need to let people reach bottom. It may be part of their journey to hit bottom, part of their lessons to learn in life. I can't fix everything for them.

I had to be very careful at first because I wanted to fix everything for everyone...I knew it would be easier for me and I could afford it.

Sometimes we transport them and maybe you should not do that. Or you might bring them something that you know she could really do herself if you empower her. But you also realize that sometimes it is just so damn difficult for these people, dragging all of those kids around town on the bus, and it just seems like something you could do to make their life a little bit easier.

Nurturing: The nurses attempt to sustain their emotionally impoverished clients by using behaviors and spoken words to convey caring. This is a continuous process in on-going interactions.

This was a family that had some problems and needed all of the love and care they could get. I did some visits there during the pregnancy. They had their baby and it was apparent that they would need lots of nurturing to be able to pull this parenthood

thing off. They were not affectionate themselves and now did not show any to the baby either. It was almost like I was parenting them.

There is not one person we meet that we can't find something to get us caring about them and showing some love. We care about all persons unconditionally and that will serve to nurture them.

Sometimes it is the dignity factor. I like to think that I can scratch the surface and just uncover a little bit of dignity or integrity, helping them realize that they can really be something they want to in their lives. They have never had the opportunities to love or hold their heads up high. Nurturing is important. Maybe all of the other stuff like housing, transportation...doesn't matter as much.

We just saw the Lion King...last night. And I was thinking that it really reminded me a lot of what we do as a public health nurse... when the father said, "remember who you are." That is how I nurture the woman, what I truly do give to the mom...you're a wonderful woman, a wonderful mom, you desire to make things better...

Teaching / Counseling: The nurses teach and counsel clients after assessing potential or actual health problems to assist them in developing healthier outcomes.

A developmentally delayed mom wanted to have a healthy, bright baby. I worked with them and taught them how to take care of her. She got thrush and I had to spend a lot of time pulling up all of the doses, writing down the times. The dad was slow too and I wanted to make sure I taught them right, and had it as easy as possible.

It was he who had been abusive and she had finally left. I went over and told him that his acting out was going to cause nothing but trouble for him. And he was doing a lot of drinking, it was really bad for his physical condition with HIV in this stage. He was calling her all kinds of names and I just told him he should just get it under control and to cool his jets.

It is very difficult when you identify things which require very quick handling to right a wrong. The long term goals we

can counsel on and expect to see changes over a long time. But even the things I sometimes find to be urgent do not always get acted on very quickly. And I have to also learn to just allow them to take what I have to offer in information and support and do what they will with it, because I am not in charge, really, of how they choose to address the issues. I can only bring them what my concerns are...from a health perspective.

When I was new at home visiting I was rarely confrontational. I would just go...like God, that's terrible when they shared things with me. Now I realize that part of the teaching includes being confrontational, yet in a very loving way. Now I probably would have said, "Do you want to upgrade your situation?"

I use to just feel because I was a guest in these people's homes that I just had to be respectful of everything they did there. But is is changed now. Now I am asking people to turn their TV's off, it is so loud! I tell them that it is overestimating the baby. We sometimes will tell them the scientific stuff... he baby needs some light in here to help with his development, and it's true! And we always talk about second-hand smoke. I think it is our responsibility to teach about these things, and I think these environments just add to these peoples' depression.

Sometimes I just happen to be in the right place at the right time. ...and I just said, "are you interested in getting drug treatment?" She had just used speed about an hour before and did go in to treatment...

I was hammering away, you know...looking for results of my teaching, and a more experienced nurse pointed out it was like planting the seeds in a garden.

Advocacy: The nurses take action on behalf of individual clients and the entire client population by representing them and speaking to others about client needs.

And I fought and fought and fought. I talked to child protective services. A foster parent had made accusations and was taking video pictures of the baby. I watched the tapes and realized something was really wrong here, the baby did not want to be there. I advocated to get her out of that home.

They were really desperate. He wanted to have an HIV screen, was ill and had some symptoms, and he just needed to know if it was positive. I got on the phone made some calls, and got him tested. He ended up being HIV positive. He was really worried about how his family would manage without him. I supported the whole family emotionally, then was later able to get him on disability services.

I basically left that house feeling really down, really depressed and trying to think about the scenario, it just wasn't right you know. So I walked right over to a church I had seen across the street and knocked at the door, and just said, "You know, one of your neighbors is really in need here. She has no food, no power... and I want to know what the church can do." They wanted to know who she was. I told them if they had any monies I could go and purchase food. I asked them if they could handle fixing the electricity for the weekend...or whatever. He just basically said you'll have to come back on Monday, and there is no one here that can help you...I felt so mad. I just teared up thinking about it. She and her boys would be without any money, any food for the weekend. It was a Friday and I couldn't get a hold of anybody...

...These little eyes just looking at me. Sometimes it is really hard to make eye contact with them. I know that the soul and the spirit of these children are too vast a wisdom to get lost. But the physical trauma to this child is a repetition of the trauma that the mother has had. And that is what I really have a difficult time not being able to speak to...why I do call child protective services when I do see neglected and abused children. Because a mother who strikes her child and has been abused herself, my instruction at that moment is not gonna change her. She is gonna keep striking that child because she was struck.

Sometimes we can come in and just do really simple things that we know how to do really well. We know who to contact to rectify situation, but they are overwhelmed and can not quite figure it out on their own.

I think for us that advocacy means we want for our clients to learn to do things for themselves. Not so much that I want to do things for them, but to introduce ways to them that will help them learn real independently. They need to really come into their

own way, sort of come of age so that they can basically advocate for themselves.

Empowering: The nurses assist clients to identify and build the necessary skills to face challenges, create change, and become independent of the social system.

I actually see no end to the client problems unless we can empower them. It's the only way that they can become independent of us and of other agencies.

A bright nurse can always find another resource. You can just about go nuts with resources if you want to... But the idea isn't just to give it all to them, the idea is to encourage them to come forward and be willing to begin to do the things themselves. We're not really here to find them a house, get them a job, get their kids taken care of. Not really, it's deeper than that. When they start walking forward I will meet them. It won't help to drag them along.

I remember a client that told me when she was nine years old that someone took a broomstick and beat her...she described it really graphically, and just the thought of that poor little girl. She was such a sweet spirited woman, you know. And I thought of my own daughter. It was like she just accepted it, so matter of fact. And my rage was just rising at the time she was telling me about all of this. It was her mother's boyfriend and she had not been able to ever tell anyone outside her family, and there was no protection there. I came right out and told her then, "that is not all right! That is a violation of you, and you're body. You are special." And I don't really know that anyone had ever told her that before.

It's obvious to anyone that looks at him that he is real sick. She is telling me that he is abusive, controlling, will not even let her out of his sight now, cuz he knows she will run. I told her, "you have to just do it, consider the safety of yourself and your kids first and foremost. Yes he is sick with HIV, but he's abusive and you have to take care of yourself." We made a plan for someone to distract him, his sister, so that they could just get out...

