The Experiences of New Zealand Primary Health Nurses When Working With Children They Suspect are Being Abused or Neglected

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Abstract

This study explored the experiences of primary (community) health nurses in New Zealand when working with children they suspect are being abused or neglected. It grew from a concern that little is known about what this experience is like. I was also concerned that primary health nurses did not seem to have a voice relative to this significant experience.

Child abuse is highly prevalent in New Zealand. Primary health nurses work across a variety of settings. They are, therefore, more likely than other health professionals to encounter children whom they suspect are at risk.

Hermeneutics, informed by Hans-Georg Gadamer [1900-2002], guided the research approach. During the analysis stage, the data required that I also draw on philosophical notions from Schön, Benner, Levinas, and Dewey.

Thirteen registered nurses and nurse practitioners working with children in primary health settings were interviewed using in-depth semi structured interviews which were audio-recorded and transcribed. Findings were developed through dialectical engagement in the activities of writing, reflecting, and rewriting.

The nurses' experiences begin with what matters most. They must get to know the children and families with whom they work. They must also continually nurture and maintain these relationships, overcoming numerous obstacles.

What the nurse feels signals what matters. The bodily experience of a 'gut feeling' arouses suspicion. Yet, caution is essential. One has to have proof. Thus, to be with suspicion is secretive by nature. Importantly, it is being with suspicion which prompts action.

Working with at-risk children creates a significant burden for nurses. They carry this burden because they care about children at risk of harm. The burden is experienced emotionally, physically, and as a legal threat. The burden is further experienced as a weight—one which nurses often feel they carry alone. Understanding the nature and impact of this burden is an essential prerequisite to providing primary health nurses adequate and appropriate support.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Susan Platt

Date: 19 November 2022

Acknowledgements

These acknowledgements are an opportunity for me to pause and express my gratitude, for which I have much to include. I would like to acknowledge the Auckland University of Technology Ethics Committee for approving this study (application number 16/317; 27 September 2016).

I am incredibly grateful to the nurses who willingly and openly participated in this study. They shared stories which provoked an emotional recall of the events retold, and I could feel the compelling sense of their emotions during the interviews. All of these nurses have a significant desire to make a difference and strive continuously to do so. Their compassion towards the children and families with whom they work is something I will always remember. To honour the stories gifted to me for this study, I wanted to ensure I represented all participants through showing their stories at some point. Some nurses' stories are used more than others which was a source of initial discomfort to me; however, I simply could not leave these out. I am also grateful for the Māori and Pacific nurses who gave their time to participate. It was important to me to have representation by nurses whose population of families they work with are predominantly of Māori and Pacific heritage.

I am grateful to my colleagues who gave their time to listen to my thoughts and tribulations. Without realising, you kept me focussed and I found these conversations incredibly supportive and inspiring. Your words of encouragement about the study topic reassured me that this is important and that these nurses' experiences must be told.

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With gratitude, Susan.

Chapter 1 – Introduction

An Overview of the Study

As a nurse and teacher of nurses, I have experienced situations in which I have suspected child abuse. Child abuse and neglect occurs more often in communities than most people realise. With New Zealand ranking high in the Organisation for Economic Co-operation and Development (OECD) for child abuse and neglect (Child Matters, n.d.), it is not surprising that primary health nurses are highly likely to work with children whom they suspect have been abused or neglected. I have always been interested in nursing practice in the community and have often wondered about nursing's role in relation to child abuse and neglect. When I started thinking about this research project, I wanted to know more about what it was like for primary health nurses who were concerned that a child may be living with abuse and/or neglected. I wanted to hear their stories, their insights, and what it felt like to work with at-risk children and families. My feeling was that there was much that was not spoken about and that these stories were an essential beginning to adequate understanding of this important topic. I also wanted those who had not thought about this area of nursing practice to begin their own journey of understanding what they may experience.

This study, therefore, sought to explore the experiences of New Zealand health nurses who work with children whom they suspect may be abused or neglected. 'Suspecting' abuse or neglect is a nursing decision based on assessment, and something that may be proven or disproven throughout the assessment process. There are times when suspicions remain unproven; yet they still engender concern on the part of the nurse.

The participants were registered nurses and nurse practitioners working in the community. According to the Nursing Council of New Zealand (NCNZ, 2019) only 15% of the total nursing workforce in New Zealand works in primary health/community settings, yet the majority of people seeking healthcare services do so in the community. Primary health is the second largest practice setting for nurses (NCNZ, 2019) which includes registered nurses, nurse practitioners, and enrolled nurses. The total number of registered nurses working in the primary health/community settings is 15%, whereas for nurse practitioners it is 42% (NCNZ, 2019). The registered nurses and nurse practitioners who work with children in the community do so across areas described as school health, public health, primary health, and general practice settings (NCNZ, 2019).

Article One of the Convention of the Rights of the Child (UNICEF, n.d.) defines a child as a person under 18 years. Under the Oranga Tamariki Act 1989 previously known as the Children, Young Person and Their Families Act, a 'child' is defined as under 14 years, and a

'young person' or youth aged under 18 years (however, parts 4 and 5 of the Act address specific youth issues and define a young person as under 17 years). To be consistent with the international literature, this study uses the term 'child' to refer to a person under 18 years of age.

In the year ending 30 June 2021, there were 13,478 (1.17% of all children) substantiated claims of child abuse and neglect—a 20% increase since 2020 in substantiated child sexual abuse claims (The Salvation Army, 2022). According to the UNICEF Innocenti Report Card 14, in 2017 New Zealand had the seventh highest child homicide rate across 41 countries (UNICEF Office of Research, 2017). In New Zealand, one child is killed from abuse or neglect every five weeks and 90% of these deaths are perpetrated by someone the child knows. Most children are killed before 5-years old (Gammon, 2016).

Children and their families see nurses more often than any other health professional. Nurses in New Zealand working in areas such as public health, specialist community nursing roles, district health nursing, Plunket, and practice nursing, are the "professional face of health promotion, home based provision of care, prevention and surveillance" (Carryer, Dignam, Horsburgh, Hughes, & Martin, 1999, p. 6). A unique role to New Zealand, Plunket nurses are based in the community and conduct home visitations and clinics for children under the age of 5 years. They are mainly concerned with assessing anticipatory guidelines for the age/stage development of these children. In New Zealand, nurses constitute the largest regulated health workforce (NZNO, 2018). They are, therefore, well placed to assess if children are at risk of abuse and/or neglect. However, little research has been undertaken with respect to what this experience is like for nurses; thus, little is known about what it is like when suspecting a child is being abused or neglected.

A hermeneutic approach in the tradition of Hans-Georg Gadamer [1900-2002] underpinned and guided this study. Hermeneutics allowed exploration of the deeper meanings experienced by nurses working with children whom they suspect may be living with abuse and/or neglect (Cerbone, 2006). The action-oriented nature of nursing is founded on the nurse wanting to make a positive difference, and thus being called to care. During the analysis stage of writing, rewriting, and reflecting, I was drawn to explore other philosophers to further illuminate the findings. While hermeneutics guided the way in which data were collected and analysed, philosophical notions from Schön [1930-1997], Levinas [1906-1995], Benner [1942-], and Dewey [1859-1952] brought new meanings and understanding of what it is like to work with children at risk of abuse or neglect. These philosophical underpinnings enabled new interpretations and insights (Moran, 2000).

How I Came to the Research Question

My initial interest in child protection started as a parent of sporting children in 2004. I spent many hours at my children's sporting practises and at game day. There were times when I observed behaviours from adults to children that caused discomfort. Conversations with the Chief Executive of one of these sporting organisations made me realise that I was not the only adult with concerns. Subsequent to this conversation, I carried out voluntary work leading a group of people with industry experience and wrote a child protection policy for the sporting organisation. The policy outlined a process for when concerns were raised, such as behaviours of coaches hugging and kissing children at competitions. This was important, because prior to the policy's implementation, parents had not known what to do with their concerns. Furthermore, interpretation about what was unacceptable behaviour varied, leading to parents talking to other parents or the Chief Executive of the sporting organisation. The former resulted in rumour and innuendo, often finding its way to the Chief Executive. The policy was implemented before sporting organisations were officially required to have one. The presence of the policy led to concerns being referred to the government organisation 'Child, Youth and Family' (CYFS) because they have expertise in this area.

While children's sports started my interest in child protection, I had also experienced suspicions of child abuse as a nurse and nurse educator working with students. My first encounter was as a student nurse in a children's emergency department working with a 6-month old female whom the medical staff suspected was being sexually abused. Then, on a home visit, I worked with a primary health nurse who suspected that a baby was being neglected.

As a registered nurse, I have worked in a children's hospital and in an adult specialty setting which also cared for children due to the nature of the specialty. In both settings, suspicions that a child may be being abused or neglected arose. I have also had experiences working as a nurse educator with students in primary health settings where children were suspected of being abused or neglected. I do not, however, have specific experience of working in a primary health setting.

My interest in the wider issues of child abuse and neglect was piqued; and, being a nurse, it felt important to question the nurse's role in the child protection field. When I read news media accounts of yet another child homicide, I found myself asking: where was the nurse? Was there a nurse involved in the care of this child? What was it like for nurses to discover a child had been admitted to hospital and/or died as a result of non-accidental

injuries or neglect? Such questions led me to gain further insight into what is currently known, and my research question arose from a review of any literature I could find to help me further understand this topic.

There is little known about the depth and breadth of the work that nurses do and, as a profession, nursing is less than effective in communicating their work to the public (Buresh & Gordon, 2000/2013). A preliminary literature search highlighted limited research about nurse's work with children who may have been abused or neglected. There were few who were telling their stories. Rather, as Buresh and Gordon state (2000/2013) there was silence. Again, according to Buresh and Gordon, nursing has an ongoing problem with practice that is unknown and unseen. I wanted to better understand nurses' experiences and to take their stories from what I believed was silence to their having a voice.

Defining Child Abuse

Child abuse, neglect, maltreatment, at-risk, and vulnerable are terminologies used in various literature. Child abuse refers to the physical, sexual, or emotional abuse children experience, and neglect refers to the absence of care from a responsible adult (described in further detail in the review of the literature—Chapter Two). 'Child abuse', 'neglect', and 'maltreatment' are terms often used interchangeably, with the World Health Organization (WHO, n.d.) using maltreatment as an umbrella term to describe the abuse and neglect of children under the age of 18 years. In a report for the Child Poverty Action Group in New Zealand, Wynd (2013) described child maltreatment as all physical, sexual, and emotional abuse, with neglect being differentiated separately.

There is no one universal definition of child abuse (Pitz & Wachtel, 2009). For the purpose of this study, child abuse is defined using the Oranga Tamariki Act legal description: "the harming (whether physically, emotionally, or sexually), ill-treatment, abuse, neglect or deprivation of any child or young person" (subpart 2). Physical abuse, whether or not there is intention to hurt the child, includes hitting, kicking, punching, shaking, biting, burning, or throwing a child; severe or excessive punishment; and can result in injuries such as fractures, bruising, bite marks or, in the extreme, death. Emotional abuse includes criticism, rejection, isolating, exploiting, or terrorising a child. The effects of emotional abuse are not always clearly visible; however, they can have long lasting effects such as difficult or disturbing behaviour as the child grows older. Sexual abuse includes behaviours such as touching for sexual purposes, having a child touch the perpetrator for sexual purposes; exposing oneself to a child or having a child expose themselves;

photographing children inappropriately or child pornographic activities; and using the internet or phone to initiate sexual conversations with a child.

Neglect constitutes patterns of behaviour that occur over time and result in impaired functioning or the development of a child. It includes failure to provide the basic needs for a child. This can be a failure to provide physical needs such as shelter or food; failure to seek medical attention or follow medical advice; failure to provide adequate or legally required supervision for a child; unwillingness to provide appropriate care for a child, and/or abandonment when a child is left with no intent for the adult to return.

Key Terms Within the New Zealand Health System

During the data collection phase for this study, the New Zealand government department previously known as CYFS went through a rebranding and name change to Ministry for Vulnerable Children, Oranga Tamariki. This was later changed again to Oranga Tamariki, Ministry for Children. It is commonly known as Oranga Tamariki. When interviewed, nurses used the name which applied to the time they were working with a particular child and/or family they discussed.

Oranga Tamariki works to support the welfare of children through social workers and is the department where reports are made when a nurse is concerned about a child's welfare and risks. A 'Report of Concern' is the official term for when a nurse refers a concern to an Oranga Tamariki social worker. Nurses in this study used the terms 'referral' and 'report of concern' interchangeably.

For clarity, child and/or family/whānau were used to describe those who were users of the health services of nurses in this study. The exception was when nurses stated a specific term such as 'patient'.

Child protection and child safeguarding are, at times, used interchangeably in the literature. Sometimes a distinction is made by describing child protection as protecting a child after an adverse event while child safeguarding attends to prevention of child abuse/neglect including protection after an adverse event has occurred. The term 'at-risk' was used in this study and by participants to describe children who were in danger of experiencing abuse or neglect. Although the term 'vulnerable' is used in the literature interchangeably with at-risk, it was only used by participants when describing how they felt in situations when they were concerned about their own safety when in the home of a family. The use of different terms can create confusion; hence, for clarity in this study, 'child abuse' has been used to define all physical, sexual, and emotional abuse, with

'neglect' defined separately. Use of the term 'maltreatment' appears only if spoken by participants or in cited literature.

Consistent with Aotearoa New Zealand's endeavours to honour biculturalism, Māori terms are used throughout the thesis. Whānau[1], for example, is used interchangeably with family, and Pākehā is used to describe white skinned New Zealanders of European descent. New Zealand, however, is the commonly used abbreviation for Aotearoa New Zealand.

Legal and Professional Context for Nurses Working With At-Risk Children in New Zealand

New Zealand has a range of legislation and professional guidelines that aim to protect children from harm. Those related to primary health nurses working with at-risk children include:

- Children's Act 2014
- Oranga Tamariki Act 1989
- Care of Children Act 2004
- Crimes Act 1961
- Privacy Act 1993
- Health Information Privacy Code (issued under the Privacy Act)
- Information Sharing Agreement for Improving Public Service for Vulnerable Children (issued under the Privacy Act)

The most recent legislation is the Vulnerable Children's Act which was passed into law in 2014. The name of this Act was subsequently changed to the Children's Act 2014. The intention of this legislation is to address the protection of children, mainly concerned with mandatory vetting and screening as a means of checking the suitability of those who work with children. Vetting and screening apply to people working in organisations who provide regulated services to children, and whose organisation receives government funding. The safety checking does not apply to volunteers or those employed privately, such as babysitters or nannies. Thus, while this legislation seeks to protect children from perpetrators of harm, sporting organisations, music and dance schools are examples of organisations that are not currently required to vet and screen volunteers. This is despite evidence of sexual and physical harm inflicted upon children by perpetrators who access children through community organisations (Brackenridge, Bringer, & Bishopp, 2005;

[1] Māori meaning for family, including immediate and extended family (Hayes, 2016).

Gillard, St-Pierre, Radziszewski, & Parent, 2022; Leahy & Fasting, 2014; Leahy, Pretty, & Tenenbaum, 2002) .

However, under the Children's Act 2014, all nurses (and other core children's workers in health and other sectors) must be screened and vetted for their suitability to work with children before their employment is confirmed. The Children's Act describes vulnerable children as those who have been identified as vulnerable according to the Government priorities in Section 7 of the Act. Vulnerable children are described as those

> who are at significant risk of harm to their wellbeing now and into the future as a consequence of the environment in which they are being raised and, in some cases, due to their own complex needs. Environmental factors that influence child vulnerability include not having their basic emotional, physical, social, developmental and/or cultural needs met at home or in the wider community. (Ministry of Social Development, 2012, p. 6)

Another important piece of legislation is the Oranga Tamariki Act 1989 which defines the role of the State in the care of children and young persons. The purpose of this Act is to promote the wellbeing of children and protect them from harm by assisting families to meet their responsibilities to children. The Act places emphasis on trying to involve the wider family in the care and protection of a child, and to minimise State involvement where possible. Section 4 of the Act addresses support for families/whānau, hapū[2] (subtribe), iwi[3] (tribe), parents; and their role in preventing children from suffering harm, abuse, neglect, or deprivation. Section 15 of the Act is concerned with the reporting of any ill treatment or neglect of a child or young person and essentially gives permission to anyone to report their belief that a child or young person has been, or is at risk of harm or abuse to a social worker or the Police. Section 15 includes the need to report concerns for children who have been and are likely to be harmed, ill-treated, or abused. Section 16 is about the protection from prosecution for a person who discloses information or child suspected abuse. Except where information is given in bad faith, these persons are exempt from prosecution.

The Care of Children Act 2004 is primarily concerned with protecting certain rights of children. It ensures New Zealand children's rights are consistent with the United Nations Declaration of Children's Rights. The Act protects the rights of children and promotes their welfare and best interests by ensuring appropriate guardianship arrangements are in place. It does not specifically address the protection of children from harm or abuse. All health professionals need to have knowledge of the rights of children to ensure children are central in service delivery. Article 19 in the UNICEF (n.d.) Convention of the

[2] Clusters of whānau including extended family groups (Stats NZ DataInfo, 2018).
[3] Māori tribe made up of several hapū all descended from common ancestors (Stats NZ DataInfo, 2018).

Rights of the Child is concerned with 'Protection from all forms of violence' which New Zealand is party to and, therefore, obliged to build children's rights into all aspects of the care of children.

Under the Crimes Act Section 195A 1961 those who work or live with children are legally mandated to report a child whom they know is at risk of sexual assault, grievous bodily harm, or death. Under this section of the Act, failure to take reasonable steps to protect the child can result in criminal liability. However, the distinction between suspecting and knowing a child is at risk becomes significant when tested in court. The Crimes Act (substituted Section 59) Amendment Bill 1961 is the only Act which focusses specifically on child abuse. This is significant because it has removed the statutory defence of 'reasonable force' to correct a child, commonly known as the 'anti-smacking' legislation. The State has discretionary powers to prosecute those who discipline their children via physical means such as smacking. Under Section 151 of the Crimes Act, anyone who has charge of a child has a duty to take reasonable steps to protect them from injury. These two sections of the Crimes Act have never been tested in court with respect to non-reporting by a health professional. There are no other legal mandates in New Zealand that require nurses or any other persons to report child abuse or neglect.

The Privacy Act 1993 Principle 11(f)(ii) addresses the disclosure of information that is necessary to prevent or lessen a serious or imminent threat to the life or health of an individual. This means that an agent, such as an organisation or a health professional (i.e., a nurse), is able to disclose information that would usually be protected by the Privacy Act when a child is deemed to be at risk of actual or imminent harm. The notifier does not need to fear consequences because this Act affords protection against disciplinary action or prosecution.

The Health Information Privacy Code (Privacy Commissioner, 1994) was issued under section 46 of the Privacy Act 1993 and affords extra protection for health information due to its sensitivity. Rule 11 subsection 2(d)(ii) of the Code is relevant for nurses and other professionals who hold health information. It provides the ability to disclose information to a person, body, or agency when the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to the life or health of an individual. This subsection provides protection for those who hold health information relating to concerns that a child is at risk of potential or actual child abuse.

The legal framework the 'Information Sharing Agreement for Improving Public Service for Vulnerable Children' was established in 2005 and authorised by Part 9A of the Privacy Act 1993. It was signed by the Ministers of Social Development, Health, Justice, Education, and the New Zealand Police, with the New Zealand Children's Action Plan Directorate

(Ministry of Social Development, 2015) being a recognised party to the agreement. The agreement was facilitated by the Ministry of Social Development after numerous reviews of child abuse reported that if professionals involved in the care of children had access to information held elsewhere, then vulnerable children could have been protected from harm. The Agreement brings more clarity and certainty about the information of vulnerable children, what government agencies can share, with whom and for what reasons. It is likely that ambiguity existed due to government departments working in accordance with varying laws pertaining to children and their protection, and reflected a need to improve information sharing. As registered health professionals, this Agreement includes nurses who work with vulnerable children. Further, the Children's Action Plan was created from an inter-agency collaboration between government agencies and non-government organisations (NGOs), and led by the Children's Action Plan Directorate. Government agencies include the Children's Action Plan Directorate, the Ministries of Social Development, Health, Education, Justice, the New Zealand Police, and Department of Corrections. Core partner agencies who supported these government agencies for the implementation of the Children's Action Plan were Te Puni Kōkiri, the Ministries of Pacific Island Affairs and Business, Innovation and Employment, the Office of the Children's Commissioner and SUPERU [the Families Commission Social Policy and Research Unit] (Children's Action Plan Directorate, 2015). The Children's Action Plan is delivered by the Children's Action Plan Directorate which "works across the sector to implement the Children's Action Plan. The Plan is a new way of working that puts children in the centre by wrapping support services around them" (Ministry of Social Development, n.d.-c). They facilitate organisations to work together to jointly deliver the Children's Action Plan initiatives including implementation of the Vulnerable Children's Act.

As with any legislation, interpretation in practice is required. Nurses who work with children at risk of abuse need to be familiar with legislation that governs their practice and decision-making. This is a means to protect children from being harmed or protect them from further harm, and is a professional responsibility mandated by the NCNZ. Competency 1.1 in the Professional Responsibility Domain which registered nurses are assessed against states a nurse "accepts responsibility for ensuring that their nursing practice and conduct meet the standards of the professional, ethical, and relevant legislated requirements" (Nursing Council of New Zealand, 2016, p. 5). Thus, there is a professional and legal responsibility to know and abide by the legislation.