I wanted them to be able to get their beautiful baby back. I

worked really closely with them, helped them learn. And they were able to do it. I think it was that knowledge that helped them to get the baby back...

I sometimes use affirmations to empower the clients. That really builds their self esteem. These clients need to be told that they are important, have a right to their feelings. They need to be told who they are human beings who can make a difference in the world.

I think it works best to be real open with the client. Help them see what could work and then just hand it back to them....these options might work, and if you don't make some changes they need to know what the consequences will be. You are honest, you help them see how to make change, you've helped them already but it is their life, their choices. They are the ones living in that life...

IV Meaning of Practice for Nurses

Enrichment: The nurses feel they expand their understanding and acceptance of others because of the nursing experience and pass this on to their families.

If I hadn't had this experience I wouldn't have an idea there's people out there in the United States of America really struggling day by day, and it's real poverty. It's not self-imposed. Sometimes I feel that by their circumstances and their decisions it's self-propagated, but most people wouldn't choose to live the life that they're living.

When it is desperate it can be really desperate, but yet there is still something there for these people.

My daughter made this visit to this girl's home and she was a young mom...just a little bit younger than my daughter...and she was so struck by that and how this girl lived and how different her life was than ours. And this girl was very free and open to share. I think that's part of that gift that we get in terms of making this real to our families.

We are kind of on the cutting edge of knowing--of the pulsebeat of society--of our society. We are seeing things now and recognizing them that other people won't have a clue for years to come, and there's kind of a sense of accomplishment in that. We're seeing it happen on the street and it will have far reaching consequences.

My parents are quite conservative politically, my father being very vocally conservative, and I bring some sense of humanity to them in our discussions.

It's almost as if you have an opportunity to view a lot of things from another side. We're real lucky that we do have that vision.

I know that my gift really in this is to be able to teach this generation of children. I mean they are wise already to what those issues are. They are incredibly aware of drugs and alcohol and abuse and denial of society. I mean they've heard this now for years and they are very well-informed, and my hope is that my public health experience is going to teach them that non-judgment.

I think the human condition is very fragile, and we don't know how lucky we are. And it makes me value and appreciate all those things in my life. We're real lucky that we have that vision.

I try to say to my children, "This is a human being. This is a person who feels and who has pain and who has joy." I really try to bring the personal side, and I was really surprised. I have one son who just would not accept homosexuality at all...not to say that we have to accept it or not accept it, but just that he was disliking people because of that...and he came home one day and said, "You know, I met somebody I really liked and come to find out she's a gay woman," and he could relate to that. I thought, good, good! I want him to see the personal side, even though people are different. They may do things that we don't agree with, or that he may not agree with, and yet they are a person, they have feelings, and they hurt if you say things to them.

And sometimes it's the hours that could attract a person to this work...really working 8 to 5 Monday through Friday, it's appealing in this profession. It started out that way for me and then it changed, and then I realized that was just one of the benefits of doing this kind of work. But being with people, going out to their homes, seeing the changes, and working self-directed...that is what I like now.

My oldest son...even though he has been raised like the others and I've always tried to get him to see two sides of everything...but he is one of those people that has his own personality and he really feels like people are where they are because they've chose to be there and that is their own problems. But he has worked for several years in the

sheriff's department during the summers and I think that the only impact that I actually heard him come home and say...because he's got no feeling for the people he picked up that were doing drugs or what...it did not bother him to bust in people's houses because they were scuzbags. But when he had to actually go in one day and remove children from two people was the first time that I've actually had him come and say, "You know it was so hard taking those kids away." And I said. "Well, what did you do?". And he said, "One of the little girls felt so bad. I just took her aside and said, 'You know it's sort of like at school and you get in trouble and you have to go to the principle's office, that's what mom and dad have to do." But for him to take a child aside and explain to her what was happening probably made the biggest impact on him. His actually being active and having to take part and that's what I think changes a lot of us...actually putting our feet in and taking part in what's going on and not just hearing from the outside... and that's how you grow.

Human Connection: The bond of humanity between the nurse and client that reveals the similarities in the human condition and instills in the nurses feelings of compassion and empathy.

I didn't come to this job expecting a bunch of pats on the back, you know. I feel like there's such isolation out there and when I had been doing home visits for about a year, I remember saying, "It's not because I'm a nurse that this works, it's not." It works because there's some kind of connection with people. These women are isolated and if you have a good meeting of the mind, they will listen to you and hear you. There's some respect there and that's what makes the difference.

I have less judgment of other human beings, that I know there's a story behind where they are. Even though it may drive me to distraction to see where they are, but I know that there are reasons for them being there. Compassion, that might be it. Maybe my compassion is increased because I've seen where they live.

I almost bawled. Just cried right there, thinking of all that sits around her, yet that was her little space where she had a little bit of flowers, a little bit of sunshine, a little bit of light. And it impacted me pretty tremendously.

And its just amazing when you start going into homes the reason you

become a little less judgmental, I think, is because you are introduced to people that have created their own societies. And it has made me less judgmental I think, knowing how other people live.

I think that I realize that if I hadn't had some of the safeguards that I just inherited, that I didn't do anything to get, like the family that I came from, some of the things that I had. If I was out there like some of the people that I serve without those kinds of things, I don't know that I would be making the same choices that they make. I think the human condition is very fragile, and we don't know how l lucky we are. And it makes me value and appreciate all those things in my life.

This is written by a nurse who went to prison for multiple reasons, but she just wrote from jail and handed it to me and it's very touching to me because she signed it "Ex-RN." And she just said, "I was thinking of you and the good work you did while I worked here (cause she actually worked there in the jail). I hear all positive comments about you from fellow inmates. It's odd to be in the greens, but a humbling experience in a positive sense. To sit on both sides of the table is indeed an honor if I survive." And that shows, you know, there but for the grace of God go any one of us and the people we work with.

My level of acceptance, understanding, tolerance would not be where it is if I hadn't had that experience. If I hadn't seen them face-to-face in the midst of their lives, you know could sit down and talk to them in their homes, and so I find it humbling in that respect that they're struggling oftentimes for the same sense of achievement...maybe different paths of achievement...but the same sense of achievement and satisfaction.

I think we're gradually becoming the extended family for all of these people who don't really have an extended family.

There was a woman in the store the other day. She was ahead of me in line...and she had this child on her hip...and she was trying to write a check...and she was poor...and she was getting food stamps out...and the child was fussy. There was a time I would have gone, "Hurry it up...I'm late!" and I just looked at her. She's really one of our clients and I said, "Can I hold your baby so you can do that?" She went, "Oh yeah." So the dirty little kid sat there in my arms and I'm quite certain I wouldn't have done that before this job. I wouldn't have invaded her space and she was so nice and grateful afterwards. There's little

ways in which I notice my job is integrated into every aspect of my life, and it's a transformation of my person to be doing this job. I mean, probably a total transformation.

I thought you know it is just that there's certain people that we connect with, and I don't know that that's unique to this job, but there just are. There's that chemistry stuff, and that a client came and sought me out to get a question answered, it made me feel good. And so I think those little tiny things just kind of keep us going along the path. Those littles connections.

If you're outside of being a nurse and have some kind of a human connection with someone that someone else might look at and say, "Oh you're being co-dependent or you're doing something to meet your..." But if you feel genuinely in your heart that what you're doing is gonna make a difference for this person...for me I have to go to bed and like myself every night, you know, and feel like I've done something okay.

I think we're probably a lot more like our clients than we want to be and that may be an illusion that we're real different cause we have a working job and nicer clothes. But we're all part of our circumstances and given their circumstances I might be doing the exact same behavior...I can't say I wouldn't. I think we all cry the same tears; we all laugh the same laughter; we all think the same thoughts.

Client as Teacher: The nurses believe the educational component of their practice is a two way interactions, and they see this as an opportunity to learn about life from their clients.

I think it's that there is the teacher, and I'm ready to learn. When the student is ready the teacher will appear and there's something there and it's my part to learn.

I don't think I'd be doing this job if I didn't have some feeling that these difficult situations teach the clients and us life lessons.

This job has brought me wisdom. I believe that I sometimes will have some thoughts and some discerning moments where I think, "Wow," you know, that's based on my public health nursing experience and it's a gift of knowledge.

It is really different to talk to people who have been there, have hit rock bottom, and have got where they are now because of a lifestyle they chose, like in the drug world. So it's like she can relate to me and she can talk on a very intelligent level and yet she is able to really understand the clientele, because she deals with a certain clientele, and she is able to deal with those clients on their low level and understand what is going on with them. I have learned a lot from her about how certain people act on drugs.

I used to see all these people on the street and I used to wonder about their lifestyle. Now it's like I go down the street and I know where they all live.

I continue to learn, almost with every client. When I find myself getting really upset and angry and frustrated, when I can do my best work is when I can stop and say, "What are they teaching me?"

Privilege of Serving: The nurses feel their practice provides them with the unique experience to serve others, and they are privileged to have this opportunity to care for society's most disenfranchised families.

I do find it a privilege. I do because there is a difference in culture that I would not be necessarily aware of it in any other way that I've ever been...my paths would not have crossed with the people that I work with had I not gone into there homes.

We do enter into very intimate relationships and that in itself is a great privilege, and there's a lot of tenderness and a lot of love that I think occurs in that time.

To me it's a privilege to serve somebody. I mean I come from a pretty normal background, and it's a privilege to see because it has increased my understanding to know that the world is not a black and white place.

It's almost as if you have an opportunity to view a lot of things from the other side.

Being in the home and being privileged with the attention of these clients.

Spirituality: The nurses recognize there are many factors controlling their

client's lives, and sometimes they must accept the situation is ultimately directed by a higher power or God.

One of the challenges to my faith is in trying to sort out why things like this are happening to the children, innocent babies and children, and the only thing that gives me any comfort is knowing that God is indeed in charge. And I don't understand necessarily why certain things happen that rob a child of their life, their innocence, their sense of protection, and somebody being a caretaker to them. To be robbed of those things are beyond my understanding and so those are the things I have to turn over to God in saying, "There must be a reason. I don't understand. I can't fight against it in battle, other than to try to help women make other choices so that they can provide for their children a safe place...a safe and loving home.." But the odds are getting greater, for whatever reason, that there are fewer and fewer safe places for children and babies. And its a hard one I'm struggling with.

I remember that this woman has her own divine processing and God is taking care of her just as he is taking care of me. If I remember that then I'm more free to let the pain go and know that someone else is taking care of it also.

I try to remember the big picture today, that God's in charge, I'm not. That's my first mantra, basically I repeat it to myself before I go into the house and I repeat is when I leave. God's in charge and I'm not because if I don't do that then I try to take it all on.

I believe that death is a great mystery, no matter how it comes, and I also believe that it's a coming home, so that way I don't think of it as an end, I think of it as a beginning. And I have adopted that belief maybe to cope with what I see, but I have a very good friend who's a hospice nurse and does some beautiful work with death and dying. I spent a lot of time with her learning from how she'd used that...that actually dying is going home and that's where we are all ultimately nurtured and protected and loved the most, so death as something negative or painful is only with the living, and it's up to us...I fully release that baby back into it's holy place, which is finally safe.

Probably the most inspirational person in my life is someone who was very, very abused as a child. I mean raped by mother and father, repeatedly, and by brothers and is a very spiritual woman today. So I

also know that out of trauma can come unbelievable glory for that individual. I don't know what that is and I do know that I need to let the children go to some greater end perhaps and not something terrible because my impending doom feeling says, "Oh my God, this is terrible. This child's gonna die here." That's what I feel in my heart, but I know that's not in fact what might be true.

I do a lot of impending doom, worst case scenario things when I'm not in a really good space. I will think that baby is never gonna make it. You know, I will think really terminal thoughts which are not true to what the nature of the situation is. I've seen so many babies survive, as well as babies die, who are born, you know, came into this world and turned around and went back, with good reason. There are reasons also that child has that whatever mother he chose and that chose him, you know, they have something they're working out here too.

Probably somewhere we choose whether or not we stay on the planet or not. I mean we know that people have wills to go fight and struggle and stay here and others don't. I don't know what the circumstances of the baby's death was, but if is wasn't getting all the nurturing and love and tenderness and stuff, and then something else happened in the process...maybe it wasn't strong enough to go hang in here.

I cried a lot (about the baby's death), grieved a lot about it, but it's still just...I mean I weighed and measured the baby. It was all right, it was nursing all right. But the parents were so sick...both alcoholics and both drinking and she was denying it but she reeked of it at the funeral so I know she'd never stopped...a terrible loss. And yet I do believe that was one of those cases where the baby did a U-turn...better now than later...and that was probably the divine safety for them in the big picture cause it wasn't a healthy place to be.

Intervention Outcome: The nurses celebrate the positive changes their clients make because of their nursing interventions. They also recognize negative client outcomes are integral to their nursing practice with this client population.

If I'm privileged enough to see the change, then it is far worth while because it's a group of people that oftentimes society has given up on and thinks there's no possibility of them ever changing. They will just continue to draw from the society and give nothing back in return, and I see that as a possibility that I may be able to elicit something

where they can come to a point where they can offer something to society that it values and that consequently they will value.

I remember the other nurse said to her, "What would you really like for your life? What would you want to happen here now? What is your dream?" I remember thinking, "Boy, that was quite a statement to say to somebody who's nodding off on a heroin high." And she said, "Well, I want what everybody wants. I want the house on the hill and the picket fence, a good man and my kids...isn't that what everybody wants?" And I just remember going "Yeah!" And it's so cute cause this spring she's clean and sober, she's got her kids, she's got a great boyfriend, and she's got a great house, and she painted her fence white.