Primary Health Nursing in New Zealand

Primary health nurses work across a variety of settings in New Zealand with titles such as:

- Care and Protection nurse
- Healthy homes nurse
- Paediatric home care nurse
- Practice nurse
- Public health nurse
- School nurse
- Whānau Ora nurse

The roles listed above include public health nurses who work for regional District Health Boards. Public health nurses visit families in their homes and are assigned approximately three low decile primary schools to visit (typically children aged between 5- and10-years). The decile system is a rating system based on the socio-economic and poverty level in which a school's population resides, and determines the level of funding provided (The New Zealand Government, 2022). In the absence of a school nurse, schools refer children to their public health nurse when a health concern has been identified. The scope of the public health nurse's role is somewhat dependent on the District Health Board they work for. The public health nurses in this study worked across District Health Boards in Auckland and reported that their visits only occurred in the presence of an actual or potential health issue, and that they are obliged to discharge children from their case load once the health issue is resolved irrespective of other remaining social issues. The role of the public health nurse is described as being an advocate for children by working alongside them, their families, and school staff. Public health nurses deliver immunisation programmes in schools; follow up with children who have vision/hearing needs; carry out health education and promotion in schools; and provide specialist nursing services in schools (Te Whatu Ora Health New Zealand Counties Manukau, 2019). Prevention of harm is not stated as part of the role. However, if nurses are to help prevent illness, then they must understand the effects of injustices on wellbeing (Grace & Willis, 2012). It is thus important to understand the impact of poverty on children.

Poverty is an environmental determinant of health. Without nurses considering the impact of a person's environment on their health, disparities will escalate and resources will be inequitably allocated (M. Mitchell, Wilson, & Jackson, 2019). Thus, understanding social justice is an important part of the public health nurse role.

Nurses may be employed in secondary schools in New Zealand (students aged between 13- and 18-years). Child protection is a significant part of the school nurse role (Wright & Potter, 2012) because they play a crucial role in the identification, intervention, and reporting of child abuse (Jordan, MacKay, & Woods, 2017). During students' visits, nurses

are able to observe for risky behavioural issues that can alert them to suspected child abuse or neglect.

District Health Boards also employ nurses as paediatric home-care visitors. Their role is described as that of a speciality nurse who works with children with special health needs in the home environment (Te Whatu Ora Health New Zealand Counties Manukau, 2022). Special health needs include care of children with acute health issues requiring care within 72-hours of discharge from hospital, and children with chronic health issues such as diabetes, requiring further support. This role enables children to be discharged home with nursing support for ongoing treatment.

Whānau Ora nurses in New Zealand work for Māori[4] health providers to provide holistic and comprehensive health services within a community setting, with a focus on supporting the wellbeing of whānau/families. Whānau Ora is a government policy implemented to improve the health of whānau, hapū, and iwi to address inequities between Māori and Tauiwi[5] (Hayes, 2016). The approach of Whānau Ora organisations is to put whānau central in the delivery of services in order to improve health outcomes (Ministry of Health, 2018d). Whānau Ora nurses work with all those who access the services of the organisation where they work.

Primary health nurses are also employed by Care and Protection services to work with young people in secure residences. These are highly specialised residences which provide intense and institutionalised interventions for children and young people deemed to have needs that are greater than other community organisations or whānau are able to provide for (Lambie, Krynen, Best, & Parkes, 2016). Residents are generally aged between 12- and 16-years. The presence of nurses in these facilities is considered essential in the assessment and management of emotional, mental health, and behavioural issues (Lambie et al., 2016).

Another community nursing role in New Zealand is that of general practice nurses, known as practice nurses who are mainly registered nurses. They have variable levels of autonomy based on their experience and education (Hewitt, Sherdian, Hoare, & Mills, 2021). For example, nurse practitioners who work in general practices "have advanced education, clinical training and demonstrated competence and legal authority to practise beyond the level of a registered nurse" (NCNZ, 2020, p. 3). More commonly, practice

[4] Māori are the indigenous people who were living in New Zealand prior to the British/European settlers.
[5] Those of non-Māori descent (Hayes, 2016).

nurses assess and treat health conditions (within their scope of practice), administer immunisations, and conduct health screening and promotion activities; thus having a strong education role. They are often the first point of contact for those seeking health assistance.

Healthy Homes nurses were employed to assess the features of homes which contribute to childhood respiratory illnesses, such as damp, mould, and cold. Their role enabled them to access all rooms within a home, beyond that of any other home visiting health professional. This access provided a survey of the environment in which children were exposed. Since the inception of New Zealand's Healthy Homes Initiative in 2013, healthy homes assessors are no longer registered health professionals. Rather, they are from trade-based or health promotion-based backgrounds who receive specific training (M. Bellass, personal communication, November 8, 2022).

Primary Health Nurses and the Wider Professional Community

Primary health nurses working with children and their families rely on interprofessional collaboration. They work with a range of professionals across many sectors in the community, including community-based organisations such as:

- Social workers
- Non-Government Organisations (NGOs) who provide services such as housing and food banks (e.g., the Salvation Army)
- Teachers and others who work in schools
- Doctors and any other multidisciplinary health professionals working in general practices
- Dental technicians and dentists in dental clinics

Social workers are important colleagues for nurses. When nurses need to discuss a concern about a child they will often talk to their nursing colleagues and, if necessary, follow up with a social worker. The process for nurses to make a referral about the risks to a child starts with filling in a Report of Concern to the social worker in their workplace or by calling Oranga Tamariki to lodge a report verbally. This decision depends on whether a social worker is situated in the nurse's workplace or within the social worker workforce at Oranga Tamariki. Thus, access to the social worker determines how the nurse lodges a Report of Concern. If a nurse phones a social worker at Oranga Tamariki to discuss a concern or to make an official Report of Concern, it is the social worker who decides whether the concern warrants further investigation. The social worker then

decides whether or not further action is required, and the nurse's concern will be recorded. If no further action or investigation is initiated by the social worker, there is little the nurse can do other than to continue to provide ongoing support and assessment of the child/family. If there are multiple concerns noted about the same family, the social worker may initiate an investigation.

Primary health nurses can access a range of organisations that assist families in need, from voluntarily run groups such as blanket, curtain, and clothing banks through to NGOs such as the Salvation Army who coordinate a variety of social support services. An extensive web search revealed a repository within the Ministry of Social Development website with an A-Z list of over 6,000 community providers around New Zealand (Ministry of Social Development, n.d.-b). The Healthy Homes Initiative, for example, is a government run initiative, carrying out housing assessments and a plan "to create a warmer, drier, healthier home" (Te Whatu Ora Health New Zealand, 2022). This programme was expanded nationwide in July 2022. Children with rheumatic fever are fast tracked into this programme; thus, primary health nurses have an important role in linking these children with services to support their wellbeing.

The networks primary health nurses establish include primary and secondary schools, general practices, and dental services. These relationships are important. For example, teachers are very important to public health nurses in that they are a source of referrals for health concerns about primary school children. A strong relationship between health and education enables teachers to refer health concerns to the nurse. Sometimes such health concerns may underpin a potential or actual social issue which the nurse can assess to ascertain which services are most appropriate.

Pre-Understandings

Researchers bring their own knowledge and experience to their thinking, sometimes without realising the influence. Pre-understandings are central to Gadamerian philosophy (Nystrom & Dahlberg, 2001). Gadamer argued that preunderstandings are part of human understanding. They are intentional feelings and thoughts which are "activated when we regard something *as* something" (Nystrom & Dahlberg, 2001, p. 339). Thus, failing to be open, and not dealing with pre-understandings, may lead to findings being a reflection of knowledge or experience that already exist in the researcher's understanding. Researchers using Gadamerian philosophy must, therefore, remain open to seeing the 'otherness' of the phenomenon of interest. This is because pre-understandings derive from familiarity which can both constrain and facilitate understanding. Additionally,

dealing with one's pre-understandings enables the researcher to remain open to new interpretations, because interpretations are not fixed (Nystrom & Dahlberg, 2001).

Gadamer argued that it was only through recognising one's pre-understandings that understanding was possible (Fleming, Glaidys & Robb, 2003). This is because Gadamer (1990) believed historical awareness was essential for all understanding. We all have a history, and Gadamer (1993) argued that it was impossible to step outside this and look at history or texts objectively. Such historical awareness always carries prejudice and researchers must, therefore, identify their pre-understandings or assumptions before and during the research process (van Manen, 1990).

Most of my historical understanding comes from experiences as a parent of sporting children. Because I do not have a primary health nursing background, I had little understanding of what primary health nurses' jobs entailed. My experiences as a parent, student nurse, nurse, and nurse educator with potentially at-risk children combined to shape the understandings I brought to this study. A pre-understandings interview with my primary supervisor helped reveal my biases in relation to the research question. These included beliefs that:

- the nurse was the most prolific identifier of child abuse or neglect
- nurses were undervalued and unappreciated by others and the system they worked in
- a lot of the nurse's work in child protection went unnoticed; and that while nurses can identify at-risk children, they have no power to act
- the dominant narrative in child protection is from a social work perspective and that the nurses did not have a voice in this area
- the nurse's ability to protect children from harm was determined by a social worker
- nurses have more knowledge of a family and work more often with them
- nurses' way of knowing assists them identify a child at risk.

Overview of Chapters

This study seeks to explore primary health nurses' experiences when they work with children whom they suspect are being abused or neglected. The purpose is to uncover the meaning of 'being' a nurse in this context. Chapter One has set the scene by outlining the purpose and rationale for this study. I have described the New Zealand context specific to children's health, primary care nursing, and my beginning position as the researcher. Chapter Two provides a review of the literature to contextualise the study. It synthesises

literature relevant to the topic. Chapter Three outlines the methodology used in the study, with Chapter Four describing the methods employed to carry out the research. Drawing on the work of Gadamer enabled an exploration of meaning through use of a hermeneutic approach. Ethical considerations, recruitment of participants, how interviews were conducted, and the process of analysis is described in this chapter. What follows are three findings chapters which presents the nurses' experiences, interpreting data excerpts from face-to-face interviews. Notions from Gadamer's hermeneutics and Levinas' philosophy are used to illuminate insights and new meanings derived from the participants' stories. Chapter Five describes how nurses try to build and nurture relationships. Chapter Six presents the theme of being with suspicion. Chapter Seven, the last findings chapter, describes the burden of concern that nurses carry when working with children at risk of abuse or neglect. Finally, Chapter Eight concludes the study by relating the findings to previous research and discussing the implications for nursing practice, education, and further research. What I have learnt throughout this research process has challenged my pre-understandings. Staying open and acknowledging my historicity has been critical to expanding my horizons.

Summary

This chapter has introduced and provided justification for the research question and approach. I have described the context for primary health nursing practice in New Zealand. Key terms have been defined and an overview of the thesis chapters has been provided. It is my hope that the everyday practice experiences of nurses working with children whom they suspect may be abused or neglected is given voice and understood in ways previously unknown.

Chapter 2 – Literature Review

Introduction

This chapter reviews literature pertaining to primary health nurses and their experiences with children they suspect are being abused or neglected. I seek to open and encourage dialogue about the little known and discussed experiences of nurses working with at-risk children through making visible what it means for nurses. I followed the approach to a hermeneutic literature review articulated by Smythe and Spence (2012). Hallmarks of this approach include reviewing a broad range of literature, endeavouring to present a variety of meanings and provoke thinking. Researchers must also reveal their own prejudices so that these can be examined for how they contribute to the researcher's thinking and thus interpretation. Another recommendation is to acknowledge what is both known and absent from the literature. This is because the absence of voices can be as important as those which are present. Smythe and Spence's recommendations support the aim of hermeneutic research being that of developing and extending knowledge while acknowledging limitations rather than seeking an ultimate understanding.

Searching for Literature

Looking for keywords was helpful in narrowing down search words and phrases. The health databases EBSCO, Scopus, and CINAHL were used for literature searching. My initial intention was to exclude literature beyond 10-years old; however, when there was limited literature or older, very relevant research, I could not ignore it. In keeping with a hermeneutic approach focused on meaning, I was led primarily by what literature seemed most important and thus reviewed literature irrespective of its age. The search terms used are in Table 1.

The keywords were linked to child abuse, maltreatment, and neglect to reduce unrelated primary health nursing results. I then looked at words and phrases in relevant articles and published research which helped widen my horizons and further understand how I had judged some words and discarded them. For example, for some, 'surveillance' may imply military or police monitoring context, yet nurses may use surveillance when assessing a family. I also explored words for meaning beyond their assumed contemporary understanding and examined etymological meanings. This helped to uncover understanding of my own biases towards words and phrases. The review thus became a cyclic endeavour of searching, finding new key search ideas, and repeating this cycle until I believed that I had exhausted what could be found in the literature. There were times when I strayed to interesting but unrelated material. I knowingly allowed

being led astray but remained focused on the research question. This would often lead to a place of knowing that I had not previously considered. Boell and Cecez-Kecmanivic (2014) viewed such encounters with the literature as serendipitous and ones which can enhance hermeneutic understanding.

Table 1.

Examples of Literature Search Terms

Key words	Proximity terms
Child abuse/neglect	"child maltreatment" OR vulnerable "child abuse" OR "neglect" OR (child abuse N8 reporting) OR (child abuse N8 mandatory) OR (child abuse N8 barriers) OR safeguarding OR child abuse statistics NZ OR child abuse reporting OR identifying child abuse OR child neglect
Primary health and nursing	primary health primary health care primary nursing community nursing public health nurs* (responsibilities N6 nurs*) OR (nurs* N8 teach*) OR practice nurs* OR school nurs* hermeneutic OR phenomenology* OR pragmati* OR call to care OR otherness OR suspic* burden (and) nurs*

* denotes truncation

A New Zealand Context to Child Abuse and Neglect

Child abuse is a worldwide phenomenon that occurs in all socioeconomic groups (Lines, Hutton, & Grant, 2020b; Nayda, 2004). It usually occurs in the context of multiple risk factors, more commonly with parents who have drug or alcohol and/or mental health issues (Coates, 2017). According to the Treasury (2016), there are four indicators that statistically put children at greater risk of being abused or maltreated in New Zealand (Spratt, 2011). These four indicators are:

1. having parents supported by benefits for most of their lifetime;
2. having had a substantiated CYFS finding of abuse or neglect;
3. having a parent who has been punished by the courts (community and custodial sentence); and
4. having a mother with no formal educational qualifications.

Furthermore, having two or more of the indicators means that children are three times more likely to leave school without any qualifications, three times more likely to receive a prison or community sentence between the ages of 25- and 34-years, six times more likely to be referred to Youth Justice services, and four times more likely to be on a sole parent benefit by the age of 21-years (English, 2016).

In a UNICEF (2013) report, New Zealand had a child poverty ranking of 21 out of 35 countries. Child poverty is an important factor in this discussion because research in New Zealand shows an association between child poverty and child maltreatment and neglect (Wynd, 2013). New Zealand could not be ranked in UNICEF's 2017 report because New Zealand only supplied one of the three indicators to measure child poverty, of which UNICEF was critical (UNICEF Office of Research, 2017). From 2004 to 31 March 2019 every 8th person killed by homicide in New Zealand was a child, equating to one child homicide every five weeks. More than two thirds of these children were under the age of 2-years (Child Matters, 2019).

Further statistics from Oranga Tamariki (2020) show that from 1 April 2019 to 31 March 2020 there were 83,300 Report of Concerns to Oranga Tamariki. This includes 60,200 children and young people, representing the total number of individuals (meaning some children and young people were reported more than once). From these Report of Concerns, 42,800 assessments or investigations (including 35,800 distinct children and young people) resulted. Following on from these assessments, there were 8,350 Family Group Conferences (FGCs) (including 6,100 distinct children and young people). This led to 1,100 children and young people entering care and protection custody. It is unclear

whether such care was with other family/whānau, non-family/whānau, government or non-government organisation (NGO) placements.

Māori children from 0 to14-years are projected to comprise 28% of the population in 2023 (data for those between 15- and 17-years is not extrapolated) (Statistics New Zealand, 2022). However, Māori children (0-17 years) comprised 57% of all children and young people in care and protections custody as at 31 March 2022 (Oranga Tamariki, 2022a). This illustrates the disproportionate representation of Māori children compared to non-Māori children. Also of concern is the estimated one in four girls under 15-years who have been forced to do something sexual against their will or have been touched sexually (Gammon, 2016). Most concerning, however, is the statistic that Māori girls have a sexual abuse rate twice that of European and other ethnicities (Gammon, 2016). Gammon goes on to state that rates of sexual abuse of boys are likely to be much higher than what is reported due to under reporting, and it is estimated that one in eight boys have been abused sexually.

Child abuse and neglect costs approximately $2 billion (New Zealand) per year. This is just over 1% of Gross Domestic Product (GDP). Yet, just under 0.1% of GDP is spent on preventive measures (New Zealand Family Violence Clearinghouse, 2011). In 2014, the cost of child abuse including Intimate Partner Violence (IPV) itself, was estimated at between $4.1-$7 billion per year and rising (New Zealand Family Violence Clearinghouse, 2014). Of note, one in three women had reported experiencing sexual and/or physical Intimate Partner Violence (Gammon, 2016). Given that women remain the primary carers of children, the adverse effects of Intimate Partner Violence on children are highly likely (Cagliesi & Hawkes, 2021; Melesk, 2020; Rice, Walker, & Main, 2008).

Primary Health Nursing – Home Health Visiting

Primary health nurses are privy to valuable information which places them in an ideal position to detect and respond to child abuse (Dahlbo, Jakobsson, & Lundqvist, 2017; Nayda, 2004). Nurses' relationships with patients develop due to the intimate and complex nature of their work (Nayda, 2004). They play a key role in child safeguarding and identify risks to children and young people (El-Radhi, 2015). It is essential, therefore, that nurses know how to recognise signs of abuse or neglect (El-Radhi, 2015; Payne, Fernandez, Jenner, & Paul, 2017; Saltmarsh & Wilson, 2017). Preventing and responding to child abuse is an important part of their role (Jack et al., 2021; Lines, Grant, & Hutton, 2020). As of 31 March 2019, there were 52,065 registered nurses and nurse practitioners

in New Zealand with 15% of these nurses working in primary health/community settings (NCNZ, 2019).

The main themes in the review of literature on nurse home visits centred on the usefulness of these visits for identifying concerns relating to child safety, and some of the barriers to reporting these concerns. A randomised clinical trial was conducted in upstate rural New York with first time mothers who were considered vulnerable to abuse and neglect (Olds, Henderson, Chamberlin & Ratelbaum, 1986). The study found that nurse home visiting was effective in preventing child abuse and neglect with women who experienced moderate to severe intimate partner violence. In contrast another study in a semi-rural setting in upstate New York, United States of America (USA), reported no benefit for nurse home visits in the presence of increasing frequency of domestic violence episodes (Eckenrode et al., 2000). However, this study was a 15-year follow up of a previous study, and assessed 81% of women originally randomised in the initial study. The study by Eckenrode et al. is important because it brings attention to the critical need for early detection and intervention of Intimate Partner Violence with nurse home visitations. More recent evidence supports the benefits of nurse home visits for protecting children from harm (Kobayashi, Fukushima, Kitaoka, Shimizu, & Shimanouchi, 2015; Lines, Hutton, & Grant, 2021; MacMillan, 2000; Peckover, 2013).

Typically, in New Zealand, public health nurses visit families in their homes. Such visits enable strong relationships to develop with families, seen as crucial in protecting and safeguarding children (Peckover, 2013). Through observation during home visits, nurses have the opportunity to identify risks to children before abuse occurs. Home Care for Kids is a home health visiting service in New Zealand wherein a paediatric nurse visits children aged 0- to16-years in their homes. The service is provided for children who require ongoing nursing care at home, often following a hospital admission (Waitemata District Health Board, 2018). Plunket nurses are another home visiting nursing service in New Zealand. They mainly do anticipatory checks for children under the age of 5-years, although they also support families with problems related to sleeping and eating (Plunket, 2022). My search found only one study conducted in New Zealand, a dissertation which explored what it is like for Plunket nurses to make decisions on reporting suspected child abuse and neglect (Carter, 2010). This dissertation interviewed six Plunket nurses and found that they face complex challenges when building relationship with families, and feel as though they will lose a family's trust when needing to report abuse or neglectful situations. Additionally, the dissertation found that Plunket nurses find child protection work stressful, and not only feel this as a bodily disturbance, but that they frequently think

about leaving the job. Due to the limited literature in New Zealand, the following discussion has drawn on overseas research.

The Nurse-Family Partnership is a nurse home visitation programme for first time disadvantaged mothers. The original study by Olds et al. (1986) provided evidence that for first time mothers in disadvantaged families, child abuse and neglect is best prevented through a programme of frequent home visits by a nurse. Such visits help reduce the incidence of child maltreatment when there is a limited number of domestic violence incidences (<28 reported incidences) (MacMillan, 2000). Adaptations of this early programme have been implemented internationally. Currently, randomised control trials to evaluate these programmes are in progress in countries such as Canada, England, Scotland and the Netherlands (Jack, Catherine, Gonzalez, MacMillan, Sheehan & Waddell, 2015).

However, evidence suggests that when Intimate Partner Violence incidence becomes more frequent (>28 reported incidences), home visits do not reduce child maltreatment (Eckenrode et al., 2000). Further, evidence shows that intensive home visits by nurses are more effective in preventing child abuse and neglect than preventing recurrence (MacMillan et al., 2005). However, Kobayashi et al. (2015) found that repeated home visits by public health nurses did, in fact, reduce the recurrence of abuse and neglect.

The areas of most significant parental behaviour towards a child and the reduction of these behaviours after the repeated nurse home visits were: punching or beating, committing domestic violence in front of a child, kicking, refusing a child medical care, quarrelling in front of a child, and raising a child in a dangerous environment (Kobayashi et al., 2015). The areas which reduced to zero recurrence were squeezing the neck of a child, putting cigarettes out on a child, confining a child under a bed, and exposing sexual organs/naked body to a child. Based on such findings Hanafin (2013) and Jack et al. (2021) pointed to how central the role of public health nursing is within child protection.