I love it, I mean I just love it. I love knowing that we do have our common strengths as women, that I see people grow and change...phenomenal changes. People say to me all the time, "Oh honey, how do you do what you're doing? Gee whiz, this must be awful." And I say, "Well, to each his own."

I run into kids quite often that I've seen two and three years ago and it's so neat to know that even in a store or whatever that they come find you and they want to tell you exactly what's been going on because to me that's a measure of success. It says that they haven't shut out everybody on a different level, that they're still seeing that there's another level and another place to go out there or they'd be hiding and not wanting to run into you, and those are real positive things that you just don't even think about until you go away.

There are moments like that where I happen to be in the right place at the right time, and she was ready and she went in treatment and she went in sober and it was a wonderful moment. But I come into those moments that aren't so wonderful too, when they are truly not ready. Still I believe people don't have to die of the disease, but I also know there are times when the disease is bigger than I am. That's about acceptance on my part, I guess.

I had a client say to me, "Wouldn't be boring if you didn't do home visits. Nobody has ever helped me in an office, you know, like in the same way as you have when you come to my house and the kind of things that we can talk about." And she's really a person you can't measure a lot of progress with in terms of our culture compared to

hers, but I was able to just really see some really beneficial things in her kids, that she had given to her kids, which is really incredible.

You have to realize that there are some people that will never be okay, that you can never fix, that you can never help, ever. And I think that is one of the hardest things about public health.

Have you ever worked with a family you couldn't save, you couldn't intervene with...I don't think it happens very often, but I think ever so seldom. And you don't want to believe it, but sometimes you just have to sit down and say it's time to cut bait...as painful as that is.

I saw that woman years later in the grocery store just yelling at this child, at 11:00 at night, and the baby had 7-up in the bottle....but the baby survived, and it was a pretty sassy little thing. I just never know what the end result is gonna be.

Temporality of Change: Nurses accept change as an evolving process and understand they may not see the results of their nursing interventions. They see their work as planting seeds of change and know they may not reap the rewards of their work.

I think that we can change things at least for that time, and who knows what the dividends are that will pay down the road because we planted a seed.

We don't change things and make it all better, but maybe in some way we've alleviated some problems there, and maybe made them a better parent or better capable of handling situations.

I used to carry it home all the time with me and just agonize over the things when I wasn't at work. But a very experienced public health nurse said, "You may plant the seeds, somebody else down the road...it may be years down the road that will see the change." I kind of liken it to raising something in the garden, that one person plants, the other person may water it, and somebody else way down the road that they may have an interaction with, they see the fruits of it.

We never hear anything back. They never come back...very seldom come back. So the feeling that we get from the clients is not immediate, that's for sure.

It's not gonna happen right away, but eventually those families will be identified as being stronger because of the intervention. But it's not a quick fix.

It's a long-term, slow process and I hold inside of myself that maybe, with these new moms, that we're planting seeds that we may never see germinate for five years down the line or something, but that there's something positive I'm bringing to them and I may never know it, and that's okay

V Ways Nurses' Cope

Boundaries: Nurses learn through their experiences in home visitation to set behavioral boundaries to direct their interaction with clients. These limitations keep the nurses from owning the client's problems and allow them to maintain some balance between their personal reaction to client's situations and appropriate nursing care. Nurses also set limits on acceptable client behavior and clearly know when to include child protective services in their intervention.

I've got a new nurse right now that's working with me that's going, "what's my boundary here? I could do everything here. I could spend the day and night. I'd wake up in the middle of the night dreaming of this." I think its something you learn as you grow, mature, and get older.

My work with my clients I have gotten down to a fairly fine science that I consider to be my profession and it's all around boundaries. I listen to my clients more than I listen to anybody, and while she's talking I am present and listening with her and feeling what it is that she's telling me that she can do. The listening in itself tells me what my boundaries are and what I can and cannot do.

There's a lot in my particular profession with addiction about enabling and caretaking and going over your boundaries, and I have certain very strong rules around that...phone numbers and giving resources before the woman is clean so that the money would be used for the drugs instead of transportation...a lot of things that I have just set up safeguards for myself.

Experience...experience, finding out later that being with them on off-hours, giving phone numbers, doing those types of things that new

nurses tend to want to do so much and I'm speaking of myself in the early years too. But you find out that it doesn't have any different outcome than when you set boundaries and say, "I can assist you; I cannot do it for you. Here's some resources for you to use".

...and to assure them that they don't have to be everything to that person. That person in need has other resources, maybe not healthy ones, but that they will have to rely on and develop newer and healthier ones...if that's what they so choose.

When I first started this job I couldn't get out of their house. I'd get in there and I couldn't get out. I'd be there way overtime, and then I'd be late all day long. Now I limit it to one hour because after that people are just babbling and you're babbling and it's just not working. I've found that I had to be really careful doing home visits, that I wanted to fix things and make things better. And so if somebody needed something I thought, "Gosh, it would just be nothing for me to go buy this for them and give it to them. It would be nothing to pay for their power bill for them." And I had to really teach myself how to not do those things for them because I would have to tell myself, "Well, if I did do this what is going to happen next month? And what is going to happen if this problem comes up again?" They are going to say, "Well someone is going to come out of the clear blue and take care of this problem for me," not learning how to solve it for themselves. So I fought myself on that all the time.

I have a process in my brain that I go through where I've gotten the information I need and I've given what I think I can give based on what she's willing to do today, and then I start backing out. I get out my book; I schedule my next visit; I close up my things. I start acting differently and it does sort of make it clear to her that I'm getting ready to leave, and I never used to do that because I was to much of a co-dependent. I didn't want her to think I wasn't listening or whatever she was gonna think. I was writing the script for what she was thinking all the time and now it doesn't matter what she's thinking...it matters more that I get out.

That is primarily the only area...self abuse and child abuse...those are the points at which I need to take some kind of physical or legal action or whatever. Those are the areas where my heart cannot take it.

If the baby's dirty, the baby's dirty. If the baby's mistreated, that's a

different matter. My clients don't keep their babies as clean as I wanted my babies to be kept...they let their dogs lick their faces..they do things that I wouldn't do, but that's their decision as a parent until it comes to the point of child abuse and neglect. That's where I need to take some kind of action or direction that's more forceful.

Processing: Nurses develop ways to integrate the meaning of their experiences with clients into their psyche. This allows them to experience the depravity of their client's condition and cope with the emotions the experiences create.

I intellectualize as I'm listening to her so that I can get the facts as far as what needs to be documented, and I don't know that I always feel safe to let it into my heart in her presence.

I think it's my husband. I still dump it on him. I share it with him , and I guess we internalize a little bit of it too.

I think that we bring up unpleasant topics and in the process I can grieve with her and for her and I'm not afraid of grief anymore. I don't see grief as really a depressing thing. It's maybe a down time from being joyful and happy and free, but it's an experience...it's part of my work now. I can feel some anger for what she's going through. I can bargain with that...why does this woman have to go through this torture. I very much want to skip to resolving, but I can't. I have to go back to feeling what it is she is telling me.

I think you just have to be careful about confidentiality because I think you do have to be able to share and talk about what's going on. Sometimes I'll call a friend on the phone and process...who's a nurse who, you know, to go process without names of client or a situation that's been hard and just get some feedback or something like that. But I think if I wrote about it, it would be too painful.

We tend to talk about the ones that are more positive in the tight-knit group in the office. It's like the nurse can't wait to run out of her office and talk about this family and the successes, and that's kind of neat, because we're tending to want to focus and share the good stuff.

I've had to pull my car over sometimes. I've done that more times than not just to collect my feelings about something, but it is a grief process experiencing it and not denying that happened to her, because

oftentimes in our interviews we're not therapists. We don't document every ugly thing that we heard, it's not required to document everything like that. A matter of fact, it might be an invasion of her to do so. But in my work we read police reports and things too that are extremely violent in nature and it is secondary trauma if I don't let myself process it some way.

The process I go through is to recall it all, read what I wrote, either through dictation or just re-reading it, and look at it and feel it and, you know, experience it as much as I need to...knowing that I have learned as much as I can about it, then I turn it over to a higher power. Or if I can't turn it over yet, find an alternative to the pain, which for me sometimes is putting it on a shelf.

Disengaging: Nurses learn to release their emotional and intellectual responses to their community health experiences to maintain a balance between their professional and personal lives and to protect their psychological well-being.

I found myself driving home one time to my house and my head was just churning with probably four home visits, which is a mess for me. I mean, if I do five I'm nuts. But I had done four and I remember their names, their faces, their kids...I mean I was just a complete nut case, and I ran a stop sign. Just totally ran right through it, didn't even see it. I pulled over and thought, "Oh my God, what are you doing. You can't do this. What are you going to do to take care of yourself between the two miles between now and your four children?" and I started out thinking, "Okay what can I do?" And there were rural mailboxes, you know real close together, and I just put a client in each mailbox on the way home. (Laughter) All right, here's this kid, here's that mom, here's that, and then once I'd passed the mailboxes it was a done deal, you know. They were behind me and I wasn't going to take them back out again. And I use little stupid things like that constantly to be able to get over the experience, to be able to let go, to be able to, you know, decompress the pain that I fell for them.

I noticed the nurse who has the spirituality that can let go and let God handle this scenario does well with her post-traumatic stress. Everybody suffers stress in nursing but she's more likely to process it and move through it if she has a God or a higher source to go to, to turn to. The nurses that burn out, that leave, that can't handle it, that are pulling their hair out all the time are also nurses who have a

difficult time turning it over, going,"I'm not in charge of this, you know, I can only do my little bit".

They are going to grow up in spite of us. They can move, they can leave, they can go some place else, and the child will grow up. They will survive. I think that person is pretty naive if they feel like they've never had a family like that in their heart of hearts.

I think when you first maybe get into things and when I first wanted to heal everybody, I did take more of it home. But the more you live life and the more you have happen in your own lives that you have to handle, the more you realize that you really don't want to fix their lives completely either if they don't want to help have it fixed and you detach yourself from that issue. You have to. You think about the benefit and why you're doing it. You have to intellectualize it a little bit.

The outcome may never change while I'm involved with that person and that's okay to me. I think I have an effect on each interaction in that I may have brought them new information, I may have caused them to think about something. Whether or not they choose to do anything, that is...I do not feel that that's...I don't take on that responsibility.

I do sometimes have big collective cries for all my clients cause I kind of don't and then I'll just reach a point where I just go head first and just let myself rage and grieve and if I don't do that I do bottle up a lot of anger.

Music helps me a lot. You know I listen to music a lot and remember things and let'em come out and let'em go. And to remember that this woman has her own divine processing and God is taking care of her just as He is taking care of me and if I remember that too then I'm more free to let the pain go and know that someone else is taking care if it also

Maybe it's just rationalization, but it's helped me...it's just remembering that these people have gotten to twenty years, forty years...whatever they are...without me ever knowing them. They've got their own survival skills, they've made it this far. So why do I need to feel all this responsibility for their lives and I am only a small piece. Fate has put me into coming into their home at this day and

now, what...I'm supposed to like make this all better...no. I mean they've gotten this far without me and if I'd never walked in their door they'd still be getting through day by day. Somehow that makes it like, "Okay, I don't have to own all this."

Advocacy for Social Change: Nurses channel their frustrations with their clients' condition and the lack of social support for these disenfranchised families into work for social change.

Next Sunday I'm bringing a panel of recovering drug addicts, my clients, to talk at church. Now it's one thing to sit there and say, "These darn welfare rats," and "They're spending our hard earned money." And it's another thing to see a human being sitting in front of you who is saying, "This has been my struggle."

Another thing that keeps me doing it is somehow I feel like we have to. There's just so much need there I just feel like we have to keep at it. It's like a battle that you just have to keep working at. you just have to. It has to be done. Somebody has to do...to be art of that. We're a small part of it. There's lot of other parts, pieces to the puzzle.

I do a lot of public speaking and I had a young woman's poem that I couldn't read aloud because I'd get to a line that said, "What are you doing to stop the pains of this world?" and I would choke up because I felt that's our responsibility. I feel that's why I am a nurse...I think that's why God has me doing this job because He thinks I am capable of doing something.

I mean it's interesting to be able to turn things around and I think we have a lot of power like that, I think we can call agencies and say you know, "I'm coordinator of this program at the health department. I would like some feedback on why this client is being evicted," and write support letters to judges. I get a lot of energy channeled that way, helping women to get into treatment instead of going to the state penitentiary and there's power and clout in knowing the people in the community.

There's a quote that I love that I have in my office that says, "Comfort the afflicted and afflict the comfortable." And that's my role, I think. I delight in it. And I think that my job is to comfort the afflicted...I'm there to comfort them and also to draw them into community. But then on the other side public health nursing has such a bold adventure

of afflicting the comfortable, of being able to say, "This is a false perspective." We get to speak for, be that liaison, the voice for people that the target population we work with. We're drawn there for probably some great inner reasoning which we may never know, that we really are them.

Self-care: Nurses learn to incorporate self-care behaviors into their daily lives to maintain their own mental and physical health.

I have a very strict program of recovery that requires two or three meetings every single week of AA of NA of Al-anon, or I belong to a women's spiritual support group also. So I absolutely make three meetings every single week, but it's probably more for my work that it is for my home cause that's where a lot of the stress comes from.

It's very much not that immediate gratification, that immediate pat on the back, and so I think we need to support each other and make sure that we do that.

I schedule people purposefully in my book so that I don't put together two people who I know are new. I really look ahead and I schedule everybody accordingly. I'm not gonna race from one end of town to another...I don't do that anymore...I used to. I don't crowd people together anymore because I need process time between each family and I don't put two really ornery clients back to back..I'll put 'em on different days.