A study in Ireland found that public health nurses are a key worker in the community with at-risk children. The public health nurses described their role in terms of child protection as one wherein they identify and refer suspected cases of child abuse. They reported unease with the notion of their role being one of 'monitoring' because they believed this implied policing (Kent, Dowling, & Byrne, 2011). However, assessing the risks to children is inherently part of the nurse's role and inevitably involves monitoring the child's environment to identify suspected or actual signs of abuse or neglect. Monitoring is, therefore, an inescapable and necessary component of risk assessment, as is the reporting of any concerns. Crisp and Lister (2004) alluded to Scottish nurses' unease related to monitoring. In research involving 99 nurses, they concluded that many believed that child

abuse surveillance conflicted with supporting families. Recent evidence from the USA promotes widening the eligibility for children and families who have experienced traumatic events so they can access public health nurse home visiting (Ballard, Turner, Cuca, Lobo, & Dawson-Rose, 2022). The adverse childhood events included in their definition of trauma included multiple forms of abuse and neglect. Results have shown promise in reducing the impact of health-related trauma.

Nurses in Secondary Schools

Some secondary schools in New Zealand employ a nurse to maintain the health and wellbeing of students. A school's decision to employ a nurse is based on budget priorities. Such budgetary constraints were identified by Maughan et al. (2018) in the USA as a reason for schools not having a dedicated school nurse. It was recommended that both health and education sectors work together to fund what they regarded as an important role in the health and wellbeing of children and youth. A study by Kwatubana (2018) in South Africa points to the growing evidence that shows an inextricable link between health and education. However, it also showed that due to a lack of trust and openness, the school nurses' role of health screening and the teachers' role of screening for learning barriers are difficult to harmonise.

Jordan et al. (2017) argued that school nurses are ideally placed to take the lead in collaborating with the school and wider community to protect children. However, nurses in Scotland also claimed that others such as school managers, parents, and external agencies, may have unrealistic expectations of what nurses are able to do in relation to child protection practices (Hackett, 2013). School nurses believed this could be due to confusion as to whether they or the school managers were responsible once they raised child protection concerns.

A qualitative study in Finland explored school nurses' methods when working with children who had been abused (Paavilainen, Astedt-Kurki, & Paunonen, 2000). The sample of 20 experienced school nurses came from a variety of schools. The participants reported that their first alert to child protection concerns was through increased frequency of visits to them, but they also observed that children at risk of child abuse did not talk about their families easily and tended to protect their parents (Paavilainen et al., 2000). Twenty-three Swedish school nurses participated in another study which explored their ability to recognise and support abused children, and how trust was built (Kraft & Eriksson, 2015). The school nurses in this study were first alerted to child maltreatment based on their intuition deriving from their knowledge and experience. After an initial

concern, these school nurses used trust-creating and trust-strengthening strategies to enable them to provide support and assistance to children who were abused. A survey of school nurses in England with 775 responses (Longfield, 2016) revealed that child protection duties were a substantial part of school nurses' overall workload. However, a barrier to the effectiveness of this work was the need to spend between 2- and 4-hours a day on paperwork instead of seeing children and young people (Longfield, 2016).

Thus, while evidence points to the importance of the school nurse role in child protection, it also highlights concerns regarding the delineation of roles when nurses work in educational settings, and the complexities inherent working with at-risk children and their families. Importantly, there are few, if any, insights into the experiences of the nurses themselves, and what this is like for them.

Nurses in General Practice Settings (Practice Nurses)

In New Zealand, practice nurses work in general practice clinics, usually in a nursing team alongside general practitioners ([GPs], doctors) delivering care to the population (Lane, 2017). Most practice nurses are employed by GPs who usually own the practice, either alone or in partnership with other GPs. In New Zealand, 93% of the population is enrolled in a Primary Health Organisation (PHO) comprised mainly of GPs' practices but also include primary care providers such as midwives and iwi. PHOs are contracted by District Health Boards to provide primary health care to enrolled patients (Ministry of Health, 2018a). Thus, practice nurses have an important role in the community because many of these enrolments are children and their families. It is argued that in order to establish good practice in primary care, practice nurses must liaise effectively with others such as health visitors, GPs, and other interagency staff (Batley, 2014).

While there are numerous studies and opinion pieces on the work of practice nurses, there are very few which explore their work in relation to child protection. This is somewhat surprising because, as Batley (2014) proposed, the role of the practice nurse in child safeguarding is becoming more recognised. Further, the significance of their role is increasingly evident because of their ability to assess the signs of abuse and due to the insights they gain into family life and their understanding of potential risks to children. In New Zealand, practice nurses concerned about the risks to a child, usually refer and discuss their immediate concerns with nursing colleagues and doctors within their practice. Hence, the importance of these relationships. They may then contact a social worker at Oranga Tamariki for further advice if they are uncertain about how to manage a

concern, and/or to seek assistance working with the child. Batley's findings emphasised the importance of organisational support of practice nurses managing child safeguarding.

Interprofessional Context – Nursing and Social Work

Social workers are a registered group of professionals in New Zealand who are mandated by law to protect vulnerable children and youth in any setting or context. In the 2018 New Zealand Census, there were 8,019 social workers actively working (Careers database, 2020), 1,646 of whom were working for Oranga Tamariki as at 31 August 2018 (Oranga Tamariki, 2018). Oranga Tamariki social workers conduct the assessments or investigations when a Report of Concern is received. There were 42,800 assessments/investigations carried out by 1,646 social workers in 2018. This points to an extremely high workload, particularly because assessments/investigations are only part of their role. In comparison, there are 52,065 registered nurses working in New Zealand (NCNZ, 2019), of which approximately 7,800 work in primary health settings and may be involved in suspecting child abuse and neglect.

In New Zealand, literature on the work of social workers with at-risk children and on child protection issues is easily found. This is unsurprising considering an integral part of the social worker's role in New Zealand is to work with populations affected by social and health inequalities (Döbl, Huggard, & Beddoe, 2015). Considering the limited literature on the nursing role with at-risk children, the dominant discourse on child protection comes from a social work perspective. In New Zealand, the Ministry of Social Development (n.d.-a) administers legislation such as the Oranga Tamariki Act 1989, the Children's Commissioner Act 2003, as well as the Social Workers Registration Act 2003.

Tensions may arise between nursing and social work when working with vulnerable families. At times, child protection services can be perceived as heavy handed and powerful (Deisz, Doueck, George, & Levine, 1996; Jack et al., 2021). A study in Scotland reported that families with whom nurses worked in the area of addiction described the work of social workers as taking children away and the work of nurses as helping with people's health (Crisp & Lister, 2004). A New Zealand study similarly found tension between the neonatal nurses' role in child protection and nurses' perception of a lack of effectiveness of child protection services (Saltmarsh & Wilson, 2017). In the previously mentioned English survey of 775 school nurses (Longfield, 2016), nearly half the nurses reported difficulties referring at-risk children to social services. This was because nurses believed that local authorities' threshold for intervening in child protection concerns was too high and that, in many cases, the nursing referrals were not accepted. Of particular

concern was the fact that half of the school nurses who participated in the study were unsatisfied with the outcomes of at least half of the referrals they made to social services.

Interprofessional Context – Nursing and the Primary Education Sector

In New Zealand, public health nurses are employed by District Health Boards who allocate public health nurses to a cluster of primary schools (children aged from 5- to 10-years). The schools allocated to public health nurses have a low socioeconomic status and increased barriers to education, otherwise called 'low decile' schools (Ministry of Education, 2022b). Thus, the public health nursing role is one which creates a valuable link between health and education. Amongst other provisions within their regular visits to schools, the public health nurse role includes child protection assessment (Clendon & McBride, 2001). Even though this has been a recognised part of the public health nurse role for over 80 years, there is no research in New Zealand that explores the relationship between nurses and teachers. There is, however, some literature from overseas.

Public health nurses and teachers were highlighted in a report in Ireland as two professional bodies in particular that needed to work together at system and organisational level (Hanafin, 2013). The role of schools in child protection is significant because it allows teachers to observe the nature of children's relationships with others (Bell & Singh, 2017; Buckley & McGarry, 2011) and their physical condition (Buckley & McGarry, 2011). Fumarco, Francesia, Farinetti, Negro, and Bona (2012) supported this view and stated that collaboration between primary school teachers and child health community nurses is important in identifying and preventing situations where children are at risk of abuse and neglect. They found that early reporting of child abuse and neglect can be achieved by teachers and nurses working more closely together and sharing information. Studies have shown that teachers are able to identify over half of the children who are maltreated (Bell & Singh, 2017), with Australian (Australian Institute of Health and Welfare, 2008) and Canadian teachers (TReport of Concernmé et al., 2003) the second highest reporters of concerns to the respective child protection agencies.

Recognising and Responding to Child Abuse and Neglect

Evidence from the USA (Herendeen, Blevins, Anson, & Smith, 2014) and Australia (Pitz & Wachtel, 2009) show that nurses often have first contact with children who have been abused. Furthermore, the trusting relationships they seek to establish means they are well placed to recognise and intervene when they observe signs of child abuse or neglect. In Scotland, practice nurses were often the first point of contact with patients and

therefore in a useful position for identifying child abuse (Crisp & Lister, 2004). In community settings and emergency departments, nurses are often the first health professional to recognise child abuse (Nayda, 2004).

A study of advanced practice nurses (APNs) working in primary care settings in the USA found a lack of nursing assessment of the significant risk factors for child maltreatment, even though these risk factors had been known as highly predictive of parenting difficulties (Hanafin, 2013). Thus, even when nurses know how to recognise signs of child abuse, the following reasons prevented effective intervention by nurses in primary care settings: a lack of clarity relating to their roles and responsibilities compared with other health professionals, lack of information in documentation, and gaps in communication between community and hospital staff. Studies of nurses in paediatric settings in New Zealand (Saltmarsh & Wilson, 2017) and in the community in Sweden (Dahlbo et al., 2017), found that nurses relied on their clinical judgement to decide if they suspected child abuse may be occurring. They then used this judgement to decide whether to refer to authorities. As Saltmarsh and Wilson (2017) showed, however, neonatal nurses who had identified 'red flags' of child abuse could still fail to take appropriate action. Evidence about what influences nurses' assessment and responses to child abuse is limited (Lines, Hutton, et al., 2020b), as is research on nurses' experience of this phenomenon.

A study in the United Kingdom (UK) found that most nurses said they could recognise child neglect but few knew how to respond (Daniel, Taylor, & Scott, 2013). While intuition helped nurses recognise child abuse, it was thought to be the culmination of their experience which alerted them to further assess the child (Nayda, 2002). In order to respond effectively to children suspected of experiencing abuse or neglect, nurses needed to understand how child abuse is shaped by sociocultural contexts, personal views, and professional experiences (Lines, Hutton, et al., 2020b).

Daniel et al. (2013) outlined several steps that nurses should take when they suspect child abuse. The first was to know the signs and risk factors of child abuse. They also emphasised the importance of early reporting rather than waiting for certainty and risk being too late. After discussing concerns with a colleague, they recommend that nurses used self-questioning to elicit the needs of the child. Thereafter, they recommended nurses follow their organisation's child protection policy or guidelines.

Research from the UK and The Netherlands has identified a strong association between child abuse and neglect, and severe dental caries (Bradbury-Jones, Innes, Evans, Ballantyne, & Taylor, 2013; Smitt, Mintjes, Hovens, de Leeuw, & de Vries, 2018). Smitt et al. (2018) cited a strong association between child abuse and neglect with severe dental carries being an important factor in insufficient parenting. They argued that anyone

involved in the care of children should be aware of the link between severe dental caries and abuse/neglect in order to be alerted to the need to provide early support for families. While dental caries may be an indicator of health inequality related dental neglect rather than generalised child neglect, Rodrigues et al. (2016) argued that routine dentistry can potentially diagnose orofacial injuries that may result from domestic violence against children. Public health nurses tend to associate dental neglect with broader neglect, but reported that they did not consider it appropriate to inspect children's mouths nor did they feel qualified to do so (Bradbury-Jones et al., 2013). However, they did feel there was a gap in communication between dental services and themselves with lack of feedback, particularly if children consistently failed to attend dental appointments.

When doing a comprehensive health history for children, nurse practitioners in the USA are advised to complete a dental check including the number of teeth, cavities, extractions, and dental visits (Fenstermacher & Hudson, 1997; Mahat, Lyons, & Bowen, 2014). However, 10 nurse practitioners who participated in another study exploring child protection concerns did not have any dental examination training and struggled to identify dental issues in children (Olive, Tuthill, Hingston, Chadwick, & Maguire, 2016). This is consistent with the study by Mattheus, Shannon, Gandhi, and Lim (2018) wherein nurse practitioners who did not receive oral health education were not confident conducting such assessments. The NCNZ (2017a) has stated that upon completing the nurse practitioner education programme students will be able to "demonstrate advanced knowledge of pathophysiology, pharmacology, assessment and diagnostic reasoning" (p. 7); however, there is no mention of specific assessments such as oral examination, nor is this prescribed in the nurse practitioner education programmes in New Zealand. In New Zealand, a study found that dental therapists believed they had an important role in child protection; however, only about half of the cases they suspected arose from child abuse were reported to authorities. This was due to the fear of reporting non-abuse (Tilvawala, Murray, Farah, & Broadbent, 2014). There is currently no formal conduit for communication between dental therapists and nurse practitioners in New Zealand.

Mandatory Reporting and Associated Barriers

Mandatory reporting refers to the legal requirement in a country or territory for the reporting of any suspicion of abuse or actual knowledge that a child is being abused. Internationally there is ongoing debate about the compulsory nature of reporting with strong views both for and against. New Zealand has a legal requirement in the Crimes Act 1961 s151 and s195A that anyone who lives with or visits a child or adult in their home and suspects or knows the child (or adult) is at risk of sexual assault, grievous bodily

harm, or death, must report it. However, this does not include a requirement to report neglect or physical abuse that does not meet the threshold for grievous bodily harm or death. Grievous bodily harm is described as "really serious harm interfering with health or human function" (Courts of New Zealand, n.d.). Thus, New Zealand does not have a legally mandated reporting requirement that covers all forms of child abuse and neglect. Even in the presence of mandatory reporting, many healthcare professionals remain unaware of the regulations governing child abuse reporting (Azizi & Shahhosseini, 2017). Paediatric nurse practitioners in the USA are legally mandated to report any injuries they suspect are a result of child abuse or neglect (Herendeen et al., 2014), as are nurses in Taiwan (Feng, Jezewski, & Hsu, 2005). However, Taiwanese nurses have reported they do not believe it is their responsibility to report actual or suspected cases of child abuse (Azizi & Shahhosseini, 2017). In Australia, nurses are legally required to report actual abuse or suspected child abuse (Kuruppu, McKibbin, Humphreys, & Hegarty, 2020; Pitz & Wachtel, 2009) and student nurses are also mandated notifiers in some States (Nayda, 2005). It is important to note that once a report is made in Australia, the notifier has no further involvement in the case. Personal details remain confidential within the case records (Nayda, 2005). While intentionally protective, this often leads the nurse to feel marginalised from the process with no or little feedback and feelings of frustration about the uncertainty of family outcomes (Nayda, 2005).

Negative experiences with child protection services make some nurses reluctant to report abuse despite the mandatory legal requirement (Kuruppu et al., 2020). Nayda (2002) reported that nurses did not believe the child protection services interventions were always in the best interest of the child. They also believed that child protection services were overburdened (Nayda, 2002). Other barriers to nurses reporting child abuse cases included:

- a perceived lack of uniformity in reporting systems, inconsistent reporting process a lack of legal support (Borimnejad & Khoshnavay Fomani, 2015).
- complex and lengthy reporting documentation (Lines, Hutton, et al., 2020b).
- a lack of documentation guiding what constituted 'suspicion' (Nayda, 2004).
- a belief that systems designed to support child abuse reporting were at times confusing and ineffective for nurses (Lines, Grant, et al., 2020).
- a belief amongst some community nurses that the documentation of child abuse concerns was the responsibility of doctors (Nayda, 2002).
- nurses' perception of a lack of training in child abuse, even when positioned within a mandatory reporting environment (Herendeen et al., 2014; Pitz & Wachtel, 2009).
- nurses' fear of the potential for being 'sacked' (Lines, Grant, et al., 2020).

- insufficient education about signs and symptoms of child abuse, and the need for more knowledge on ways to assess for further information without compromising their relationship with the family (Feng & Levine, 2005; Limandri & Tilden, 1996).
- fear of damaging relationships with the families with whom they are working (Kuruppu et al., 2020). This was particularly evident in smaller communities where the anonymity of the reporter would be harder to maintain (Limandri & Tilden, 1996), creating a sense that nurses were betraying a family by reporting concerns. In addition, they were concerned that such reporting could have negative consequences for the child (Nayda, 2002, 2005).

The prospect of the nurse's documentation becoming a legal issue was also a concern and adversely impacted reporting of suspicions. Nayda's (2004) earlier research noted that nurses feared being wrong in relation to their suspicion, a possible factor being the fear of one's documentation being presented in court. Significantly, a lack of documentation that supports reporting can lead to identification failures and mean that children remain at risk of abuse. Despite Australian law requiring mandatory reporting of abuse, it was found that community nurses believed it was more beneficial to support families and implement strategies than to report abuse (Nayda, 2002). This research reported that when making judgements on whether to report child abuse, community child and youth nurses had difficulty assessing the difference between wilful neglect and a failure to meet what they viewed to be middle class standards (Nayda, 2002). The nurses realised they could be imposing their own values on struggling families, thus creating a moral dilemma about whether or not to report their concerns. Furthermore, some nurses who recognised cases of emotional abuse tolerated the abuse because they accepted it as an aspect of society that could not be changed.

Home visiting nurses in Ireland experienced difficulties when reporting their concerns to social workers. These were due to the frequent changes in social worker, creating the need to rebuild a relationship and start again and confusion between the public health nurses' and social workers' priorities and role boundaries (Kent et al., 2011). However, a more recent study in Israel found that having access to an in-service social worker was an important factor in nurses' reporting practices (Zusman & Saporta-Sorozon, 2021). This was because social workers were viewed as experts, they were easily contacted, and helped simplify the reporting process. Key findings in an Australian study (Lines et al., 2021) found that nurses believed they were not taken seriously when reporting abuse and neglect to child protection services, resulting in feeling powerless to enact change for children at risk. This led to some nurses thinking that multiple notifications about the

same child would improve the likelihood of getting a response from child protection services.

Overcoming Barriers for Reporting Concerns

A comprehensive review of the literature by Kuruppu et al. (2020) found overwhelmingly that education and training had a positive impact on reporting. It also found that child protection training improved nurses' preparedness for reporting and thus were more likely to report suspicions. Nurses in Vietnam were found to have improved recognition of child abuse after participating in a programme to develop knowledge of and assist with child abuse recognition (Flemington & Fraser, 2017). Corlett and Taylor (2009) identified that further research is needed on how nurses working in child protection can be better supported in their work and on how they manage their own responses to concerns.

Herendeen et al. (2014) found that paediatric nurse practitioners had a higher rate of reporting concerns than their physician counterparts and suggested this to be due to the nurses' strong advocacy for children. When nurse practitioners did not report suspicions to the authorities, the reasons were varied: that they worked with the family to resolve it; they referred their concern to another professional; disagreement with the physician on the nurse's assessment resulting in non-reporting or, in some instances, while the physician agreed with their assessment the nurse was persuaded not to report it. According to Mummery (2002), a high level of professional skill and judgement is required to understand and decide whether a child is at risk of significant harm. Importantly, they proposed that theory, practice experience, and the most recent research findings must inform these decisions.

There are many studies that show nurses feel inadequately prepared to care for or manage children when they suspect or know they have been abused (Feng & Levine, 2005; Nayda, 2005; Pitz & Wachtel, 2009; Vilainen, Astedt-Kurki, & Paunonen, 2000). For example, health practitioners in the UK reported not knowing how to respond when faced with a child abuse concern. This may explain why children feel ignored when they do make a disclosure of abuse (Taylor & Bradbury-Jones, 2015).

Undergraduate nursing programmes in New Zealand are required to teach students to observe and communicate effectively with children and their families (Nursing Council of New Zealand, 2017b). However, there is no mandated requirement to provide education about child protection and/or specific assessment of child abuse. The Violence Intervention Programme run by the Ministry of Health (2018b) supports District Health Boards in New Zealand to implement and evaluate family violence interventions.

Saltmarsh and Wilson (2017) found that while in-service education in a District Health Board neonatal unit focussed on the identification and observation of the signs of child abuse, the context of the education was unrelated to the nuances of the neonatal unit. However, regardless of the effectiveness of in-service education in District Health Boards, not all nurses work in District Health Board based services where such programmes are offered. Nurses who work outside of District Health Boards in New Zealand have access to NGOs who run programmes on the identification and reporting of child abuse and neglect (Ministry of Health, 2018c).

Summary

The evidence shows that nurses who work in the community, irrespective of their specific setting, are at the forefront of working with children and their families and are well placed to recognise and respond to concerns. Nurses in New Zealand are regularly confronted with child abuse and neglect and have to navigate a complex range of dynamics and decision-making. They play an essential role in the identification, intervention, and reporting of child abuse and neglect in a country with some appalling child health statistics.

However, it would seem that little is known about nurses working with at-risk children in New Zealand's community/primary health settings. In particular, there is a scarcity of literature about primary health nurses' experiences, despite evidence in the literature of the important role that these nurses have in identifying, intervening, and reporting child abuse or neglect. It is, therefore, important to more fully understand the work of primary health nurses, and ensure their voices contribute to improved child protection at all levels of practice, education, and policy development. The next chapter discusses the philosophical underpinnings that guided my exploration of nurses' experience when suspecting child abuse and/or neglect.

Chapter 3 – Methodology

Introduction

This study uses hermeneutic methodology informed by Hans-Georg Gadamer [1900-2002]. Gadamer (1975/2013) argued that all understandings are interpretations and vice versa. His philosophical hermeneutics aims "to explore the meaning of individual experiences in relation to understanding human interpretation" (Regan, 2012, p.286). Thus, while the nurses in this study interpret their own experiences, as the researcher, I am an interpreter of their collective storied experiences.

To reveal understanding of how primary health nurses experience suspecting a child is being abused or neglected, this study has drawn on the key philosophical notions of effective historical consciousness, dialogue, dialectic, the hermeneutic circle, and fusion of horizons (Gadamer, 1975/2013). During the analysis stage, other theorists contributed to the development of my interpretation of the data.