I try and cope with the more positive things when I leave here so that I'm kind of just trying to go say, "I'm leaving work and making a clear distinction between work and home," and I don't do that real well but that is my goal.

If I know this is my hard family, they are not seen on a Friday. That's one of the coping things, cause sure as anything somebody's gonna be falling apart. It's going to be that family on a Friday and you're gonna be 3:30 in the afternoon going, "What am I doing?" And don't take it home. That's a lesson I think I learned. That's one way of taking care of yourself.

I think there is more humor in my work today than there used to be. I know it's still very difficult, but I do try to find humor...especially in the children, cause children are always funny....I mean, almost always

funny, the things they do and expressions, you know.

VI Effects on Nurses' Lives

Personal Safety: Nurses visit in unsafe areas and occasionally receive threats of physical violence from clients and their families. Nurses recognize their vulnerability, and some nurses incorporate safety measures into their professional and personal lives.

I believe I was stalked by a client. My name was on a hit list she had developed. And one time, I was completely blown away, I was doing immunizations in the back. I came out to call the next number and there she was standing up against the wall. The look on her face...you know if it hurts. When you feel funny in your stomach or something, it's probably odd. And I'll never forget looking at her and seeing her eyes and it frightened me. It really, really frightened me.

I went to see a girl the other day. I drove up to this place and this guy came out from up above on this balcony kind of thing and I thought, "Oh man, I should have brought a radio or something out here." It really gave me the creeps at first because he was staring at me.

I don't even feel like it is our responsibility to put ourselves in danger. I had that philosophy that when you feel that there is a threat there, then you should trust that feeling and you should pull away from that until you can put enough safety there or let somebody else who feels safe about it handle it.

I've had feelings where I've felt a little jeopardized or compromised. I just went on an assessment about a week and a half ago where a fellow came out of a shed. I'd gone up to this house and it was real rainy and gray. I'm thinking in my head it was like a scene from a movie, you know, knocking on this door and this shed kind of thing was there, and he came up behind me without saying anything and then he just said, "I don't think they're home." And the description of him is just that he had some teeth missing, Harley Davidson tattoos, long kind of biker hair...he was very nice actually. But that sense of, you know, should I be just not giving him eye contact and leave right now, or is it okay to go ahead. You're always checking yourself out in those situations.

The first time we go onto a piece of property, I kind of pay attention to

what's around me. We go into some really strange situations. I think at first going into the motel situations made me feel uncomfortable. I can remember one time winding up this logging road...God knows how I ever found this place. The way you had to get up there, you had to pass these little trailers that were just run down and I was kind of going, "What if something happens to me out here...flat tire...anything. I don't have a phone with me." I can remember feeling anxious. But more the motel situations are the ones that feel out of my comfort zone.

I don't allow that too much, the fear stuff, to get into me. I think I'm smart enough and I don't have that sense like I've got to be appropriate. So if something ever felt really wrong in my gut, I would just get up and leave.

The only time I've ever felt unsafe was years ago when I was fairly young in public health and the client that I was going to visit had divulged that her husband had some bizarre sexual proclivities and she was afraid of him...he was physically abusive. I drove up there one fall night and it was in November and the roads were muddy and they were wet and sloppy. It was a long muddy road up there and I was driving the tank that the county provided. I went to the door and he was there and he was doing drugs and he was not somebody I would trust at all. There was another male with him at the house and my client was not there. I got stuck in the mud with this big old car and it was dark and the night was falling. That was one area where I felt really alone and frightened by these two men...they could either help me or they could make it really ugly. They chose to help me, which I was really grateful for.

I feel that I'm pretty brave, but the reason I think I'm brave is that I believe I'm covered by the divine plan, which is real good reimbursement, and that there is basically...doing the job that I do, I feel that there is a special place I feel I have in the divine protection process. Some people think that's foolish, but I don't do it foolishly. I do it with great respect for the environment that I'm in, but I feel the energy...I listen to the energy.

I've had a number of times that I have been afraid. One of them was where the father of the baby, on the phone, threatened that anybody who came to the door was going to be killed and I knew this baby was failing to thrive...so I had to make a decision, "Do I go with this baby or

not?" And I just made the decision that I'd been in there before and I knew these people...and I went and it was fine.

Post Traumatic Stress: Nurses witness abuse and hear accounts of trauma during their home visits. They continue to reexperience the events by reliving and remembering them and often have strong emotional responses.

I had one day when I came back from doing three assessments and I'd heard three women's really hard stories, you know...being whipped by her father with a bullwhip that he'd bought in Mexico till her back was bleeding and sexual abuse and everything, and it was right around the time that woman pushed her kids in the lake, you know, in the car...and I came back to the health department and I started crying...I came into the office and it just was all in my throat and I just started, you know, it's just too much. I was just on overload.

If it's her stuff and I'm feeling it you know, I'm getting it in here and it's starting to go down fast and I'm going, "Aaaah" into my heart. I feel like I'm starting to really get emotional in her presence. I do let myself but sometimes I collect it all in here and I will get in the car and think, "Did she say that? Did she really say that?"

I had a situation in my car where it was so in my head about leaving this new mom that I wasn't paying attention...that's not me. I'm usually really a careful driver and I had to pull over into the left-hand lane to let this other guy merge and I realized, "Gee, I'm not even paying attention to my driving." You do get that wrapped up in the thought stuff...and I thing there's been other nurses in the department who have had accidents and stuff...you're human, you're not a robot, you can't shut this stuff immediately, you know. You don't just get in your car after you've seen those things and then just, you know, turn it off. It's just there in your mind...like a movie, you know, like a scene you kind of replay.

It's is really a very delicate and sensitive place for me and I have had to cope with what I do with pregnant drug addicts really shut out a lot of it. And I don't believe I'm particularly hiding a lot of feelings that I have. I know that I feel them, I just choose not to explore them a lot because of the pain I feel towards what children go through.

Where I have I think a harder time than with death is with the living.

The living children who suffer and are neglected in their home and I see their sorrow. I see it in their faces.

I was not surprised that baby died. I mean, my intuition was deeper at the time than it sometimes is, and I went to the funeral and she had me hold the baby at the funeral, took it right out of the little casket and put it in my arms, and it was a really bad, painful case for me, I just felt I had tried. I kept trying to distance myself and just kept coming back to it, you know, I would try to walk away from it emotionally and just be right back there.

Dreaming: Nurses react subconsciously to client interactions and to accounts of their coworkers experiences by dreaming about real and imagined events.

I didn't go on a home visit because there had been some concern about my safety at that home visit through someone else's dream, so I think we all think of each other, worry about each other, and dream about each other on different levels. I think that's bringing that job with us.

There's a lot of dreaming and talking about our dreams and sharing our dreams and dreaming about clients and dreaming about each other in different situations.