Gadamer believed that our past informs the present and anticipated future. This historical consciousness emphasises the temporal nature of human existence. More recently, the ideas of reflecting on the past and in the present moment are what Schön (1983) described respectively as reflecting on-action and reflecting in-action. This is something nurses are encouraged to do in relation to their practice; that is, to learn from past actions in order to anticipate/inform present and future actions. Thus, the analysis also draws on Schön's philosophy of reflective practice and nursing theorist Patricia Benner as one of nursing's foremost thinkers on reflective practice.

In this study, nurses' actions and reflections centre on the children and families with whom they work. Nurses' relations with others are bound by ethics and influenced by values (Held, 2006; New Zealand Nurses Organisation, 2019). Levinas' philosophy of ethical relations and the call to action led me to draw on his notions of Face of the Other, and responsibility for the Other (Critchley, 2002). Encountering the Other through the face is a pre-reflective ethical call to acknowledge the humanity of the Other whereby the human face calls us to reject sameness, thus rejecting stereotyping. Simultaneously, we become responsible for the Other during the face-to-face encounter; therefore, interactions with others are bound by an ethical relation. Responsibility for the Other is the foundation on which awareness of the Other's vulnerability demands (Benaroyo, 2022). This is the basis for the ethical call to action. In this study, the call to action also draws on John Dewey's (1922/2007) philosophical notions of means-ends and consequences. Means-ends is a continuum where means become the reason to take action—the purpose of which is to achieve the ends (or goals)—therefore informing the

value of the means. Consequence is the outcome of acting. It can be anticipated, and thus gives meaning to and justifies acting.

How I Came to Hermeneutics

During the early planning stages of this research, I had considered case study methodology because it would provide insights from the differing perspectives of those involved in service delivery. However, after deciding to focus more on nurses' experience, I ruled out using case study. Grounded theory had also been a consideration because it would help articulate the process characteristic of nurses' work with at-risk children. Yet, so little was known about the role of nurses, their experiences, and the often taken for granted nature of their work in this field. When I came to a decision about what I specifically wanted to know, the research question became: 'what are primary health nurses' experiences when working with children whom they suspect are being abused or neglected?' While 'experience' is often associated with phenomenological studies, understanding and interpretation in hermeneutics focuses on how humans experience the world (Gadamer, 1975/2013). Thus, it became clear that this question was more congruent with a hermeneutic approach. I therefore commenced the study using Hans-Georg Gadamer's [1900-2002] hermeneutic philosophy. To elicit stories during interviews about participants' experiences, questions hermeneutically phenomenological in nature were asked.

The Philosophers and Philosophical Underpinnings

Hans-Georg Gadamer

Hans-Georg Gadamer was a German philosopher whose philosophical hermeneutics derived initially from Heidegger, of whom he was a student. Gadamer is best known for his seminal work *Wahrheit und Methode* (Truth and Method) in 1960 and his philosophical challenge to scientific method. Gadamer's sole career pursuit was that of an academic and philosopher (Davey, 2007).

Gadamer: Hermeneutic Experience

Gadamer speaks of experience, as both *erfahrung and erlebnis*. Both are central to understanding and creating meaning and fundamental to hermeneutic inquiry. *Erfahrung* is a German word best translated to mean experience (Lawn & Keane, 2011). Gadamer uses *erfahrung* to describe experiences one is engaged in over which no one has control, and which *happens* to oneself (Roy & Bayo, 2011). In other words, it is a reflexive and primordial experience lived in the moment, from which one draws meaning (Spence,

1999). It is difference which forms Gadamer's concept of *erfahrung*, meaning that understanding starts only when we are forced to see something different from that expected (Davey, 2019). *Erfahrung* is often illustrated during moments which are negative when one is forced to see their short-comings, and to what degree they have contributed to these (Davey, 2019). Nurses in being with families during home visits sometimes sense that a child is at risk of abuse or neglect. This study seeks to show what the experience of suspecting a child is at risk is like, and what this means for the nurse.

Erlebnis comes from *erleben,* a verb, and also from *leben*, meaning 'to live'. It is often translated to lived experience or "to live something" (Iannilli & Matteucci, 2021, p. 42). For Gadamer, *erlebnis* is an ontological process of "taking part in" (Davey, 2019, p. 303). Gadamer used *erlebnis* to focus on how moments within experience are reflected on, and how they relate to underlying historical process which can be anticipated (Davey, 2019).

Gadamer: Understanding and Interpretation

This research focused on nurses' work-related experiences. To enable interpretation and understanding of these experiences, I sought stories that described what it was like to suspect a child was being abused or neglected. Hermeneutics comes from the Greek word *hermeneuein*, which means 'to interpret' or 'to understand' (Crotty, 1998). In research terms it refers to the study of interpretation (Byrne, 2001; Orange, 2011). It is the journey of interpretation which culminates in understanding, but is not a journey that never ends (Gadamer, 1975/2013).

Gadamer says that understanding is always interpretation (1975/2013), for which there is no one truth (Regan, 2012). He argued convincingly, according to Annells (1996), that definitive interpretation is not possible because understanding is inextricably bound to interpretation and both are always evolving. Thus, there can always be other possible understandings and interpretations. As the researcher, I can only come to my own interpretations and understandings of the nurses' experiences, knowing that others may develop their own. This is because we cannot know anything other than what we interpret against our own experiences. As the interpreter of the participants' stories, it is important I am aware that my past learning and experiences will shape how I understand and create meanings from the research data. Thus, there is no understanding without prejudice.

Gadamer: Historical Effective Consciousness

Further to Heidegger's belief that human existence is temporally situated, Gadamer argued that one's history and experiences shaped them, meaning that people have historically effected consciousness or prejudice. For Gadamer, historically effected consciousness is

the essence of experience (Nystrom & Dahlberg, 2001). Human understanding is always historically situated (Roy & Bayo, 2011), with our past and present being the source of anticipation (Grondin, 2002). Thus, there can be no understanding without preunderstanding, meaning that interpretation comes from a particular horizon (Nystrom & Dahlberg, 2001). Awareness of preunderstandings occurs when confronted with new ideas. New understandings are dependent on willingness to examine one's prejudices and being open to new ways of understanding the world. Thus, the temporality of Gadamer's past-present-future applies to, and effects all, interpretation and understanding (Spence, 2001). Experienced nurses cumulatively acquire skills and knowledge from past experiences. This not only applies to practice, "no research whatsoever is interpreted without historically derived preconceptions" (Nystrom & Dahlberg, 2001, p. 341). It means that as a researcher I must explore my own historical horizons. This is important because history influences what we perceive as worthy of inquiry (Nystrom & Dahlberg, 2001). Situating myself temporally and exploring how past and present understandings shape what I view as important, will help me to remain open to new understandings as I interpret the nurses' stories. The dialectical relationship of one's historically effected consciousness to the data is described metaphorically as the hermeneutic circle and the means of transforming understanding.

Gadamer: The Hermeneutic Circle as a Metaphor for Understanding

The concept of the hermeneutic circle did not begin with Gadamer, although he was responsible for bringing it to the fore in hermeneutics (Annells, 1996). Heidegger, and Schleiermacher before him, used the hermeneutic circle to describe the way partial and whole understandings move dialectically in order to develop further understanding (Koch, 1995). Gadamer (1975/2013) described interpretation as a process of going back and forth between whole and part understandings. He recognised that understanding deepened through understanding detail in relation to the whole, and of the whole in relation to the detail.

For the person who is open to new understandings, this is an evolutionary process and is continuous in nature. Thus, there is no end and no final conclusion. The hermeneutic circle recognises that we do not necessarily go back to past understandings. Thus, it is less of a circle and more a spiral of understanding. This is congruent with Gadamer's approach wherein there is no literal circularity in understanding (Motaharim, 2007). It is, however, commonly referred to as a circle.

Gadamer's analysis of the hermeneutic circle shows how understandings develop. He argued that we always start with some anticipation of what we think the 'whole' is. Then, these are revised as we engage with the text, or the subject itself (Grondin, 2002). Lawn

and Keane (2011) described these anticipations as expectations of meaning based on preunderstandings which help form the interpretation of text. Therefore, grounded in the hermeneutic circle is the need to explore one's preunderstandings, which are part of our effective historical consciousness and therefore part of any interpretation. Through my preunderstandings as a researcher, I initially understand the nurses' stories in a certain way. Moving between these texts and continually questioning preunderstandings enables the development of further understandings within the hermeneutic circle (Fleming, Gaidys, & Robb, 2003). Thus, past and present understandings lead to a fusion of horizons.

Gadamer: Fusion of Horizons as a Metaphor for Understanding

For Gadamer (1975/2013) *horizons* comprise preunderstandings or prejudices that enable us to make sense of events and people (Spence, 2001). They are a vantage point from which we interpret our world. Yet, they are not fixed. Because we are constantly interpreting the world, our horizons are continually being formed and reformed (Gadamer, 1975/2013).

Our horizons, or perspectives change in small ways over time (Lawn & Keane, 2011) as new interpretations/understandings develop. Horizons are acquired through language which both reveals and limits our understandings (Lawn, 2006). Having a limited horizon means not seeing far enough or putting too much value on the familiar (Gadamer, 1975/2013). Being aware of a horizon means that we have the potential to see beyond that horizon (Gadamer, 1975/2013).

Gadamer (1975/2013) used the notion 'fusions of horizons' to show how one's historically effected consciousness operates. It is a metaphor to describe how different vantage points, or points of view come together or meet, and evolve through language (Gadamer, 1975/2013). "In the process of understanding, a real fusing of horizons occurs" (Gadamer, 1975/2013, p. 317) during which historical horizons are both projected and superseded. While understanding develops when past horizons fuse or meet new understandings, this can only happen if one is open (Gadamer, 1975/2013). Therefore, using hermeneutics requires the researcher to remain open to other standpoints, allowing the coming together or fusing of different horizons. Specific examples of how I did this will be provided in the Chapter Four where I discuss research methods.

Gadamer: Dialogue and the Dialectic Nature of Understanding

The meaning of Gadamer's notion of dialogue was twofold. While dialogue includes conversation between people, it also refers to the dialogue that occurs between the reader and text (Gadamer, 1975/2013). In Gadamerian hermeneutics, understandings develop and evolve dialectically through conversation (Orange, 2011). Gadamer's belief is that

people “fall” into a conversation (Orange, 2011). Falling into conversation can also occur within oneself, where there is internal dialogue when reading and/or interpreting events.

There were, however, caveats on his meaning of what constituted conversation. For Gadamer, it involves the open conversation between people (Chin-Yee, Messinger, & Young, 2018). It is not merely asking questions to get to know another person or, as Gadamer would describe, getting to know their horizons. True conversation is one when the participants are “seeking agreement on some subject” (Gadamer, 1975/2013 p. 314). By this he does not mean reaching a conclusive end through the contemporary notion of agreement. It is the fusion of the differing horizons of the researcher and participant which thus leads to new understanding (Fleming et al., 2003). Dialogue thus requires an openness to hear something anew. Always dialectical in nature, dialogue is not a debate nor an attempt to force one’s point of view. It is openness to the transformation of one’s own horizons. Fleming et al. (2003) made the point that the researcher does not try to see things from the participant’s perspective; rather, their horizons work together to develop new understanding. However, we cannot predict whether or not further understanding will come from conversation. It cannot be forced but is something that happens to us (Gadamer, 1975/2013). Gadamer argued that in hermeneutic research, understanding was only possible through dialogue if researchers were open to the considering the opinions of others (Fleming et al., 2003). Furthermore, the dialogue that occurs between the researcher and the text does not rely solely on literature and textual data in the written form. Text also includes non-verbal expressions noted by the researcher because these contribute to understanding the researcher’s observations and the recorded voice conversation from the interview (Fleming et al., 2003).

The dialectical process of hermeneutic interpretation occurs when the researcher is to-ing and fro-ing between their own horizons and those of their research texts. This involves understanding the text as a whole, while relating how particular sentences or parts connect to the meaning of the whole (Fleming et al., 2003). During data analysis and the iterative process of writing, thinking, and rewriting, my interpretations changed and developed. This was a dialectical process which revealed the movement of the interpretation through language and the shifting of my horizons. Knowing one’s historical horizons, questioning current horizons, and being prepared to engage with prejudices in the texts comprise the dialectical process of coming to new understandings.

Donald Schön: Reflection-In and On-Action

Donald Schön was influential in helping develop the concept of reflective practice. This describes thinking both in-action and on-action (Schön, 1992, 1995b). Reflecting in-action refers to thinking which occurs whilst an action is being performed, while reflecting on-action occurs after the action has occurred (Cattaneo & Motta, 2021; Edwards, 2017; Iowa State University Library, 2018). Schön's theory is that reflecting on one's actions generates knowledge (Kinsella, 2010). Learning from reflection also enables anticipation of future actions. Thus, reflection on and in-action are both essential in nursing for the development of practice knowledge and skills (Edwards, 2017).

Knowledge gained from 'doing' or from past actions is what enables tacit knowledge, therefore the more one experiences through 'doing', the greater their tacit knowledge (Schön, 1983). Thus, nurses' previous experiences inform the unconscious and spontaneous commencement of an assessment when meeting a family. In these moments, nurses may not necessarily be able to verbalise their assessment, but they will have made initial observations of the environment that unconsciously inform their assessment. They are, or seem, to be doing without thinking. Knowing-in-action is often described by others as intuition or instinct (Schön, 1995a). It is the rapid recognition of complex patterns and relationships that are hard to articulate which form part of a nurse's intuition (Benner, Hughes, & Sutphen, 2008).

Reflecting in-action is a way that practitioners describe what they understand intuitively and is able to be articulated. However, it does not involve stopping and thinking (Schön, 1992). "Reflection-in-action is both a consequence and cause of surprise" (Schön, 1983, p. 328) which enables practitioners to cope with unexpected practice situations. According to Schön (1983), reflection in-action is bound by the time in which one's action can make a difference whether this be amidst action or beyond. This means for nurses, reflection-in-action may occur in minutes or over several or more shifts in which they are faced with the same problematic situation and context. Thus, reflection-in-action is temporally situated as one reflects on the past, the present, and what this means for future practice situations.

Schön used different terms for retrospective reflection— "reflection on knowing-and reflection-in-action" and "reflection on in-action" (Schön, 1992, p. 126). Benner (1982) referred to this as reflection on-action. It describes the 'stop-and-think' occasions wherein one reflects upon the reflection-in-action moments, and is a way of becoming aware of the understandings that were formed during those actions.

Patricia Benner: Learning Through Reflective Experience

Human experience is a source of reflection, and reflection on nursing experiences has become an essential part of nursing education (Benner & Tanner, 1987). The capacity for critical reflection is an essential nursing skill. It involves questioning facts and the validity of arguments and examining assumptions. Reflection assists nurses to reconsider potentially outdated approaches to situations in clinical practice, rather than accepting nursing actions without significant evaluation and understanding (Benner et al., 2008).

Benner (1984), in her seminal work '*From Novice to Expert*', described the development of nurses' capacity for intuitive decision-making. Her discussion of intuition alludes to Schön's description of reflection as the development of tacit knowledge. Benner argued that reflection in practice helps nurses to find deeper meanings within practice situations. There is a wealth of literature on reflective practice in nursing and the benefits for practice development and competence (Braine, 2009; Levett-Jones, 2007; Rees, 2013; Walsh, McAllister, & Morgan, 2002) supporting Benner's stance.

Benner noticed that upon exposure to different experiences with patients and families, nurses learnt from these experiences and developed what she called 'skills of involvement'. These distinct stages go from a novice student nurse needing to follow a 'to do' list, through to an expert nurse who has an intuitive grasp of a situation which is based on their in-depth knowledge and experience. They do not always rely on rules or guidelines to respond to a situation and can recognise the resources required to reach an outcome. They are able to prioritise what is a relevant and irrelevant problem in an evolving situation, focus on the 'whole' of a situation, and can notice more subtle changes in a patient's condition.

Benner: Intuition in Practice

Benner and Tanner (1987) defined intuition as "understanding without a rationale" (p. 23). They argued that the understanding within intuitive judgement was not accidental or mystical, and sought to better understand intuitive judgement through research involving interviews and observations of 21 nurses deemed expert by their peers. In every interview they found rich examples of intuitive judgement. While these aspects are separated by definition, they cannot be separated in practice and work in synergy with each other.

There is a strong link between what is happening with a patient and how the nurses intuition leads to action (Benner, Tanner, & Chesla, 1997). This is because Benner's adoption of Dreyfus' aspects of intuitive judgement shows that intuition leads to judgement, which leads to action. This is supported by Leners' (1993) observation that

"intuition carries patterns of information from the perceptual world into cognition and affect" (p. 138).

As nurses gain experience, they acquire additional skills which attune them to moments wherein they get more information. Primary health nurses need to be attuned to a range of different cues. Understanding their use of intuitive skills becomes important when working with children whom they suspect may have been abused and/or neglected.

Expert nurses use their intuition to look at the whole, and understand what is relevant in a changing situation (Blum, 2010). Thus, expert nurses have developed intuitive links through reflecting in-action, and are able to respond in situations because they can see what is salient. Their intuition is a kind of knowing, a bodily understanding where their body responds almost before they think.

Emmanuel Levinas' Philosophy of Ethics

The etymological meaning of ethics comes from the Greek word 'ethos' meaning 'personal disposition' (Ayto, 1990/2011), implying that ethics are part of who we are. Levinas' philosophy is based on a foundation of ethics whereby the presence of the Other is something we feel strongly. His notions are underpinned by a philosophy of ethical responsibility and how this means we relate to others. His postmodern ethics of human relations was developed during the second half of the 20th century (K. B. Mitchell, 2013). As a Jewish man, he lived during a time of persecution of the Jewish population, likely leading to his philosophy of ethical relations. Levinas argued against individuals becoming faceless in a crowd, thus potentially diminishing their worth and potentially endangering them. He contended that unless we approach social interactions as ethical relationships, we risk dehumanising the other person to the point where they and their life potentially become of no concern to us. His philosophy is a deliberate attempt to consider others before oneself.

Such is the importance of being ethical in nursing, that maintaining ethical standards is mandated by the International Council of Nurses (2021) who published their first Code of Ethics in 1953. Ethics in nursing centres on nurses as advocates, which supports Levinas' attempts at preventing diminishing the worth of others and potentially putting them in danger. This is particularly relevant for primary health nurses trying to build relationships with children and their families.

Levinas: Understanding Through Face-to-Face Encounters

Levinas' ethics is a framework for human responsibility which involves extensive exploration of the face-to-face relationship between people, leading to questions of social

existence and justice. His philosophy challenges stereotyping and generalisation that undermines and erodes human dignity. The notion of face-to-face encounters is underpinned by Levinas' view that we are not only responsible to, but for, the Other (K. B. Mitchell, 2013). When Levinas refers to Other, he is referring to the other person, someone other than oneself whom we meet face-to-face. Levinas' ethics proposes putting the Other first. He looks to the Other as lying absolutely beyond one's comprehension, that they should be preserved in all their irreducible strangeness. His notion of Other is a deliberate singular use of the word because he believes we encounter others one at a time, face-to-face (Critchley, 2002). He emphasised that when meeting someone, we first notice their face and that we are encountering the face (of the Other) as the living presence of another person in a non-subsumptive relation. When experiencing this pre-reflective experience, we cannot yet possibly know anything about the other, thus eliminating judgement. Non-judgemental care in nursing is a professional obligation (Koh, 2002); therefore, nurses need to enter any encounter with the Other without prejudging an outcome. Levinas' ethical relation concerning the Other attempts to protect the Other from the aggressions of sameness, hence his emphasis on the pre-reflective meeting of the Other.

Levinas: 'Face of the Other'

Nursing invariably means working face-to-face with other human beings. Moreover, most nurses feel responsible and accountable to those whom they nurse. Levinas believed we encounter the face of another person as a living presence, something which is experienced socially and ethically. The Other person is also exposed and expressive in other ways; for example, through speech, gestures, action, and bodily presence. However, the face is the most exposed, vulnerable, and expressive characteristic of the other's presence.

The Face of the Other represents an ethical call of conscience as a humanistic concern for our fellow human beings. For Levinas, the failure to acknowledge the humanity of the other is viewed as the worst that could happen. He argued that the worst can happen if our social interactions are not underpinned by ethical relations (Critchley, 2002). Face of the Other is important in nursing because it enables relations through accepting the Other and aims to prevent labelling and/or stereotyping. This allows the self to speak to the Other and identify the true needs of the Other, leading to action (a call for action). Thus, the approach to the face is the most basic mode of responsibility. It seeks to ensure that the other person does not become someone whom we simply pass and whose life or death becomes a matter of indifference. Face of the Other reveals how nurses are called to the other pre-reflectively and how this signals an ethical call to care.

Levinas: 'Responsibility for the Other'

In nursing, words such as 'tolerant', 'non-judgemental', and 'without prejudice' are used when describing how nurses should interact with patients and their families. While some philosophers such as Gadamer look at identifying pre-understandings and prejudice, Levinas took a slightly different but complimentary approach. Levinas argued that the encounter of the Other through the face reveals a certain poverty. This prohibits reducing the Other to sameness and, simultaneously, installs a responsibility for the Other in the self. Levinas' theory of responsibility is an ontological or fundamental ethic in that it asserts how things are rather than how they should be (Walsh, 1989).

Encountering the Other as a face, as a singular being and when exposed to their irreducible difference is when responsibility is most felt. Responsibility is felt despite oneself; one is pulled towards the Other as though it commands responsibility as a powerless force, unable to resist. Before and beyond reciprocation of any equivalent concern, oneself is responsible for the Other (Critchley, 2002). Responsibility is *my* affair; reciprocity is the other's. Thus, responsibility calls the nurse to action towards the Other. Responsibility in encounters means understanding that care is the foundation of a nurse's ethical existence when in a relationship with another (Slunt, 1994b). Furthermore, to experience the call in nursing is to want to relieve the suffering of others (Kallio, Kangasniemi, & Hult, 2022).

John Dewey

John Dewey was an American philosopher most known for his contribution to pragmatism, which is a problem-oriented philosophy based on the belief that an idea is true if it useful and/or works satisfactorily. Pragmatism originated in the late 19th century with Charles Peirce, followed by William James, John Dewey, and George Mead (Kaushik & Walsh, 2019). Peirce's pragmatism focussed on logic and the analysis of thought and signs, while James used pragmatism to answer what practical difference would result from trying to settle an endless metaphysical debate. Mead's pragmatism was grounded in moral theory and had strong links to his theory of the 'social self', focussing on the "individual as irreducibly involved in social relationships" (Keith, 1999, p. 328). Dewey's pragmatism focused on practical problem solving from one's experiences as a way of resolving uncertainty (Kaushik & Walsh, 2019). Through his process of inquiry, beliefs and actions become linked (Goldkuhl, 2012), and the relationship between action and consequences becomes known (Kaushik & Walsh, 2019). As I read the data from the interviews, I found myself thinking about how the nurses' past experiences and knowledge contribute to their actions, and how they consider the consequences of potential actions

and inaction. This led me to explore Dewey's notions of means and ends, and consequences because I recognised these notions in the data.

Dewey: Understanding Experience Through Action

Pragmatism represents the epistemological stance of pragmatics in that knowledge always comes from experience (Kaushik & Walsh, 2019). Fundamental to Dewey's pragmatism is the connection between thinking and purpose. Importantly, the purpose of thought is action. In pragmatism, knowledge only has meaning when combined with action, with practical application of knowledge being at its foundation (Bragg, 2005).

Pragmatism explores past experiences and what people interpret from these experiences. Thus, thoughts cannot be separated from action (Kaushik & Walsh, 2019). Dewey argued that humans learn through hands-on experience. The essence of Dewey's pragmatism is: thinking (our ideas) and knowledge (our theories) lead to action (the testing of our knowledge through action). This leads to consequences which give the action meaning and justifies its purpose, resulting in understanding the meaning of something (Dewey, 1922/2007). Based on consequences of an action, theories are developed to inform further action, illustrating Dewey's suggestion that pragmatism is a continuous and interconnected way of understanding and bringing meaning to experience (Garrison, 1998).

Dewey believed that experiences are social in nature and always involve a process of interpretation. Action is generated from the interpretation of one's beliefs, and further beliefs are generated from the interpretation of action (Morgan, 2014). In this process, the benefits and consequences of the decision about to be made are weighed up. Thus, it is the consequences which arise from previous actions which lead to understanding the meaning or purpose of a given situation. Consequently, future actions change with the possibility that responses or practice improves.

Dewey: The Continuum of Means and Ends

Dewey (1958) described means and ends as points along a continuum. The means-end continuum describes a process of evolving actions and understandings to achieve an end point. Means-ends help us develop more understanding which informs future actions. Thus, any consequences (ends) along the continuum inform further understanding and actions.

Dewey's view of consequences, while in themselves may be considered as ends, are also the means along the continuum to a final consequence. Means are the causal conditions employed to achieve the ends and include both the thoughts that lead to actions and the actions themselves. Means are a consequence at an earlier time (Dewey, 1958).

The value of means relies on its ability to achieve ends. Our judgment on the value of an end is tied with our judgement of the cost of achieving the end—both the means needed to get there and the unintended consequences of getting to the end (Dewey, 1958). Ends hold value in themselves and are either achieved or not. The value of the end depends on the costs or benefits of the means, of which consequences are a part.

Means are the ends-in-view. Ends-in-view are a plan, whereas ends are unforeseen accomplishments. There is no complete understanding of the end until the course of action to get to the end has been grasped. Practical judgements help identify obstacles that could be encountered in a situation, the means needed to overcome the obstacles, and the ends that are needed to be achieved to reach a satisfactory outcome in the situation (Dewey, 1916).

In relation to this study, means and ends has relevance. When a nurse recognises the signs of neglect or abuse within a child, this becomes the means and thus the reason to take action. It draws the nurse to make a judgement about the home environment and perhaps question what else is going on for the child. The consequences are related to the nurse's judgement about the child. Thus, it is the nurse's knowledge of the consequences for the child that bring the ends-in-view into focus.

Dewey: Consequence and Moral Judgement

Consequence is the outcome of an action which gives the action meaning and justifies the purpose of the action (Dewey, 1922/2007). Consequences can be unintended or anticipated and can be an outcome that is either positive or negative (Dewey, 1922/2007). An example of consequence can be deciding between two actions. The choice of one action will have consequences in terms of forfeiting the other. The act of making one choice over another is measured by the consequences, making the purpose of selecting one choice over another clearer and thus justifying this choice. Thus, consequence and purpose are invariably linked, meaning the consequence leads to understanding the purpose.

Considering consequences requires exploration of moral judgement because judgements have consequences and the value of our judgements depends on the consequences. Dewey (1922/2007) argued that morals are acts within our control yet to be performed. Until we know more about the conditions of those we approve or disapprove of, we are 'blind', and therefore not able to arrive at a moral judgement. Nurses who work in primary health are doing so in the environment, context, and conditions of the families they work with. Making judgements on the home environment of a child they suspect is at risk of abuse or neglect is based on the nurse's knowledge of the consequences for the child.

Hothersall (2018) justified the use of pragmatism in social work research because it enables the possibility of consequences. I would argue the same applies for this study in relation to the complex nature of nurses' work with at-risk children, and that the opportunities to 'get it wrong' can have significant consequences for a child, their family, and the nurse. It also allows nurses the opportunity to 'get it right' and experience better consequences that inform practice.

Summary

To gain a deeper understanding of primary health nurses' experiences, Gadamerian hermeneutics shaped how this study was conducted and analysed. Hermeneutic research has the potential to uncover complexities that have previously been hidden, unrecognised, and taken for granted. I have argued that understanding more about nurses' experiences with at-risk children will enable better understanding about the meanings and consequences for nurses who work within the context of primary care in New Zealand.

Insights from Schön, Benner, Levinas, and Dewey's philosophies helped to elucidate the meanings derived from nurses' experiences. When I was reflecting during the iterative writing-rewriting stage of analysis, notions from these philosophers assisted development of my interpretation of the data. This chapter has outlined the philosophical notions used to guide the study's research processes, analysis, and interpretation of data. The next chapter describes how I conducted the study.

Chapter 4 – Research Methods

Introduction

As discussed in the previous chapter, the philosophical underpinnings of Gadamerian hermeneutics were chosen to guide this study. The study sought to understand the experiences of primary health nurses who suspect a child is being abused and/or neglected. In this chapter, I outline the methods used during the research demonstrating their congruence with their philosophical underpinnings. Outlining the methods includes: describing the ethical approval process; recruitment and selection of participants; background information relating to the participants; consent, confidentiality, and anonymity; data collection; transcription and crafting stories; interpreting the data; and criteria used to determine trustworthiness and rigour.

Ethics and Approval for the Study

An ethics application was lodged with and approved by the Auckland University of Technology Ethics Committee (AUTEC) (Appendix A). The approval enabled me to recruit up to 20 nurse participants for the study. The initial AUTEC approval covered interview locations at an AUT campus (North, City, or South campuses). However, these locations and the after-hours scheduling of interviews proved a barrier for some participants, so I applied for an amendment to have the interviews at times and places which were mutually agreed upon between myself and the participant. Because the interview location can change the power dynamic during the interview (Quinney, Dwyer, & Chapman, 2018), it was important to ensure the location was one with which the participant felt comfortable.

This study did not seek to recruit nurses from any particular ethnicity; however, because Māori children are overrepresented in the statistics for child abuse and neglect, I was hoping Māori nurses, who are also underrepresented in the nursing workforce, would consent to participate. To uphold obligations to Te Tiriti o Waitangi/The Treaty of Waitangi[6], I needed to ensure the study upheld the key principles of partnership, protection, and participation (Hudson & Russell, 2009). Partnership included seeking advice from the Kawa Whakaruruhau Komiti, in the School of Clinical Sciences at AUT, to ensure the rights of any Māori participants were respected and protected. There were no additional recommendations from the Kawa Whakaruruhau Komiti in respect to the proposed design of the study. To ensure the protection of the rights of Māori participants

[6] The founding document between Māori and the British Crown formalising the relationship to recognise and protect Māori values (Hudson & Russell, 2009).

over their cultural values, any Māori concepts that were spoken would be clarified with them to ensure correct representation of their meanings.

In S195A of the Crimes Act (1961), nurses who do not take reasonable steps to protect children can be criminally liable. Therefore, I had to inform every participant before commencing the interview that should they disclose a failure to take reasonable steps to protect a child, I may be obliged to report this event. Thankfully, I was never in this position. All nurses interviewed worked under workplace policies of mandatory reporting and all explained that whenever they were in doubt, they sought guidance. Protection was also necessary to reduce the potential for re-traumatising the nurses who were telling their stories. This risk was mitigated by offering every participant three free counselling sessions through AUT Counselling services. No nurses availed this offer.

The initial conversation with participants included introducing myself, an explanation of the purpose of the study, and emailing them a Participant Information Sheet (Appendix B) if they wanted to consider participating. If I had not heard back after 14 days, I emailed again to enable further consideration to participate. No further contact after this ensured they did not feel pressured or coerced to participate, thus ensuring self-determination.

Aware that I, too, may be at risk of trauma because of the complex and emotional situations that might be shared, I enlisted the support of a trusted nursing colleague qualified in counselling. She was someone with whom I could talk should I feel overwhelmed by the interview data. This person signed a confidentiality agreement (Appendix C) which was kept in the office of my primary supervisor.

Consent, Confidentiality, and Anonymity

Once participants agreed to participate and be interviewed, they were emailed a Consent Form (Appendix D). When participants arrived for their interview, I re-explained the purpose of the study, the process of the interview, and asked if they had any questions. If they had not filled in a consent form, I would give them time to read and sign if they were still happy to proceed. Participants understood they could withdraw from the study at any time; however, no one chose to do so.

Participants' confidentiality was maintained by removing any identifiers they or I thought could lead to their identity being revealed. This included people's names and workplaces. I assigned a pseudonym to each participant unless they preferred a particular name. Consent forms were stored in a locked cupboard of the primary supervisor. All digital audio recordings and transcripts were assigned a numeric code and stored on a password protected hard drive during data collection and analysis. Any audio recordings were

deleted from the device they were recorded on once I received the transcripts from the transcriber. I read each transcript to check for identifiers, then sent the verbatim transcripts were sent back to each participant for verification and to check for anything they wished to delete or change. One person made a change to a named place that could potentially be an identifier. I also made changes to one participant's transcript because their workplace was unique and could potentially identify them. All computer files were stored on my AUT laptop which was password protected and covered by AUT's secure network. Recordings and consent forms will be destroyed after 6 years in secure storage.

Selecting Participants: Inclusion and Exclusion Criteria

The eligible participants were registered nurses with at least 1-year practice experience since qualifying. They currently worked in a primary health setting and self-identified that they had encountered children whom they suspected of having been abused or neglected. I excluded nurses with less than 1-year experience since graduating because practice experience helps develop nursing intuition and practice development, particularly situations which are unpredictable (Benner, Tanner, & Chesla, 2009). Additionally, within the first year of post registration practice, nurses often experience high stress levels and burnout symptoms (Epstein, Söderström, Jirwe, Tucker, & Dahlgren, 2020) and I did not want to add to this experience.

Exclusion criteria were those who had insufficient conversational English to be able to describe their experiences. While this was an exclusion criteria, it was unlikely to exclude any participants because nursing registration in New Zealand requires an IELTS (International English Language Testing System) score of 7.00 for reading, speaking, and listening (NCNZ, 2022).

Almost everyone who expressed interest in participating met the inclusion criteria. One nurse said she would have liked to have participated but knew she was not eligible because she had been practicing for less than one year.

Recruiting Participants

Nurses in primary care settings were invited to share stories of their experiences of working with children whom they suspect are being abused or neglected. Purposive sampling was used to select participants based on their experience (van Manen, 2014). Purposive sampling enables the researcher to select a sample from the population that they can learn most from based on the need to understand and gain insight into the phenomenon (Merriam & Tisdell, 2016). Snowballing is a type of purposive sampling

(Elliot, Fairweather, Olsen, & Pampaka, 2016) and was used to recruit several participants. Intermediaries were helpful for recruiting participants. These people were known to me through my nursing networks and had wide access to those working in community child health settings. Once I had confirmed they were happy to act on my behalf, I emailed them a poster to place on their work noticeboard. This had my contact details should anyone wish to enquire about participating. The intermediaries also offered to promote the research and hand out posters at staff meetings. Participants were also recruited through word of mouth. Advertisements were placed in District Health Board newsletters. The workplace advertisements were preceded by gaining locality agreements from two District Health Boards in the Auckland region which allowed nurse employees from those organisations to be part of this study should they so wish.

Although a colleague who works as a nurse leader in primary health expected that many nurses would want to tell their stories, I did not have an influx of interested nurses. I heard from several nurses in a short period of time but then had periods when no one contacted me. It seemed that taking time away from work, family, and other activities was limiting those who might be interested but could not spare the time. Participants who were interviewed early in the study told me they found talking about their experiences beneficial. Many had never had the opportunity to share their experiences and said they found it therapeutic. As such, they recommended the study to others in their network and, with patience, I finally recruited 13 registered nurses who met the inclusion criteria.

The Study Participants

Planning, interviewing, analysing the data and writing a thesis for an emerging researcher under supervision can limit the number of participants due to the time constraints within the doctoral process. I fell slightly short of the original intention to recruit between 15 and 20 participants. However, having interviewed 13 nurses, it was clear there were many very detailed stories to choose from and with the support of my supervisors, recruitment ceased.

Some participants had extensive experience working with at-risk children. Irrespective of how experienced they were, all nurses told stories which were insightful and seemed important. All participants were female and worked in the Auckland region of New Zealand. There are fewer male nurses working in community child health (NCNZ, 2019), thus the absence of male nurses is unsurprising. Male registered nurses comprise approximately 9.4% of the total registered nurse workforce, approximately 6.5% of the total registered nurse workforce in primary health, and approximately just over 2% of

registered nurses working in child health (NCNZ, 2019). The NCNZ child health workforce data combine community and inpatient child health areas of practice.

At the time of the interview, I asked if participants would like to disclose their ethnicity, of which all were willing to do. Two nurses identified as Māori, and two as Samoan. One nurse identified as Eastern European/English and 10 identified as New Zealand European/Pākehā[7]. The participants worked across a range of settings, one working concurrently in two settings, and one having previously worked in other primary health roles. Their pseudonyms, current role and ethnicity are outlined in Table 2.

Table 2.

Participants

Pseudonym	Current (and previous roles if applicable)	Heritage
Yvonne	Public health nurse	Samoan
Abby	Public health nurse	New Zealand European/Pākehā[3]
Ana	Public health nurse	New Zealand European/Pākehā
Megan	Public health nurse	Māori
Tania	Public health nurse	New Zealand European/Pākehā
Emma	Public health nurse	New Zealand European/Pākehā
Natalie	Public health nurse	New Zealand European/Pākehā
Aroha	Whānau ora nurse	Māori
Mary	Home care for kids nurse	New Zealand European/Pākehā
Amy	Nurse practitioner in general practice	New Zealand European/Pākehā
Debbie	Public health nurse, Healthy homes nurse	New Zealand European/Pākehā
Karen	Youth and adolescent nurse practitioner	English/Eastern European
Grace	Practice nurse, Care and protection nurse	Samoan

The nurses in this study gave their time, commitment, and stories generously. They re-told accounts of their work with children which, for some, caused distress. I appreciated

[7] Pākehā is the Māori term for non-Māori and non-Pacific Island people who have arrived and settled in New Zealand since colonisation.

their openness and honesty. Some of their stories were quite disturbing and I felt privileged to have been trusted with them.

Collecting the Data – Interviewing

Prior to interviewing participants, a pre-understandings interview was held between myself and my primary supervisor. Chenail (2011) suggested these are useful for exposing unconsidered biases or prejudices. Interpretation of lived experience is influenced by preunderstandings (Annells, 1996; van Manen, 1990) and it is thus important for the researcher to acknowledge these. Spence (2017) recommended that, following the pre-understandings interview, research students also need to attune to how their emotional responses reveal what matters to them; whether some interpretations are being weighted more than others, and how one's pre-understandings fuse with the participants' stories as well as other literature as analysis proceeds.

I transcribed the pre-understandings interview to enable a longer period of pondering and thinking about what had been disclosed. Next, I identified the pre-understandings as outlined in Chapter 1. I also made notes about the interviewing style my supervisor modelled to guide my own interviewing and to ensure congruence with hermeneutic philosophy. Throughout the analysis phase, I recorded and dated my emerging thoughts and interpretations in a journal.

Semi structured interviews of a conversational nature took place and were, on average 1.5-hours long, ranging between just over 1 hour to 2 hours. Before commencing recording interviews, I would give each participant time to think about a situation in which they vividly remembered working with a child whom they suspected was being abused or neglected. During interviews I wanted to ensure that I made my participants feel at ease as much as possible and thus free and open with their accounts of their experiences. When asking questions during interviews, I tried to minimise leading the participant with pre-understandings that I had already identified, and to ensure my questions maintained the integrity of the phenomenological interviewing process.

The first five interview transcripts were sent to my supervisor to get feedback on my interviewing skills. As recommended by Howitt and Cramer (2005/2016) and Spence (2017), questions in the interview remained open-ended and conversational, but led the participant sufficiently to stay focussed on the phenomenon. For example, when nurses spoke about their feelings and concerns, I would use the prompts "tell me more about that", "what was that like for you?", "how did that make you feel?" which according to Laverty (2003) allows the interview to remain as close as possible to the experiences

being described. I also remained silent at times to enable fuller descriptions (van Manen, 1990). On occasions when stories drifted away from the experience or question, I used gentle prompts such as: "can you tell me a bit more about…?".

As suggested by Crist and Tanner (2003), I recorded intonations, gestures, and physical expressions in my interview notes and these were transcribed into text. This assisted the subsequent analysis of experiential meaning. I distinctly recall times during the analysis where my notes on the non-verbal emotional response (such as facial expression and body language) of the participant gave additional meaning to their words. It was as though I was taken back into my visual memory of those moments because of the depth of emotion conveyed by the participant.

Considerations and Consequences for the Researcher and Participants

The sensitive nature of asking nurses to describe and relive their experiences with at-risk children was anticipated prior to commencing the research. The nurses participating often became deeply reflective during the interviews, providing very rich data. Some of their stories also prompted a range of raw emotions. I sensed their feelings of frustration, distress, bewilderment, grief, and, paradoxically, both hopelessness and hopefulness. As well as sensing their feelings, I could also see how nurses felt by their facial expressions and body language when they remembered particular situations. Sometimes this was so powerful I almost felt as though I was experiencing some of the emotion the nurse was re-experiencing.

Transcribing and Re-Crafting into Stories

The interviews were recorded on two devices to allow for one device failure. I transcribed the first interview which took a significant amount of time but allowed me to become very familiar with the data. Subsequent audio recordings were sent to a professional transcriber and transcribed verbatim. The professional transcriber was an AUT approved transcriber who signed a confidentiality agreement (Appendix E).

When reading and rereading the transcripts, there were stories which commanded my attention. I was captured at times by an emotional, almost visceral, response to some stories and had to work hard to ensure my attention remained focussed on the research question. After reading, rereading, and identifying stories from a transcript, I started to craft the important stories. Crafting stories involved rewording the text without changing meaning to improve flow and reduce grammatical errors (Smythe, 2011). I also removed extraneous detail from the story (Crowther, Ironside, Spence, & Smythe, 2017). The

interpretive process of crafting stories seeks to show the experience and engage the reader while maintaining the participant's meaning (Crowther et al., 2017).

As I worked my way through the transcripts, I found myself noticing the recurring nature of thematic ideas. Essentially these became sub-themes which, over time, became the main findings of the study. It was through working with each transcript individually and then together that the essential elements of the nurses' experiences were developed.

Interpreting the Data

Gadamer's hermeneutics guided the analysis and interpretation of the data. During the analysis there is much to-ing and fro-ing between the researcher and the data, between the researcher and literature, and between the data and the research question. This dialogic process enables the researcher to consider the parts and whole of the phenomenon. It exemplifies the nature of the hermeneutic circle in the interpretative analysis of the texts (Gadamer, 1975/2013). The iterative questions that are posed and consideration of possible answers during the process of hermeneutic analysis led to new interpretations and insights, thus demonstrating the dialectic nature of hermeneutic research.

Writing, reading, thinking, and rewriting characterised the analysis. It began with crafting stories and writing interpretations of these. This was an evolving cyclic activity where I questioned whether my interpretation captured the nurse's experience; whether there was anything I was not seeing or responding to; and whether there were any interpretations I was privileging over others (Spence, 2017). This cyclic activity including self-questioning occurred throughout and within the analysis. As themes emerged, I put each on an A2 sheet of paper. Using a mind mapping approach (Appendix F), I created a visual display which showed a main theme as a whole, and the sub-themes as smaller parts of the whole. Themes changed slightly in order to better elucidate their meaning. The sub-themes evolved more often as I moved between interpreting and understanding the data contributing to the whole and the parts of the phenomenon. Continuing to think, ask questions about meaning, and rewriting helped to reveal connections and overlap. Thus, the whole and the parts were continually shifting in a dialectical manner while I made sense of the nurses' experiences. At times this was confusing and challenging but there were times of clarity where I was able to connect the part to the whole and vice versa. As Smythe, Ironside, Sims, Swenson, and Spence (2008) suggested, understanding comes from the writing in hermeneutic phenomenological research. It was this writing, thinking, reading, and rewriting that led me to explore other philosophers. As discussed in

the previous chapter, the writings of Schön, Benner, Levinas, and Dewey helped to develop the findings more fully. The decisions taken to use these philosophers occurred throughout the analysis stage. Nurses work ethically within relationships and reflect upon these. Thus, drawing on Levinas to illuminate ethical relations and Schön and Benner to deepen understating on reflective practice was important. The writings of Dewey helped to illuminate the ways in which nurses understand the consequences of child abuse, and the connection between the means and ends they employ.