Dreams seen really real. It's like some of the ones that I've had come true about clients...like when the baby died. Seems like something I pay a lot of attention to.

Mental Health: Nurses' experiences effect their mental health causing emotional responses including frustration, depression, anger, and profound sadness.

I think that public health nursing is probably the most difficult thing I have ever done, as far as nursing, because you are so intimately involved in people's lives. It's like you are so involved, not just in the outcome of their life, as far as physically, but the mental part of success and failure in their life.

For me, with the depression...depression is something that I have kind of dealt with at different points. I think if things are hard at work, but things are going okay at home I deal with it. But if things are hard at work and things are hard at home I can feel myself getting really down.

I don't want to become bitter, jaded, burnt out. I don't want that to happen.

There was a little girl on a visit and I knew that she was being abused and had been hurt. She had some bruises on her face, and I remember sitting there with her mother chattering about different things. I remembered somebody told me he was abused as a child, and that everytime a person like me came into the home he hoped that was going to be the person who would rescue them at last and they would be free. And I remember this little girl sitting there staring at me knowing what my friend had told me and wondering if that's what that little girl was thinking of me and knowing that I couldn't rescue her and how helpless that felt.

I asked her, "How are you coping with this really depressing time in your life?" and she said she just sat there and every raindrop was a prayer that her boys would come back to her. And I just was, "Uhhh," started tearing up myself.

I see some fellow workers kind of take it out on themselves, become a cause and are emotional taxing to be with. I see a lot of borderline mental illness, and I think if we sat down and they were in this room you would probably see it yourselves.

There's been times that I've gotten in my car and had just a real profound sadness that people are in the condition and babies are in the condition they're in, so yes tears have come, very occasionally with clients. Oftentimes...probably more lately it's been just kind of that collective...where I'm going along okay and then just one more case will just kind of trigger kind of a flood of anger and exasperation and just, just grief.

And those are the times it's awful for us, that it really crashes on us and we look for each other...to each other for the support we need to say, "Boy, this baby's gonna be taken away from this woman. We have laid it out there umpteen times. She's not doing it". Then we have to advocate for whatever is safest for the child and it sometimes leaves the parent in the dust and those are the horrible, horrible times.

I eat in ways that I probably shouldn't. Uh, isolate myself from my family at times. Um, have an extra glass of wine. I'm real aware of some of the stuff I do, you know, and I know I could make the choice to

go take a walk, you know take that bubble bath...and sometimes I choose not to do that. Sometimes I don't want...sometimes I...maybe it is you need to just be in touch with it. It's shitty out there, you know, it's hard stuff that we hear...it's hard, and so sometimes I don't take as good (care of myself).

I tend to get angry is how I cope with that...that helplessness. I see it around me all the time. I see very sick women and nurses. I think some of my colleagues are sicker than my clients.

Intolerance for Violence: Nurses exposure to abuse and trauma makes them less tolerant of societal expressions of violence as specifically portrayed on television and in movies.

I tend to stay away from television. Been there, done that, don't need this now. It's enough in real life, I get enough of that in real life.

I only read the paper. I don't watch TV. I don't listen to the news. I don't go to violent movies. I believe it damages the psyche in every way, shape, and form. You know I've believed this for years, but I have very much guarded myself against...I have enough trauma at work and I do not traumatize my...I do not watch any news shows and haven't for years. The violence I believe promotes our illness in our society and has for years, and we sitting here are a result of having viewed a great deal of violence on TV. There's certain things that I personally believe have promoted the violence and illness in our society, in a very, very convoluted way, and I'm not about to assault my senses with any more of it.

I have my boundaries too in my personal life. Things that I won't tolerate. I mean I have certain things, like I can only stand so much violence and hearing so many kinds of stories or I know it's not healthy for me. So I don't tolerant television at all, or you know certain kinds of things. I'm just like, "No, I'm sorry, it's not okay."

I've got a girlfriend that won't go to movies with me anymore. I walked out on two of 'em. They were...I mean, I will get up and walk out and go ask for my money back. And they give it to you. (Laughter)

If somebody at home wants to go watch some Dateline or 48 Hours and that kind of stuff, I can't listen to that. I don't want to, I hear it all day here.

Ineffective Client Interactions: Nurses feel helpless when faced with difficult client situations where client interventions are ineffective. They are often worried about their client's future and troubled about why they are ineffective to make changes.

I find those individuals sometimes the hardest cause they just don't have a sense of what they want to do or what they want to be...they're just kind of out there free floating. I find I don't have the skills to draw them into organizing what they want for their lives and those are the most frustrating too because I just can't get to the beginning. You know I can't get to the starting point..."I'll try to help you with some skills that I've got to reach you goals. What are they?". "I don't have any goals." "Gosh lets see, should I give you some?" No, can't do that, but how can I stimulate some thought of the future. Those are to me the most frustrating.

I think it's depressing that you can't come up with a real answer to some of these things cause you just keep thinking, "Okay this is the problem. We've identified the problem. We've applied the nursing process, empirical problem, or whatever." And you go, "Okay , so drugs are the issue. So how do you stop that?" You do this and things just don't seem to get better. Sometimes...it's just a band-aid. You really want to do something that will have lasting and maybe a more inclusive treatment of the problem so that you can actually get to the end of it at some point in time and feel like you've made some end roads and maybe some completion on it. Somehow that doesn't happen and that's real frustrating and discouraging.

The baby was really not thriving at all. Mom was paying no attention to it. She had lost a significant amount of weight, she was really listless. And I was just kind of panicky, like "Oh gosh, what am I gonna do?" I told the father that he needed to get the baby to the clinic or ER that night, that the baby was not doing well. But coming back I think that was probably the first time that I felt really helpless, like "What can I do for these people? How can I help them?"

I think the feeling of helplessness, of entering a situation that's just on the verge of collapse, if it hasn't already before we got there, and identifying a number of needs that will not be addressed and corrected within moments is one of the hardest things.

So it's just a muddle sense of frustration oftentimes, and looking down

the road, which I tend to do...maybe that's not a good thing...but I tend to look down the road. "What's going to happen in two or three months with this, when that baby comes it's gonna probably not be a whole lot better." And indeed it wasn't a whole lot better...but a real sense helplessness.

She's nineteen with a three week old baby and I looked around...I remember this moment of looking around the room and going, "It's hopeless. I mean this room is a craphole." She's got this mother-in-law who's an alcoholic, a brutalizing boyfriend, and she's gonna be evicted this week-end.

APPENDIX E

Informants' Literary Contributions

In this appendix are poems the informants brought to share at the interviews. Two were written by one of the informants, one was written by a client, and two were identified in the literature by informants as representing aspects of their practice. These poems were used in the analysis as external evidence to verify the content and interpretation of the interview text.

Informant Poems

-I Resent the Rich-
By Robin Turgesen

On Thomas Road
you are having a miscarriage.
Carnival glassware in
your living room.
A boyfriend named Luis
with silver teeth.
A sick father who cannot
raise his head.
Army blankets.

You still get dressed:
stretch pants, sandals, earrings,
even though you're bleeding
You have lost four children
to the Authorities. to Addiction.
"if my baby has a heartbeat,
will they take him?
if they take our babies,
we'll just have more."
You are crying

Out of jail last Friday,
Now we pass over the tracks
to the hospital where lawns
are trimmed and
swimming pools have covers.

where you will lose
your baby

-home visit-
By Robin Turgesen

your three pound baby
sleeps in a Goodwill crib
aluminum foil mobile.
your irascible mother-in-law
tipsy on Valium
answers every question for you,
as she adjusts her wig.

your lip is a shut-up snarl.
how much formula does she drink?
I don't know.
how much does she sleep?
I don't know.

the addiction beast has you
by the guts
has blinded you.
created you in his strange image.

my voice is distant
and this time
the God in you is smothered,
and you may die.
you cannot hear,
and you may die.

Client Writing

The Pains of the World
Anonymous Client

I have often wondered why so many strange things happen. I can never understand the pains of this world. They go way beyond me. Why do people strive to hurt the other, friend or foe? Why do the hungry go hungry or the homeless go homeless? Why do people want to live life without the essentials they need to live it? Life is a gift no matter what you believe. How can a person rob another of life without a second though, or steal from one who has less than they? How can one beat a child? Is it just for the pleasure of the weak? How can you live without seeing what has happened right before you? What can happen to this world if these illnesses do not stop? What kind of world are we leaving for the child that has done no wrong? What are we leaving for you and what are you doing to stop the pains of this world?

Literary Contributions

An Introduction to Some Poems
By William Stafford

Look: no one ever promised for sure
that we would sing. We have decided
to moan. In a strange dance that
we don't understand till we do it, we
have to carry on.

Just as in sleep you have to dream
the exact dream to round out your life,
so we have to live that dream into stories
and hold them close at you, close at the
edge we share, to be right.

We find it an awful thing to meet people,
serious or not, who have turned into vacant
effective people, so far lost that they
won't believe their own feelings
enough to follow them out.

The authentic is a line from one thing
along to the next; it interests us.
Strangely, it relates to what works,
but is not quite the same. It never
swerves for revenge,

Or profit, or frame: it holds
together something more than the world,
this line. And we are your wavery
efforts at following it. Are you coming?
Good: not it is time.

(Stafford, William. (1977). Stories That Could Be True.
New York: Harper and Row.)

Autobiography in Five Chapters
By P. Nelson

Chapter One
I walk down the street and there's a deep
hole in the sidewalk
And I fall in. I am lost. I am helpless.
It isn't my fault and it takes forever to
find a way out.

Chapter Two
I walk down the same street and there's a
deep hole in the sidewalk.
I pretend I don't see it and fall in again.
I can't believe I'm in the same place but
it isn't my fault.
It still takes a long time to get out.

Chapter Three
I walk down the same street and there's a
deep hole in the sidewalk.
I see it is there. I still fall in. It's
a habit but my eyes are open and I know
where I am. It is my fault and
I get out immediately.

Chapter Four
I walk down the same street and there's a
deep hole in sidewalk.
I walk around it.

Chapter Five
I walk down a different street.

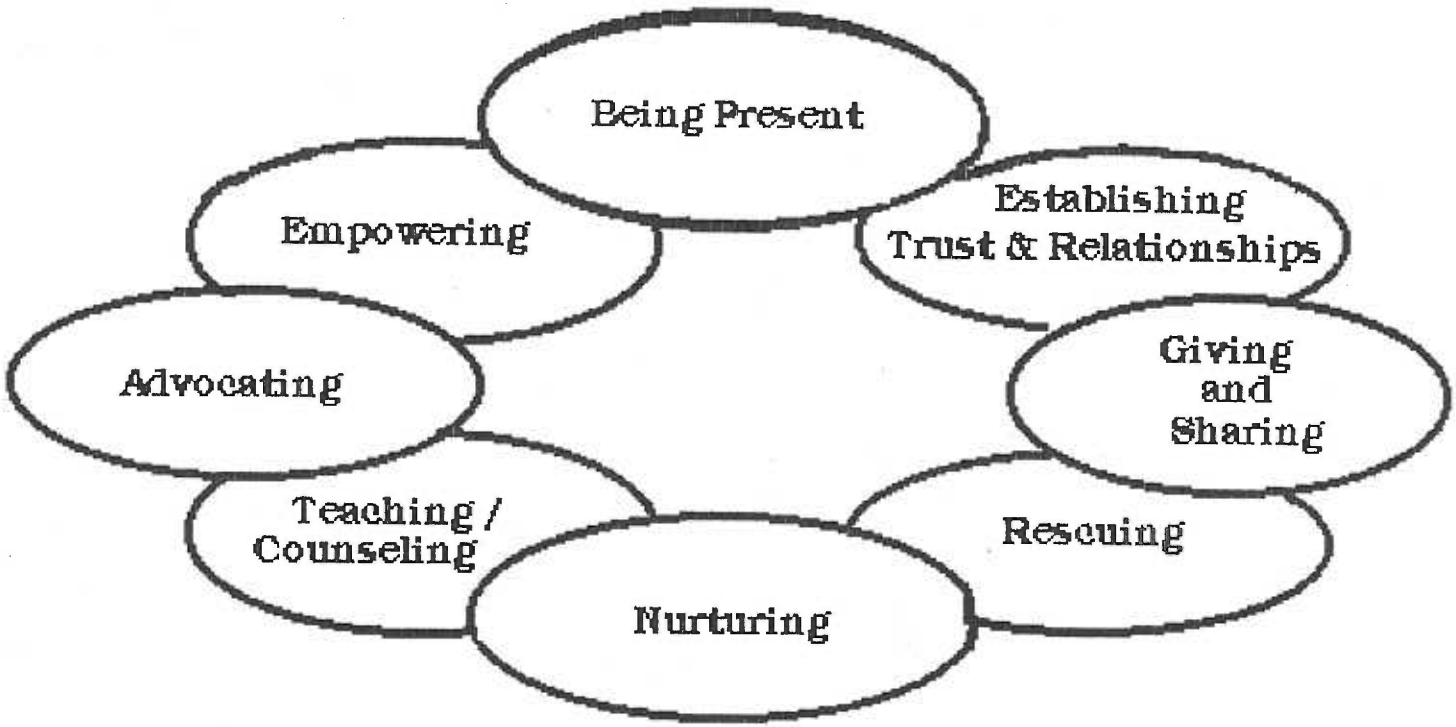
(Nelson, P. (1989, Spring). Autobiography in Five
Chapters. Safehouse News.)

APPENDIX F

Domains of Practice Model

This appendix is a model we developed from the domains of nursing practice identified in the text.

COMMUNITY HEALTH NURSING DOMAINS



AYERS, J. & WILCOX, B., 1995