There were so many compelling stories from the nurses' experiences, but they were not always aligned to the research question. Sometimes I drifted towards the experiences of families and children and had to reorient to the nurse. At times I struggled to focus only on the experiences as lived by the nurses rather than being side-tracked by my opinions of their stories and the concerns they generated. My supervisors challenged these beginning interpretations. Their questions ensured that I did not settle for superficial analysis and remained focused on articulating deep and thought provoking findings closely aligned to the research question.

Rigour, Relevance, and Trustworthiness

The rigour of the research process and the relevance of research are both encompassed in the concept of trustworthiness in qualitative research (Finlay, cited in Baillie, 2015). The first criterion for establishing trustworthiness is establishing whether the study is understandable and appreciable (Annells, 1999) and that the findings are believable (Koch, 1996; Lincoln & Guba, 1985) or plausible (Koch, 2006). Believable and plausible are some of Koch's (2006) terms for rigour. The findings of this study will be critiqued by its readers in this regard. The worth of a study comes into question if it is not easy to comprehend or interesting to the reader. This is not intended to minimise the researcher's role in ensuring rigour. It behoves the researcher to write a persuasive and coherent account of their findings (Rolfe, 2006) to ensure it is understandable and appreciable.

The second criterion for rigour is providing evidence of a clear decision trail (Annells, 1999). Koch (1996) suggested that a journal describing the researcher's decisions, both theoretical and philosophical, can potentially establish trustworthiness, and thus the practice of journaling creates an audit of events. As Annells (1999) asserted, the researcher needs to plainly and simply allow the reader to see the methodological decisions that led to the interpretations, which are essentially the findings in hermeneutic research. This is what helps make the research process understandable to the reader. It

does not mean, however, that the researcher and readers' perspectives or horizons will necessarily be the same. Rather, that the reader should be able to follow how the researcher achieved the interpretations (Rolfe, 2006). Establishing the trustworthiness of a study through conversations with others, in this case, other nurses working with at-risk children, is important. This is exemplified by resonance with the study's findings (Smythe et al., 2008).

The third criterion for establishing rigour relates to assessing the usefulness of the study; that is, determining its value for nursing practice and, potentially in this case, for the children and families receiving nursing care. Thus, typically, hermeneutic research does not fully establish usefulness until nearer the end of the study.

The fourth and last criterion for rigour is establishing whether Gadamerian hermeneutics was the right choice of methodology for the study. This was done by critiquing whether or not the study adequately describes nurses' experience of working with children who may have been abused. Additionally, the wording of the research question needs to show there is meaning and experience to be found.

Demonstrating researcher self-awareness enhances credibility in qualitative research (Koch, 2006). This was achieved through regularly journaling my reactions to the stories and literature used in this study. Journaling is an experience in which the researcher is living the hermeneutic circle (Koch, 1995). I was able to see my horizons surfacing, being challenged and extended. Returning the crafted stories to participants for checking was another technique for ensuring rigour (Baillie, 2015). Readers also play an important role in determining the credibility of the findings, wherein they resonate with them even if they have different interpretations. Credibility may mean recognising experiences they have had themselves, or that they have a connection with the study findings. Furthermore, interpretations continue after the study ends (de Witt & Ploeg, 2006). The researcher and readers may experience this at a later time, for the thinking continues. "It would be a poor hermeneuticist who thought he could have, or had to have, the last word" (Gadamer, 1996, p. 579).

Summary

This chapter has outlined and justified the research methods used in this study. I sought to ensure congruence between methodology and methods. A hermeneutic approach provided the framework for collecting the data and driving the findings. Thus, in the analysis phase, my interpretation of the data led to the introduction of notions from other philosophers and theorists. Creating a persuasive argument, journaling for the purpose of

creating a decision trail through writing and rewriting, were activities undertaken to ensure the rigor of the study. The following chapter will begin to present the findings.

Chapter 5 – Building and Nurturing Relationships

Imagine, for a moment, that you are a nurse working in the community. You are meeting with a family for the first time having received a referral about their child. After reading the referral notes and case file, you are alerted to the possibility that something may not be quite right. You wonder about risks for the child, but you worry that you might be wrong, so you try to keep an open mind. Going into an unknown environment, you do not know how you will be received. The family has the right to decline health services and can refuse to see a nurse (Health and Disability Commissioner, 2018). You know you need to build and nurture a relationship with the child and their family.

Primary health nurses who work with children who may be at risk of abuse know that relationships are the priority. What matters most is that nurses get to know the children and families with whom they work. This is essential if they are to offer help and support. Yet, every child is uniquely situated, often in dynamic and uncertain circumstances. Thus, the nurse-client relationship is important, and establishing this relationship is crucial (Castledine, 2004). Nurses' relationships with other health professionals and agencies are essential for referrals and when families need additional support beyond that of the nurse. Thus, building and nurturing relationships with families and interprofessionally is critical.

Of all nursing actions, nurses' interpersonal skills are the most important (Peplau, 1988). Whanaungatanga (making connections in relationships) is such an important Māori concept that it is included in nurses' competencies for safe cultural practice (Counties Manukau District Health Board, n.d). Because Māori are often vulnerable when receiving healthcare (Carlson, Moewaka Barnes, Reid, & McCreanor, 2016), the relationship becomes one of an ethical relation. The data in this study showed the importance of relationships to nurses, which drew me to explore the work of Levinas and Face of the Other. Levinas' approach to relations is grounded by an ethical call which compels a responsibility for the Other person when face-to-face (Knapp, 2015). Levinas used the terms Other and Otherness to describe those other than self when encountered face-to-face (Critchley, 2002). Otherness rejects sameness, thus challenging the idea that one can come to completely understand their clients/families through professional knowledge and skills alone (Davis, 1996). When encountering Other, we meet their faces, one at a time. However, it is not the physical attributes of the face which are noticed in the first unreflective encounter; rather, it is the total strangeness of the Face of the Other.

Strangeness, to Levinas signifies another person who is different to oneself, but also vulnerable to oneself and thus strangeness is always relational (Saldukaitytė, 2016). Rather than thematising their suffering, we are drawn to appeal of their expression.

Therefore, the Face of the Other signals an ethical call of concern for others. Levinas believes that when encountering the Face of the Other, we are immediately compelled into ethical relations (Levinas, 1985). He argued that if ethical relations are not at the foundation of our interactions with others, then the Other becomes vulnerable. The Other is rendered vulnerable when thematised or stereotyped. The Face of the Other prevents this because it enables relations through acceptance of the Other. The notion 'responsibility for Other' rejects sameness, further validating the right of the Other to exist and not become invisible. This chapter draws on Levinas's notions of the Face of the Other, and responsibility for Other to illuminate nurses' experiences as they try to establish relationships with families whose children may be at risk. To prevent or mitigate consequences that could occur if Face of the Other and responsibility for Other are not preserved with children or their family, nurses may need to act. Thus, nurses' recognition of these consequences become their means to take action in order to achieve the ends (goals). Thus, analysis also draws on Dewey's notions of means-ends and consequences.

Building Relationships

Primary health nurses work hard to build relationships with children and their family, always with the intention of establishing rapport and gaining trust. The relationships are built across a range of settings including homes, schools, GP practices and community-based nurse-led clinics. Nurses work alongside children, their parents/guardians, and liaise with teachers, social workers, doctors, other nursing colleagues, and their own managers. There are times when building relationships occurs relatively easily but more often it is complex, challenging, and uncertain. Perseverance is essential for a nurse to adequately assess and respond appropriately in any given situation (Schaepe & Ewers, 2017). The delivery of nursing health services in someone's home is fundamentally different from doing so within an institution (Jack, Ford-Gilboe, Davidov, & MacMillan, 2017). Nurses interact with people in their homes as guests (Jansson, Sivberg, Larsson, & Uden, 2002). Thus, a cornerstone of the visiting nurse's role is the development and nurturing of the relationship with their clients (Jack et al., 2017).

Debbie remembers Wiremu who was 5-years old and being looked after by his grandmother, both of whom were Māori. Debbie struggled to gain consent to be allowed into the house so they could talk about Wiremu:

> *So this is a grandma who didn't answer the front door the first time I knocked, so I went around the back and she spoke to me through the laundry window. In order to talk to someone from the laundry in a State house, you had to physically lean over the tub, so there was a high level of suspicion. After about 3-4 visits talking to me*

> *through the window, I realised that unless I was useful, my relationship with her wouldn't work. I needed to prove I was useful and reliable quickly. On the fourth visit she said to come around the front, which I knew was a big step. So I went around the front and into the house. It was extremely clean and extremely stark, there was almost no furniture. We sat down and talked about a lot of issues, and we formed an extremely close relationship.*

Debbie knows that trust is critical in building relationships. Providing home nursing care requires a trusting relationship (Wälivaara, Sävenstedt, & Axelsson, 2013), and while Løgstrup (1956/2020) believed trust is present in initial human encounters, it is clear that the grandmother's early suspicion reveals an absence of trust. This unspoken mistrust is illustrated in her actions. Debbie's past experiences have informed her present understanding that persistence may help develop trust. Her home visits continued even though she had to conduct these from outside the laundry window, perhaps hoping that respecting the physical boundaries initially set by the grandmother would build trust. As a Pākehā nurse, she accepts the suspicion towards her and thus subordinates herself to the grandmother by waiting and not imposing herself or rushing the grandmother until she is ready to trust. Home visiting nurses typically 'read' the person to establish whether they are ready for a relationship and ongoing contact, and when the first visit does not go well, nurses do repeat visits to try and develop a relationship (Wälivaara et al., 2013). Debbie's approach to building a relationship and trust also included proving she was useful. During her attempts to build a relationship, Debbie does not know if she will be able to form a relationship with the grandmother and address the issues Wiremu is facing. During visits conducted from outside and around the back of the house, Debbie experiences uncertainty as to whether or not the grandmother will grow to trust her. Debbie's understanding about needing to be useful comes from being forced to view this situation as different to what she may have expected.

Levinas' notion of absolute Otherness encompasses the subordination of oneself to the Other, and includes the belief that the Face of the Other will only be revealed when the self is open to receiving the Other on their own terms (Ucok-Sayrak, 2016). In other words, when the grandmother is ready to start trusting Debbie, she will reveal this, which happened when she invited Debbie to the front of the house. Nurses' felt responsibility to build ethical relations underpins Debbie's relationship with the grandmother. She feels responsible for establishing trust, preserving the absolute Otherness of the grandmother, and to help keep Wiremu safe.

Aroha describes how she draws on personal knowledge of Māori cultural practices and takes time when trying to build a relationship with whānau:

> *Working in a Māori organisation we work on building that therapeutic relationship and trust right from the beginning…. I've learnt over time and use the pōwhiri*[8] *process. It starts when I am welcomed into a home and go from tapu* [that which is sacred]*, to sharing a bit about each other, where it then goes to noa* [free from the restrictions of Tapu]*, or normalised. I use my life experiences and share something we have in common and try to make a connection with them so they start to feel more relaxed. I try not to be overpowering, as nurses can sometimes be seen as overpowering, and I'm not going to tell them what to do and how they're going to do it. I work alongside them. The relationship builds from there. It's a skill I've learnt over time and you have to have the time to develop the relationship. In the community, we have that time.*

Levinas' (Critchley, 2002) reference to Other is another person and acknowledgement of an individual; therefore not someone reducible to a number or generalisation. However, Māori culture values whānau/family rather than the individual. An important cultural value is the collective nature of health and wellbeing of whānau (Te Puni Kōkiri, 2010). Therefore, when working with Māori, consideration of Other as the collective/whānau rather than the individual is important.

Historicity underpins Aroha's understanding; thus, she draws on past nursing experiences and cultural knowledge to help build relationships. She describes the process she goes through to build relationships right from the very beginning of an encounter. Aroha shows respect for whānau by starting with a pōwhiri and thus acknowledges the traditional importance of entering a new space. Pōwhiri is offered by a host (Te Ara: The Encyclopedia of New Zealand, 2013) in a time and space by the person holding the knowledge (McClintock, Mellsop, Moeke-Maxwell, & Merry, 2012)—in this case, the family. Not flaunting one's own knowledge, or *kaua e mahaki* (McClintock et al., 2012), is an essential part of the pōwhiri process. Aroha's past and present experiences are the source of her anticipating that she could be perceived as overpowering. She is thus able to moderate her behaviour with whānau, illustrating her understanding that a power imbalance could occur which comes from horizons formed from past experiences. By consciously avoiding being overpowering, she is upholding whānau as the holders of knowledge pertaining to themselves. Aroha does not assume that her nursing knowledge and skills are the only way of getting to know and understand whānau. She gives power to

[8] Pōwhiri -Māori process of welcoming visitors (Keane, 2013).

whānau in order to build a relationship that is respectful of their shared cultures, demonstrating cultural humility by putting the Other before herself. Aroha is mindful not to impose upon whānau, illustrating Levinas's recognition that the "face resists possession, resists my powers" (Levinas, 1961/1969, p. 197).

While shared culture enables the use of pōwhiri, no two whānau are the same; thus strangeness always exists when meeting Other. When encountering strangeness, Aroha tries to find something in common to build a relationship so she can find ways to assist whānau. At such time, the face of whānau compels Aroha to know more. This is explained by Levinas (1961/1969) as "the Other faces me and puts me in question and obliges me" (1961/, p. 207). For Levinas, Other is only revealed when self is open to meeting Other on their own terms, thus preserving the uniqueness of the Other. However, use of culturally appropriate ways of initiating relationships which preserve Other, do not guarantee that whānau will warm to Aroha. Aroha knows that she must continue to develop the relationship if she is to avoid the risk of being turned away.

Although Tania is Pākehā, she, too, understands the cultural importance of ancestral roots when trying to build rapport and trust with Māori families:

> *Connecting with families is important. Māori do this really well. Connecting is about finding out where they're from, sharing where you're from and giving them the chance to talk about themselves, such as where they were born, where they grew up and sharing common things with them.*

Like Aroha, Tania recognises the importance of sharing when building relationships with Māori. An openness to learning from whānau suggests Tania understands the need to know what is unique about every whānau. Her understanding shows the importance of respecting origins and connections. Finding out about and sharing backgrounds helps to build relationships that are meaningful. Whether consciously recognised or not, Tania is respecting whakawhanaungatanga, the process of establishing relationships which, for Māori, respects the establishment of cultural and personal connections (Levack et al., 2016).

Enabling whānau to take the lead when connecting with others and to express their own agency are important aspects of whakawhanaungatanga (Ministry of Education, n.d.). Her horizons of being a Pākehā nurse honouring relationships with Māori is evident in her understanding of how to connect. Having whānau express what is important to them while making connections, enables the nurse to better understand their Otherness. Such aspects of experiences with another person are described by Levinas as the Face of the Other (Knapp, 2015). Therefore, we experience the Otherness of the Other as not just the

physical presence of a face—the Other is not reducible to subjective generalisations or characterisations. The whānau in front of Tania are the Face of the Other, a face who calls for respect and care (Lavoie, De Koninck, & Blondeau, 2006). Thus, respecting and supporting cultural connections through whakawhanaungatanga is as much about building connections as it is experiencing the Face of the Other. This is because respecting whakawhanaungatanga places whānau central in the relationship, illustrating Levinas' (1991) attempts to prevent one's desire to control the Other. Respect and trust are more likely to be formed within the relationship when the nurse preserves the Otherness of the Other. This is the call to responsibility for the Other (Knapp, 2015).

Grace, who describes herself as a Pacific nurse, recognises the ways her tradition and culture have shaped how she relates interpersonally with Pacific people. In a similar, yet different, way she describes the ways her own culture helps her to build relationships:

> *I think as a Pacific nurse, I bring my values to my practice, like trying to reconnect with families and finding out their family background. For Pacific people, we all love our families and we have big families! So it's trying to build a family kind of vibe. Pacific Islanders are a lot more relaxed and informal in the way they do things, and that's kind of my nursing style, to be more relaxed and chilled. I try and be like this with the kids, so it's a more relaxed approach. I think Pacific families build trust much quicker with me because I'm Pacific, and feel I understand where they're coming from.*

Grace describes how she uses her Pacific heritage to build relationships. She knows from her own cultural background that using a relaxed approach will help her clients feel more welcome. Her efforts to create an informal space with a 'kind of family vibe' show her intention to encourage feelings of security and trust. She wants families to feel relaxed with her and knows this contributes to establishing connections and trust. Respecting mutual cultural values builds trust and shows respect for the Other. Grace is attending to this engagement using what Reynolds (2019) described as the relational concept of *va* which is unique to Pacific people. *Va* is the space between people and includes spiritual, social, and physical dimensions, and is nurtured by respecting the sacredness of this space alongside the balance and harmony within relationships. It is as though the *va* between Grace and the Pacific families she works with is the space where the difference between the self and the Other exists; the space where the irreducible strangeness of the Other awaits the self. However, *va* is not where knowledge is attained, thus it is not an epistemological feature. It is where the Other's Otherness is most exposed to the self, best reflecting Levinas's ontological ethics where the self-recognises their responsibility to the Other. Grace's call to preserve the Otherness of the Other by embracing shared culture is

one which Levinas believes arrives upon us as an ethical responsibility (Knapp, 2015). Being responsive to the Other in a way that preserves their Otherness is a way of making meaning of one's own existence (Levinas, 1981). Therefore, making sense of one's own existence is entirely dependent on the Other's Otherness (Jaworski, 2022). The similarity and familiarity of another human gives way to Otherness in order to have any sense of 'I'. Furthermore, there is no choice in that one's own sense of existence is inherently tied to the existence of the Other (Levinas, 1981). To act upon the ethical responsibility to the Other and to thus understand where her Pacific clients "are coming from" helps Grace create meaning of her own existence. It is as though their cultural identity further informs her own, reflected back with her genuine attempts at building relationships through a "more relaxed approach". This interdependence brings meaning to how we exist ethically, both with and for other human beings (Jaworski, 2022). However, like Aroha noted, there is no guarantee that being of the same culture as a client will assure a successful relationship.

Upon meeting families for the first time, nurses must quickly assess how they can build a relationship and build trust. In nursing, everyday relations with others are assisted by using a range of interpersonal skills which, in turn, help them to understand the needs of a family and assess risks that may be present. For some, building relationships is achieved through helpfulness as Debbie explains:

> *Families being open to a relationship with nurses is circular with helpfulness. I think that people perceive that we want to support them so we work it out together.*

When visiting families in their homes, nurses often have to establish relationships within short time frames in order to assess risk sooner rather than later. The need to protect children is an ethical call that requires a relationship to be formed. Debbie knows that helpfulness and building a relationship are ongoing and temporal. This is because being helpful depends on what needs are worked "out together" at different times throughout the relationship. What families require help with will change over time depending on the nurse's understanding of needs as they change over time. As understanding evolves, Debbie and the family do not necessarily go back to previous understandings. However, these previous understandings inform future understandings and areas wherein helpfulness is needed. Thus, like the hermeneutic circle, there is more of a spiral than a circularity of understanding, continually transforming into the next action with the family in regard to what is needed to be worked out. Being helpful comes from Debbie's deeply held belief that her calling is to protect those who are most vulnerable and is her way of establishing trust. Her understanding of the cyclical nature of relationship building based

on helpfulness is her way of making meaning as a nurse. She is called to responsibility which in turn transforms into action.

Berman's (1994b) assertion that nursing is a profession characterised by a responsibility towards Others draws on Levinas' notion of responsibility where a face calls another to their sense of responsibility towards them (Toumayan, 2014). Being a nurse could be described by Levinas (1961/1969) as both a legitimate personal interest as well as a calling from an exterior source. The latter is choosing that which is outside of self-interest. Exteriority enables an encounter with the Face of Other, and resists the pursuit of self-interest (Aasland, 2007). The face of those whom Debbie is serving calls and compels her to protect the children.

Debbie recalls situations when she has suspected domestic violence. She has visited homes and seen holes in the internal walls. Although immediately concerned, she is careful not to show it. The priority is to start building a relationship and develop rapport in order to gain trust:

> *…holes in the wall. That's a huge indicator of violence. I would always ask families how this hole came about. So I would just go around the house and would ask: "How did this hole and that hole happen?" When they'd explain, I'd say: "oh, that's interesting" or "that's unusual". People would either talk or not talk. Once I went to a house and counted 16 holes around the double bed. There was no other explanation apart from family violence, so I ended up sitting down and I said to her: "it feels like there's a lot happening in the bedroom, is that to protect the children?" And she said "yes". She said yes because I didn't ask her if it was violence. I just asked about protecting the children. That conversation formed a connection with us.*

Debbie's responsibility to the Other, those who are vulnerable, necessitates her to find a way to communicate in order to build trust and establish a relationship. She knows that women who experience domestic violence use a protective strategy of maintaining secrecy (Haselschwerdt & Hardesty, 2017). Nurses often have a gut feeling that a woman is living with Intimate Partner Violence and worry about how to address their concerns (Jack et al., 2017). Debbie's concern about what might be happening in the house comes from being able to see the physical environment. This encounter leads her to suspect that the mother is protecting the children by isolating the violence to her bedroom.

According to Levinas, taking care of the Other is not only impossible to resist, but is a moral obligation (Lavoie et al., 2006). Therefore, Debbie initially asks questions in ways that allow the conversation to go where the mother wishes. She uses an approach described by Ben-Ari and Strier (2010) as showing humility and open-mindedness

through dialogue. However, if trust is not established she may not receive a disclosure. Unable to resist the ethical call and her responsibility to the Other, she uses frankness as a means to develop trust by asking the woman a direct question. Acknowledging the woman's need to protect her children is a significant way of building trust.

Nurse's uncertainty about how to respond to a concern triggers reflection on-action, which is crucial for practice development and knowledge (Tanner, 2006). Debbie's reference to having had past experiences when confronted with holes in the walls of homes is likely to have informed her responses in this situation. Her frank approach is particularly skilful considering that, according to Gear, Koziol-McLain, and Eppel (2021), "uncertainty often manifested as doubt of what to do when a primary care professional encountered someone impacted by violence" (p. 1). Dialogical face-to-face encounters enable those receiving health services to reveal more about themselves (Jopling, 1999, as cited in Tsang, 2017) and can lead to health professionals understanding the Otherness of the service user (Pask, 2005). Thus, the woman's disclosure signals that a relationship based on trust is developing.

During another home visit, Debbie ascertains the risks to children and the mother living in the house. This story reveals understanding of the Otherness of the woman she was visiting:

> *I turned up to a house one day and the woman had a black eye. I asked her how she got that and she said she ran into a door, so I said, "oh that's such a relief, most women I've met have been hit by their husbands". And she said, "really?" And I said, "oh yeah, happens around here", and she said, "oh that's what happened to me". What I found out is you completely take what people say at absolute face value. It's not that I don't challenge it, but I accept the answer. And that was the most powerful thing I could do, to accept the lie, and sometimes people would disclose and sometimes they wouldn't. And if they didn't, I'd usually go back and just say, "oh I forgot to ask you something" – in case they'd had a think about it.*

Debbie's past experiences have informed her present understanding that accepting someone's answer "at absolute face value", even when she suspects it is not true, can help a relationship to develop. While accepting the woman's answer, Debbie's response creates an opening for the woman to reveal the cause of her black eye. She makes the woman feel safe enough to disclose abuse by normalising the experience of getting a black eye in saying that it "happens around here" to reflect the commonness of domestic violence.

While noticing the woman's black eye, Debbie sees beyond it. She sees the Face of the Other, a woman who exposes her vulnerability, leading to Debbie experiencing the

encounter ethically. Debbie's humanistic concern for the woman in front of her represents what Levinas calls one's ethical call of conscience (Critchley, 2002). Her past experiences and ethical call direct her response in the midst of the face-to-face encounter, and become the means needed for developing a relationship while still engaged in this encounter. Thus, Debbie hopes that accepting the lie will allow the woman to trust her with the truth.

Debbie's approach enabled the woman to open up and be seen in all her Otherness. Burggraeve (1999) stated that we are only able to see what the Other reveals or "gives us *to see*" (p. 30) in any given moment, and that the Face of the Other invites us into its being (Berman, 1994b). Without Debbie's skills in this situation, the woman may not have shown her face or, as Levinas would say, her gaze and thus her call (Wang & Jian, 2022). This highlights the importance and need to place building relationships at the centre of nursing care.

When building relationships, it is vitally important that nurses are upfront and clear about their legal requirement to report safety concerns, known as 'limited confidentiality'. Most nurses in this study spoke about limited confidentiality, meaning that when they first meet families, if there are concerns about a child's safety, then confidentiality will give way to the need to report the concern. Therefore, nurses cannot assume that families will ever have total trust in them. Aroha describes her approach:

> *When I first meet a whānau and I'm building that relationship, I say to them all the time "if there is any harm to yourself or other people, or I feel there's any safety issues, I do need to let people know".*

As part of building relationships, Aroha does not want to risk breaking whānau's trust, and therefore needs to explain limited confidentiality and her obligation to report actual or suspected harm. Nurses in New Zealand are bound by privacy legislation to keep client information confidential; however, there is provision for reporting harm (1993). Aroha illustrates her care and concern for whānau by telling them about her obligations when they first meet, and reminding them "all the time". This is because of the potential that reporting concerns and thus fulfilling her professional and legal obligations will interfere with trust. Thus, for Aroha, building relationships is founded in ethical relations.

The tension inherent in having to report concerns lies between Aroha's ethical obligation to report and the value she places on her relationships with whānau. This does not mean she doubts whether to report or not; rather, it illustrates her unwavering commitment to whānau even in the presence of concerns. Thus, the tension of potentially breaking trust if concerns arise is with Aroha at all times when building relationships.

There is a human being behind any concerns Aroha may have who remain deserving of her attending to them as Other. To place importance in building trust with whānau is to understand that reporting concerns could render the relationship vulnerable, thus requiring a moral and ethical approach from the beginning of a relationship. It is, therefore, the Face of the Other during encounters with whānau which demands Aroha's attendance to her responsibility of building trust and being upfront.

Like Aroha, Tania also works to build relationships and trust:

> *So much work goes into setting up relationships with families. When you're engaging with families at any level, you have to do a lot of listening and a lot of setting up that relationship, and it's based on trust.*

Tania also understands the importance of establishing trust with families when building relationships. The first time a nurse meets a family in a home visit, they are strangers but the nurse is also a guest. Because a trusting relationship does not automatically occur, the nurse has to consciously develop it (Wälivaara et al., 2013). Trust is an intangible asset in nursing, one which is regularly cited as being long standing in public opinion (Rutherford, 2014). It can sometimes mean that nurses are granted automatic trust at the beginning of a relationship. However, in more challenging situations where the nurse wants to observe the environment and assess the risks to children, to be let in they have to develop a relationship and establish trust. When health professionals are not able to accurately predict what could happen, uncertainty develops (Gear et al., 2021). Thus, even though Tania puts "so much work… into setting up relationships with families", she is uncertain about whether or not she will succeed in her efforts to establish trust. Experience tells her that listening and establishing trust are interrelated and interdependent. She will not be able build trust without "a lot of listening"; however, she needs some degree of trust for the family to let her in and allow her to listen to them.

Placing trust in another can make people feel vulnerable, and brings an expectation that the person who is trusted will maintain the Other's dignity. Hence, an ethical demand exists (Løgstrup, 1956/2020). Tania's ethical obligation to families demands what Levinas (1985) calls a responsibility for the Other, wherein she suspends any judgement and sees the Other/family for their uniqueness and individuality. Tania describes how she puts "so much work into setting up relationships" including the significant approach of listening in order to establish trust when a new relationship is being formed. Listening is giving those Tania works with a voice, and "requires a mind that is consciously, intentionally, and wilfully directed to attend fully to the voice of another" (Lashley, Neal, & Slunt, 1994, p. 190). Listening is both hearing what is spoken and having contextual awareness of whom is being given voice (Lashley et al., 1994). Families often feel vulnerable when someone is

observing them in their home, or at a time when they need assistance with healthcare. Thus, in nursing, listening is to understand power imbalance and the vulnerability of families.

There are, however, times when cultural difference is beneficial to the relationship between the nurse and family. Debbie, who is Pākehā, worked with a Samoan family whom she referred to Oranga Tamariki because of physical abuse by the stepfather towards a young child.

> *The CYFS social worker was Samoan, extremely well known and a very highly regarded social worker. She came to me incredulous and said, they [Samoan family] really only want to deal with you Debbie, they don't want to deal with me. The CYFS social worker said, "we don't get that Debbie, you know that's not normal". I think it was more than just our relationship. I think what happens when you're Palangi [Samoan term for non-Samoans] and you're working with Samoan Cook Island families, is they know you won't know anyone who they know. And there is an issue of shame, meaning you can't go to church and tell anyone or you can't be involved in anything.*

Debbie's response is initially one of surprise. She has built a strong enough relationship with the family that they prefer her over the Samoan social worker. This illustrates the trust Debbie has built with the family, and that they are prepared to make a choice which, according to the social worker, is "not normal". The family trust Debbie to maintain their privacy, and thus their dignity in their community where everything is known and shared. Debbie's assumption about who families choose to work with has been challenged. Thus, historical horizons have fused with new horizons, creating new understanding about what some families value most in their relationship with health professionals.

The ethics of Levinas's notion of responsibility for the Other can be translated to nursing ethics as a way of preserving, protecting and enhancing human dignity (Kong, 2008). Responsibility to another is felt most when exposed to the Otherness, or differences of the Other.

Most nurses' visits thus far have been in the home environment. Grace recalls a time when she was working with children in a youth facility. While relationship building with families is critical and can be difficult, building relationships with children with traumatic histories of abuse can be even more challenging. Grace describes how she overcame this while working with a high-risk child:

> *I remember one girl, I think she was about 14 years old, her mum used to put her in a closet for weeks. When she was able to come out, she'd binge eat and then go back*

into the closet while her mum did drugs and prostituted herself. Then she'd come out a week later and binge and go back again. In our unit, she would have one large meal and then go days with not wanting food. She was quite hard to work with, you didn't really know where the boundaries were, so there was a lot of time spent with her. She found the end of the hallway by a doorway near where we were a safe place to sit. I think she found it really hard to trust people. So to build the relationship, I'd just sit on the floor with her and tell her I wanted to be her friend and help her. And it slowly worked! I mean, some days were better than others and she'd come and chat away, and other days she didn't want anything to do with me. There's a lot of patience and a lot of getting down to her level, which she really liked. It probably took about two to three weeks, which felt like a long time.

Grace knows how hard it can be to work with vulnerable youth who have experienced abuse. Her approach to building a relationship is based on knowing the girl's traumatic background and believing that the girl finds it "really hard to trust people". Mistrust within healthcare is a barrier to receiving care (Cuevas, O'Brien, & Saha, 2019), with face-to-face encounters between the nurse and client being important in building trust (Shanahan & Cunningham, 2021).

When we start to trust, we open ourselves to the Other person who is then able to decide how to respond to this vulnerability, meaning whether to respect or abuse it (Løgstrup, 1956/2020). Being that the face calls another to their responsibility for the Other (Levinas, 1961/1969). Responsibility for the Other is not based on equal reciprocity (Lavoie et al., 2006) but on Grace's obligation to care for this girl. Grace has the skills and knowledge to help the girl and protect her vulnerability, therefore bears more responsibility within the relationship. She uses time, patience, and "getting down to her level" as skills acquired from past experiences to try to establish trust and build a relationship with the girl, even though starting to build a relationship and trust "felt like a long time".

Nurturing Relationships

Having established a relationship, primary health nurses must work hard to nurture it. While trying to nurture the relationship, the nurse may recognise that some parenting practices put children at risk. Although not wanting to break a family's trust, the nurse will nonetheless be compelled to report their concern to CYFS. Aroha describes how she nurtures relationships with Māori families even though having to report any concerns will potentially risk breaking their trust:

> *If I need to report any concerns, I tell them (whānau), and I keep them informed throughout the process and let them know what's going to happen. It does make you feel like you've gone against their trust. I keep the communication open by explaining the process and by making sure I tell them who I'm contacting and what is happening. I use manaakitanga [the process of showing support and respect for others] when I report concerns, and I nurture the family.*

Aroha describes how she nurtures relationships when needing to report her concerns. Being transparent and communicating the process of reporting concerns is Aroha's way of helping retain trust, which is necessary in order to nurture the relationship. In healthcare, manaakitanga represents caring and nurturing by showing respect and sharing of resources (Counties Manukau District Health Board, n.d). Using open and honest communication and sharing what she knows throughout the reporting process demonstrates how she uses manaakitanga without offering judgement, thus preserving the mana of whānau and strengthening relationships. Manaakitanga is of great importance in Māori culture (Thompson, Kerr, Carpenter, & Kobayashi, 2017), and Aroha knows that without this approach she risks alienating whānau and losing their trust.

She supports families through process which are unfamiliar to them and probably quite scary. Keeping them informed about everything that is happening helps whānau to accept support that they may need. Aroha's call to care and nurture by using manaakitanga is something she maintains throughout relationships, with the hope that if she needs to report concerns, trust may not be broken. Lashley et al. (1994) spoke of sustaining the call to care as a way to experience the power of connection with another. Furthermore, they believed that when nurses hear the call, they respond to others in a way that they would want others to respond to them. As a Whānau Ora nurse, Aroha works with whānau in a way that creates mutual respect.

Tania echoes the need for transparency when working with families:

> *If you ever need to refer a family to CYFS and you've been transparent and very clear with them the whole time, you very rarely break that trust.*

Tania's experience has taught her that trust is rarely broken if the nurse is transparent with families. In situations in which she is required to refer families, transparency and clarity help to nurture and sustain the relationship. Working within the bounds of limited confidentiality, Karen describes how she nurtures relationships through openness and transparency:

> *So I think what happens, if you ever talk to a family about a referral to Oranga Tamariki for help, it's "no, I don't want that because they'll take my children away*

from me". We need to be open and transparent and talk about consent and confidentiality every time we meet with a family, and say that we'll refer them to Oranga Tamariki if there's a concern.

Being transparent is one way that Tania and Karen try to nurture their relationships with families. This means being open and honest about their professional responsibilities and duty to report concerns. Although there is the potential to break trust and impact the relationship, Tania believes making full disclosures to clients and being honest about what will happen if concerns arise helps to ensure transparency and retain trust. Transparency supports the autonomy of the individual (The National Ethics Advisory Committee, 2021), and enables a family to provide informed consent for interventions. Gaining informed consent, demonstrating empathy, ensuring confidentiality, and explaining in ways that clients understand shows respect for clients (Kass & Faden, 2018). This points to the importance of nurses being transparent in order to nurture relationships.

The most common source of distress for primary health nurses reporting concerns is the feeling that they are betraying the trust of the relationship (Kuruppu, Humphreys, McKibbin, & Hegarty, 2022). This can be particularly conflicting for primary health nurses as they balance support for the parents and care of the child (Kuruppu et al., 2022). However, Tania believes that if the nurse is "very clear" with families "the whole time, you very rarely break that trust". If a relationship is authentic, a connection between people is made which leads to trust (Slunt, 1994b). Karen points to the importance of being "open and transparent and talk about consent and confidentiality" not just when meeting the family, but "every time we meet with a family", which is her way of answering the call to be authentic. Thus, she understands the ethical need to be transparent. The face calls us to an ethical responsibility that nurses cannot easily hide or turn away from. Tania and Karen understand the need to be responsible to the Other by being honest and transparent so they can continue to nurture a relationship when concerns arise.

All nurses must report concerns because they have an ethical and moral duty. They nurture a relationship because they care, but they report concerns because they are morally and legally required to do so. To have genuine concern and to be aware of the care nurses have for another is basis the nurse's ethical existence, and exemplifies living authentically (Slunt, 1994b). A moral and ethical responsibility for Other is evident in both Karen and Tania's approach to nurturing relationships.

Tania recalls a family she was asked to visit because other agencies had failed in their efforts to engage them. The family were about to be discharged from health services because they did not attend appointments. Tania remembers a mother who was wrongly judged by others and tries to visit with an open mind:

You can't visit a family having pre-judged them based on what others say. I was told by colleagues that this was the family from hell and that I wasn't going to get anywhere with them. I ignored that when visiting them. You have to be non-judgemental and have an awareness of their issues such as poverty. From my experience, there's a lot of judgement that happens with families. Sometimes nobody has asked them the right questions, so they never get their needs met or they don't get to appointments. Nobody had ever asked what her issues where, so my colleagues thought she was neglecting her son. They thought it was a form of child abuse because the child needed all his teeth removed and she'd DNA'd [did not attend] *for multiple appointments. It wasn't that she wasn't caring for her child, it was just that she was overwhelmed into inactivity, because everything was just getting too much for her. It just took someone to actually listen to what her needs were and to realise that this was not child neglect. I asked her, "tell me about what's the hardest thing here at the moment for you?" And she said she didn't have a car, so she couldn't get to the appointments.*

The Gadamerian notion of prejudice assists deeper understanding of this story. Gadamer asserted that prejudices are both false and negative or true and positive. Negative pre-judgements close off ongoing understanding while those that are open to new possibilities enable ongoing understanding. Tania nurtures relationships through being open to other possibilities. Thus, when talking to the mother, Tania attends to the Face of the Other by rejecting stereotyping or labelling (Critchley, 2002). By rejecting negative judgements, Tania was able to listen and remain open to learning more.

The lack of transportation was hidden, but only because previous health visitors did not look beyond their prejudices. Their responses to the family were prejudiced in the absence of adequate assessment. It is the nurse's responsibility to ensure they understand underlying social issues that are linked to health issues (Grace & Willis, 2012). Had Tania not visited the family, her colleagues' negative judgement may have deemed the mother to be medically negligent of her child. More importantly, the child may have been discharged from much needed health services. Being open to different possibilities enabled a way forward. Tania's story is a nursing example of a prejudice that can enable understanding while the prejudices of her colleagues limited understanding.

Challenges to Building and Nurturing Relationships

There are numerous challenges inherent in building and nurturing relationships. In the next two stories, Karen describes experiences with families and schools. In addition to the

challenge of establishing and maintaining interpersonal relationships, the nurses encounter systems that are often perceived as punitive and not to be trusted. In the first story, Karen discusses how these challenges can affect her ability to support families who have complex needs:

> *Oranga Tamariki is seen as a punitive system, it's not seen as a 'help people' organisation. They're often dealing with a small percent of people at the end of the spectrum that have the highest needs, so consequently they [Oranga Tamariki] get labelled. So when they're [parents] struggling, there's no way for them to ask for help because Oranga Tamariki are seen as this punitive system.*

She then goes on to describe an encounter relating to challenges in the previous account, where she saw a suspected strangulation mark on a boy's neck:

> *I asked the teacher what it was and how it happened, and they knew how it happened. Dad had attempted to strangle him and thought because he was naughty it was okay punishment. So of course it was a big issue and I did a referral to CYFS because that wasn't okay. The problem with the teachers and some of the other support workers at the school was they didn't realise social services are there to support rather than be punitive to families. In my experience, CYFS don't remove children lightly from families.*

Karen works hard with families and school staff to nurture relationships based on trust. However, if families and schools do not trust organisations, such as CYFS, who are there to support them with concerns about child safety, then their trust in Karen may not be assured. Such trust is not only important to Karen, it is a crucial means for her to protect children from further harm. Karen's responsibility for the Other—the children who face potential or actual harm—is fulfilled by her responsibility to act when others are unable or unwilling. While acting could possibly affect the absolute Otherness of the Other by disregarding the Others' agency, not acting would conflict with the ethical relation and the responsibility to take action. Karen's responsibility to protect and her responsibility for the Other challenges the perception of CYFS as punitive and thus to be avoided, and directs her to take action. She does this while trying to preserve the right of the child to be safe.

Karen answers the call to responsibility by speaking up and not ignoring an immediate concern. If using one's voice is a metaphor for knowing, silence can be viewed as passive or oppressive (Lashley et al., 1994). Reciprocity with dialogue only happened between Karen and the teacher once she brought up the mark around the boy's neck. Until that point, the school staff chose to remain silent over what turned out to be a strangulation

mark. It is not just nurses but social workers who also identify that gaining the trust of teachers is "essential for effective working relationships" (Csók & Pusztai, 2022, p. 497).

Yvonne knows that her commitment to building relationships is not always shared by the families with whom she works. She recounts a situation when she was working with a 13-year old girl living with two school age younger siblings, her pregnant mother, and the mother's new partner, all having previously lived with the grandmother. The mother also had a boarder whose 16-year old son was having sex with the 13-year old girl when she had been drinking alcohol. When the girl scored high on the depression and anxiety screening assessment and was disclosing suicidal thoughts, Yvonne referred the girl to the social worker who already had a relationship with the family. She reflects on differing priorities between herself and the mother:

> *When I spoke to her [the mother] about her daughter's mood and that she was contemplating committing suicide she said "yes I can understand that because she is very quiet and she stays in her room". Maybe it wasn't because she [the mother] didn't trust me, she was speaking to me, but she had other priorities on her mind maybe. It wasn't until the mother went into hospital and the grandmother came on the scene and the girl's issues were brought up at the Family Group Conference that she [the grandmother] said "I want her to have counselling and yes, you can take her to sexual health and get her seen to".*

The mother's lack of interest worries Yvonne. During our interview, Yvonne said she suspected the mother was prioritising her new partner and the pending arrival of their new baby before the needs of her daughter. While Yvonne suspects the mother's priorities are taking her attention away from her at-risk daughter, she cannot be sure. It must be distressing to know the girl remains suicidal whilst trying to build a relationship before intervening. All Yvonne can do, while trying to build a relationship with the mother, is to be constantly vigilant on the daughter's behalf and to remain available in order to protect this girl.

The Face of the Other can interrupt the expectations we acquire from past experiences (Burns, 2017). This is apparent for Yvonne with both the mother and grandmother. The former shows little interest while the latter unexpectedly appears on the scene enabling Yvonne to make a difference. The mother's response was not what Yvonne hoped for. As an ethical call, Yvonne is compelled to preserve the right of the girl to exist in a world where she is protected. However, it is not until the grandmother takes over from the mother that the girl's needs can be met.

Megan had been trying to help a 12-year old boy with his encopresis [soiling] when visiting him and his mother at home. Through her observations of the boy, Megan describes challenges she encountered while trying to build a relationship with the mother:

> *I was there to help with the boy's encopresis, but when I got to the house he was out of control. He couldn't sit still, was making weird noises, amongst other things, and was acting very immature for his age. His sister was selling his Ritalin, so his behaviour and encopresis soiling was isolating him from his peers. The boy had been suspended from school so many times, they'd moved around a lot and there was just no stability. Mum hadn't brought him to any outpatient appointments and dad wasn't on the scene. I think the boy's soiling was the least of his mum's issues. She just seemed very disconnected. I did all I could but sometimes you have to accept that some people aren't going to. Sometimes it's just hopeless. He's someone I've remembered.*

In the presence of such complexity, Megan found it hard to build a relationship with the mother. It appears as though it was equally hard to build a relationship with the boy. Nurses never know what they may encounter when making a home visit, and the unexpected and complex nature of the issues in the home seemed overwhelming for Megan. Complexity is a common cause of uncertainty (Gear et al., 2021). The first encounter at a home visit is perceived as important by nurses because it can affect their ability to further develop a relationship. In addition, the relationship is the vehicle that allows nurses to connect with those requiring care (Wälivaara et al., 2013). Relationships are therefore essential for delivering nursing care in the community, because if a family is not able to prioritise what the nurse deems a priority, the nurse risks disengagement from them.

Tension is created when a sense of responsibility and care conflicts with the inability to deliver care. Once again, the ethical call is based on nurses' obligation to care for Other (Lavoisier et al., 2006). Being unable to fulfil her sense of responsibility to the boy has left Megan feeling "just hopeless". The memory stays with her.

Megan's identity with families is that of 'nurse'. Lashley (1994) suggested that when nurses connect professional identity to their developing competence they will, at some point, encounter vulnerability, leading to uncertainty. Thus, being unable to assist this boy leaves Megan feeling exposed. The call to care thus has vulnerability as a consequence, yet perspectives cannot change without this vulnerability (Lashley, 1994). Living with and acknowledging such vulnerability can enable old horizons to fuse with new, thus creating new understandings.

Negotiating Relationships

Even when relationships have been established, there can be disagreements about how the family is best supported. Differing priorities can pose challenges for nurses wanting to maintain relationships. Aroha describes her frustration when this occurs:

> *If the whānau's needs are different to what I think, then I have that conversation with them. So, if they are planning a holiday and I know they won't have enough money for kai (food), I would suggest we look at their budget and go over things. Most of the time whānau are receptive to your suggestions, but we have to put it in a way that they see the benefit in a plan that's different from theirs. When they don't want to see that, it's frustrating!! We're only here to guide them on their journey, not to tell them what to do. But you know we need to keep supporting them as much as we can.*

In this story, the whānau feel able to assert their priorities over those of Aroha. Despite feeling frustrated, Aroha tries to support them. In accepting the whānau decision to go on holiday she acknowledges their self-determination and accepts that they do not conform to her own values. Aroha knows that to maintain the relationship she needs to remain connected with the family whether or not they take her advice.

Levinas believes tension between the self and Other is most prominent when the Other resides outside the dominant social group. Such tension is evident when Aroha and the whānau differ in their priorities. However, Aroha listens and, in doing so, provides support. Listening involves allowing the speech of another to "enter and flow through" oneself suggesting that listening, rather than speaking, is a way of answering the "ethical call of conscience" (Lipari, 2009, p. 44). Listening does not oblige the Other to be placed in conformity with us, but encourages the idea that we are able to receive what is difficult or different in order to keep the Otherness of the Other intact (Koskinen & Lindström, 2013). Thus, Aroha responds by continuing to support whānau even after feeling frustrated when they do not take her advice. Supporting whānau amidst differing priorities is what Berman (1994b) described as sustaining the call to care for others as evident by one's response to their commitment.

Building and Nurturing Relationships Interprofessionally

People often see nurses first in primary health when needing an initial assessment and care (WHO, 2020). Nurses have a wide ranging role and are key in the coordination of care (Oldland, Botti, Hutchinson, & Redley, 2020). Nurses are therefore pivotal for making

referrals and connecting families with relevant service providers. This highlights the importance of the relationships that nurses are able to build and nurture with other health professionals and agencies when caring for children who may be at risk of abuse or neglect.

Karen experienced a situation in which her concern about the risks to children relied upon the relationship and trust she had developed with other agencies in order to keep the children safe. She arrives at a home to talk to a mum about her 9-year old child who is missing school, and discovers 9-year old and 14-year old siblings are home alone on a school day:

> *Mum had mental health, gambling, and drug issues and was at a casino gambling. She had three adult mental health agencies going to see her, but no one had picked up on these kids. In the house there was a sofa that had bits picked out and torn apart. There was nothing in the fridge, and I mean nothing, and it was grimy and festering. The bedroom was spartan bare, with a bed and cover but no sheets, and the mattress was stained. So it was basic, basic, basic, it was a nice house on the outside but the inside it was derelict, it was awful. There were teenagers sleeping all over the house with another school kid there. During the visit I had to be careful not to show my shock to the two girls, as they love their mum. I had to say that it wasn't okay, there's no food, and that I needed to talk to mum as they needed to be at school. I talked to the other agencies working with the family and we all did a referral to CYFS because if I did the referral alone, CYFS would visit and the mum would deny being at the casino. CYFS didn't really pick up on it because with neglect and emotional neglect, it's always really hard to deal with the emotional stuff. People don't really pick up and react to the emotional abuse easily, which is probably because there's nothing physical to see, but I think it does far more damage long term. CYFS had already been to the house because there was a fire in the garage where an older sister was living with her baby, so CYFS removed the baby but left the 14 and 9-year olds. Mum would have had good intentions and really loved her kids, but when she got into gambling and drugging, she was just lost and wasn't present. The 14 and 9-year olds got removed from the house and made to live with their aunty.*

Karen knows that while the mum loves her children, other issues prevent her from providing the necessary care. However, she has yet to build a relationship effective enough for the social worker to trust Karen's account against that of the mother. Without testing this trust, Karen goes to the agencies with whom she has already built a sufficient relationship and is confident she has their trust. Such relationships are the means for

Karen to achieve the ends of having the social worker involved. In using a multi-agency approach, she hopes to build a trusting relationship over time with the social worker. Trust amongst healthcare team members develops over time and is important for collaboration (Johnson, Hermosura, Price, & Gougeon, 2021). A consequence of not having built a sufficient relationship with the social worker is that her assessment of neglect could be overlooked and the children could remain in an unsafe environment. However, even without a relationship and the trust of the social worker, Karen has developed ways of helping children at risk.

In the following story, Emma describes her visit to a young pregnant mother from which concerns about the risks to the unborn baby arose. The mother had diabetes but disclosed that she does not monitor her blood sugars, could not remember the last time she took insulin, and had not been attending appointments. Concerned the mother was placing the unborn baby at risk by not managing her diabetes, Emma also worried about other activities occurring in the home. She reported these concerns to the CYFS social worker:

> *There were random people in the home when I would visit, and smoking inside the house. A CYFS social worker investigated the mother and concluded everything was okay. I didn't agree with this outcome… I knew the mother wasn't telling the truth [to the CYFS social worker] …As a nurse, I know families tell you things they won't tell the social worker, because families fear the social worker will take their child away. I guess nurses come from a different angle. Even though families know I have to report my concerns to CYFS, they know we're [nurses] not going to take their child away.*

While Emma appears to have a relationship and trust with the mother, the relationship and trust with the social worker also needs to be developed and nurtured. That the social worker responded to Emma's referral and visited the mother at home suggests that a relationship and trust is developing between Emma and the social worker. Perhaps if Emma had more time to build and nurture this relationship further, the social worker may have trusted Emma's account against that of the mother. However, according to Emma, the social worker had the same access to the systems that show when prescriptions are issued and redeemed, and when appointments are missed and rescheduled. Thus, the effects of the relationship being insufficiently developed are highlighted. This can lead to nurses feeling guilt or even shame when ineffective collaboration affects the process of caring (Jimenez-Herrera et al., 2020).

Levinas (1982/2003) encourages us to treat encounters with others by respecting the humanness of the Other. He pointed to the intersubjective nature of, and the immediacy of face-to-face encounters as those which raise questions of ethics. However, even in the

midst of the mother's protectiveness, the call for Emma was to ensure the unborn child was protected from potential or actual harm. Nursing assessments are essential but so too is their ability to establish effective relationships. Lack of support for their concerns means that nurses can feel powerless and unable to protect the children in their care.

Summary

This chapter began by describing how building relationships is an essential part of being a nurse who suspects a child is being abused or neglected. Nurses try to build relationships both because they care, and because the Face of the Other calls them to establish a relationship which will support whānau. When supporting whānau, relationships with other health professionals and organisations become important to ensure that support aligns with needs. They experience the newness of meeting every whānau for the first time. Their stories have revealed what is important for them when trying to build and nurture relationships. Nurses need to remain focussed on the vulnerable child, despite significant challenges, and find creative ways to build and nurture relationships that will allow them to support, intervene, and protect the child. Yet, this is not always possible. The stories also show how nurses are adversely affected by a lack of collaboration and partnership. Despite answering the call to care, nurses are not always able to protect children.

Such experiences shape the nurses' understanding and inform how they manage situations both as they are encountered and in their future practice. There is a professional and moral obligation to protect children from actual or potential harm. This comes from an ethical call to work with openness and engage with others even when priorities conflict. In the next chapter, the nurses share their experiences of being with suspicion, another essential part of working with children whom they suspect of being abused and/or neglected.

Chapter 6 – Being with suspicion

The previous chapter explored nurses' experiences when trying to build and maintain relationships when they suspect that a child may be abused and/or neglected. In doing so, nurses often develop a deeper suspicion that a risk to a child exists. Etymologically, 'suspicion' comes from the Latin word *suspicere*, translating to "up from under" and "look at" (Ayto, 1990/2011). This points to a way of being mistrustful that may not be immediately apparent. One senses that something is wrong; that underneath is something more worrying. Evolution of the modern interpretation of suspicion reveals how it has changed from "looking at secretly" to "looking at distrustfully" (Ayto, 1990/2011). To be with suspicion in the context of this study is to feel uneasy and uncertain about risks to children. It is a concern that impels the nurse to look for other clues. Working out whether a suspicion is justified involves a dialectic between what the nurse is feeling and what they suspect may be happening. Being with suspicion describes a deepening watchfulness that heightens what nurses notice. Suspicion begins with a gut feeling. There is an instinctive sense that something may be wrong.

Gut Feeling

Working with children whom nurses suspect are being abused begins with a gut feeling. Our feelings signal what matters (Taylor, 1985) before we find words to express them. Aroha recalls how she feels when something seems wrong during a home visit. She talks about the information that leads to a gut feeling. Environmental factors and family interactions are key sources of information:

> *A gut feeling about a child that might cause me concern during a home visit comes from seeing the environment. Does it feel the same as before? Is it messier than it was before? It's not normal for mum not to have folded the washing and done the vacuuming before I visit, that sort of thing. Also the interactions. How are they interacting with me, is it the same as when I last visited? Are the clients or whānau reacting to me the same? Definitely looking at body language. You know, if mum was still in her pyjamas and it's 3pm I'm thinking, what's going on here? And then I would assess a bit more to find out what's going on.*

Aroha describes how she is alerted to a potential safety concern, one which gives her "a gut feeling about a child". Subtle cues lead her to wondering "what's going on here?" and compel her to look for more cues. Her observations of the mess, the unfolded laundry, not having attended to vacuuming, and nuances with body language are not what really

concerns Aroha. They are not problems in themselves but signal that someone is not coping, thus presenting potential risks for children. Seeing the physical signs of neglect in a house engenders deep feelings of worry. Aroha's observations are not merely before and after comparisons. There is a wealth of experience and meaning underlying these assessments as recognised by Benner and Tanner (1987) when explaining how nurses use intuitive judgement. Aroha's judgement is informed by a gut feeling based on the subtle and obvious cues she notices in the home.

Aroha's gut feeling is important because it signals the need to use greater surveillance to assess for more concerning signs. This feeling is based on what she has observed in the home, and is the means to further assess whether children are at risk or whether the mother is overwhelmed and lacking support. Our understanding is always historically situated and informs our present and future (Roy & Bayo, 2011). Therefore, while an effective historical consciousness informs Aroha's response to having a gut feeling, it is only by being open to all possibilities that she can accurately assess the situation.

Megan similarly recalls an experience when she felt that something was not quite right. She encountered a family who had consistently not attended [recorded as DNA, Did Not Attend] cardiology appointments for their 14-year old son. Megan describes what she notices when she arrives to administer the boy's monthly bicillin injections:

> *When I get to the home, the door's been punched in, the windows are all broken, and I just get directed to the bedroom where he is waiting. His bedroom only has a bed, blankets, and a pile of dirty laundry. Mum has totally failed to engage. She refuses to engage in any conversation with me at all and just says "I'm busy". There have been dodgy characters at the home when I've visited. It's hard to get a handle on who lives in the house …older brothers come back and then leave, but the boy would never tell me what had happened. You get that gut feeling there's something wrong in this house big time, absolutely, big time. It's the lack of medical care, and the fact that he just seemed sad.*

Seeing the lack of engagement by the Mum, the damaged, spartan home and "dodgy characters" engenders a gut feeling that something is very wrong. In Megan's words: "absolutely, big time". However, it is the "lack of medical care" and the boy's mood and that he "just seemed sad" which worries Megan most. Seeing and being in the home enables beginning understanding of the boy's situation. While Megan suspects he is being neglected, she remains suspicious as to what else may be happening to make him present in this way.

Gadamer posited that when in a situation for the first time, our decisions and actions are influenced by background knowledge and our prior understandings about what matters most (Polkinghorne, 2004). Before the home visit, Megan has read case notes and acquired knowledge of the missed appointments, both of which claim Megan's attention. This helps her understand what is salient before visiting the family. Thus, according to Benner, the development of intuitive links enable nurses to respond in situations because they can see what is salient (Blum, 2010). Megan's suspicion begins before she even gets to the home. Gadamer (1975/2013) argued that understanding begins with pre-judgement, and helps us grasp what needs to be understood. Such pre-understandings add nuances to understanding in nursing (Benner et al., 2008) which helps nurses understand what is salient before visiting the family. Megan's background knowledge heightens what she notices.

Like Megan, what Tania notices during a home visit alerts her concern:

> *It's the aura around the child, something in their behaviour or in the way they respond to certain people. We do a lot of home visiting which is the best situation to see interactions between family members or people in the household. We have a sense of relationships in the house and we are able to observe people for a long period of time. Sometimes you notice how the child responds to a certain person in the room, or you get a gut feeling that the child is acting differently to what you would expect in a normal relationship. Something might alert you that something may be happening in this household.*

"The aura around" a child describes a felt presence, something intangible about the child's behaviour that is so obvious to her that it cannot be overlooked. Tania is attuned to a presence that is palpable; a foreboding. It is a loud and clear voice within herself that alerts her something that "may be happening in this household". It also points to a particular type of feeling when observing others. Being in someone's home allows Tania to observe nuanced behaviour. A gut feeling leads to a suspicion that the children are at risk. Tania's suspicion causes her to pay more attention and thus is protective. Part of intuitive knowledge is what Benner and Tanner (1987) described as being able to identify changes to patterns they would usually expect and therefore understand what is salient. Identifying nuanced changes helps Tania form an assessment of the whole situation. Reflecting on and moving between the detail and the whole of such situations deepens understanding and illustrates the continuous nature of new understanding that the hermeneutic circle represents (Gadamer, 1975/2013).

Tania recalls feeling "really awful" when visiting a 13-year old girl and her new-born baby. The girl lived with her grandfather, brother and his wife and their three children. No one had known the 13-year old girl was pregnant until she gave birth.

> *Something about the grandfather gave me a really awful feeling. There was something about the way the grandfather responded to women. There was this sense of power the grandfather had in the house. We thought it was a hierarchy in the family.*

This "really awful feeling" signals something visceral and very significant. Messages between the gut viscera and the brain happen without conscious awareness. They are based on signals moving between both and evoke an emotional response and feeling (Mayer, Nailiboff, & Munakata, 2000). van Manen (1990) used the notion of lived body to describe how our bodies further reveal things that matter. The grandfather's "sense of power" was physically palpable to Tania. In the absence of proof, she wondered how and why he held this power.

The story continues:

> *…quite a lot later, the girl disclosed it was the grandfather who sexually abused her*. *It was a sordid situation where the grandfather would sit in his rocking chair and ask the girl in front of myself and CYFS people to tell [i.e., tease her] who the father was. It was really sad because he also abused the brother's wife. Neither of these two females knew the other was being abused. The older female kept the secret because she knew it would blow the family apart.*

It is through noticing subtle cues that nurses stay alert and vigilant. Tania sensed that something was not right within this family dynamic. She understood that the interpersonal tension she felt was a concern, but only learned the full story later. Similarly, Natalie also had a gut feeling about a person when doing a home visit:

> *The mum was usually quite chatty. On one visit she wasn't. At first I thought she was in a rush, but then I began to feel like there was somebody else in the house. The mum's partner was not allowed at the house because he had physically abused the baby. When my colleague did a visit unannounced, he answered the door. I suspect he was hiding in the house when I visited.*

Intuition is what Benner and Tanner (1987) called "understanding without a rationale" (p. 23). Nurses rely on what they notice to inform their intuition in order to try and make sense of a situation. Noticing subtle cues during a home visit helps support nurses' suspicions before they form rationale for their concern. The suspicion is felt before it

becomes a conscious thought. In the first step of Tanner's (2006) clinical judgement model, noticing describes gaining a perceptual grasp of a situation as they interpret their expectations of the given situation. Thus, knowing what to expect normally enabled Tania and Natalie to notice the intrapersonal dynamic within the family that prompted awful feeling for Tania, and a suspicion for Natalie.

Noticing, along with prior knowledge of clients' health issues, is the first part of the assessment continuum. As previously explained, what nurses notice depends on their past experiences and knowledge. Paradoxically, as they gain more clinical experience, they almost do not realise what they notice because it becomes embedded subconsciously. Thus, it was only with hindsight that both Tania and Natalie realised the cause of their unease and could confirm that it was valid.

Noticing Signs Engenders Suspicion

Nurses are sometimes suspicious while not *wanting* to be suspicious. They want to remain open yet are always watching for worrying signs. Ana describes the conflict she feels when she thinks parents are hiding something during a home visit:

> *You get this sense of conflict, like obviously the parents are trying to put on a little bit of a show because they are sitting with a nurse and they want to be at their best, but you can just see that there is just so much going on. We are very lucky to go into homes, because so much of our assessment comes from the information in the environment.*

The "show" makes it more difficult for the nurse to notice the subtle cues that would usually alert them to a concern. Yet trying to hide what is happening by putting on "a show" can also alert the nurse. Noticing behaviour as a *cover* creates tension for Ana. The "show" reveals power and vulnerability. The "show" is a way of persuading Ana there is nothing she needs to be concerned about; paradoxically revealing Ana has the power in this relationship. Revealing who holds the power conversely reveals the vulnerability of the other. Ana may or may not be consciously aware that she holds power in this relationship. Nurses often do not perceive themselves as having power; rather, they tend to see themselves as responding based on needs (Santos Baptista, dos Santos, Crispim Costa, de Macêdo, & Mendes Costa, 2018). However, the "show" reveals the vulnerability of the parents with the ever-present potential for Amy to exercise her power by reporting concerns. The "show", therefore, arouses suspicion.

Ana wants to give the parents the benefit of her doubt. However, her desire to remain open conflicts with the suspicion she feels when noticing the "show". Tension for Ana may

also arise from balancing trying to empower families where children may be at risk and being paternalistic. As a nurse, she has a role to preserve the family's autonomy and decision-making over their child(ren), yet she may also have to take some or all of the decision-making away from them in order to protect the children. This is a legally mandated requirement for nurses under Section 195A if the Crimes Act 1961 whereby nurses are legally mandated to report any child who is at risk of sexual assault, grievous bodily harm, or death.

Such intrapersonal tension illustrates the complexity of what nurses notice and assess in the home environment. Ana describes this array of data as "information in the environment". Understanding what is and what is not relevant is the essence of noticing in nursing (Tanner, 2006). The challenges amidst the messiness of trying to interpret complex and evolving situations is further described by Borich (2016) as *noticing in context.* Ana lives with suspicion and its inherent tension until a report of abuse is made.

Prior to confirmation of abuse, like Ana, Debbie notices signs which make her feel suspicious:

> *I know it's cliché about what they drive, but I would always look at the cars. If they're living in a Housing New Zealand house and they have a really posh extremely flash car, then I would become concerned. The second thing is the dog. If the gate is locked, that's a really big indicator, often those houses are quite frightening. If you have to ask people to come in, they're extremely suspicious, they don't want to see you, they'll talk to you at the gate and they don't want you to come in. The third is the savageness of the dog. If they have a scary type of breed, I'd always move more cautiously. The next thing is the upkeep of the house. If it's poorly maintained on the outside, the grass is neglected, the house is neglected, and the downpipes look neglected, all of those things… the gutters tell you a lot, like if they were slimy with grass growing, they just seem to be more scary. I'd always check the recycle bin and see how much stuff was in there. If there was a lot of alcohol, it would be full of cans and bottles. Inside the house I'd cast my eye to the stove because you can tell from the rings of the stove if people are cooking drugs on them. Then I'd look at the ash trays and see what sort of butts people had. So there were a lot of things I was seeing, and this would happen as I went into the house. I think nurses do a lot of assessment from the outside of the house. It sounds like I'm judgemental and clichéd, but it relates to safety and neglect. It's never concerned me if the inside of the house is quite tumbly, a bit messy, and bedding hanging around. It's different from a sense of unease I get from the outside. In my experience, houses that are neglected or*

abandoned on the outside mean it's much more likely there's family violence happening.

Debbie has acquired her understanding of risk from past experiences. Experienced nurses notice various signs and become highly attuned (Benner et al., 2009) to what concerns them in relation to the potential for risk to children. These signs have influenced her interpretation of how a property appears, and what this could signal in terms of child neglect or family violence. Thus, when she arrives at properties, she does so with an historically effected consciousness. Historicity always carries prejudice and contributes to understanding (Gadamer, 1975/2013). Thus, it is not possible for Debbie to suspend her pre-understandings when visiting a property. Gadamer acknowledged the more familiar current day connotation of prejudice as negative. However, his concept of prejudice is that of a "judgement that is rendered before all the elements that determine a situation have been finally examined" (Gadamer, 1975/2013, p. 283). Therefore, prejudice can be positive or negative. Debbie acknowledges her prejudice by stating "it sounds like I'm judgemental and clichéd" when describing what she notices and how this leads to a suspicion. She is using the more commonly assumed notion of prejudice as negative. Making a pre-judgement of the risk to children based on the appearance of a property and before meeting the occupants is not a limitation however. Her pre-understandings inform her of potential risk to both the children and herself. This is because what she has noticed in previous situations has evoked her feeling that some visits are "quite frightening", leading to a heightened sense of suspicion.

Mary similarly lives with not really knowing what may be happening during a home visit. She recalls an occasion when a cuddle with a child engendered lingering suspicion:

One time I went to do an abscess wound dressing for an 18-month old. Mum was a bit rough with the child. When I'd finished, I gave the child a cuddle, and they didn't want to let go, and you're thinking, why won't they let go? I'm a total stranger to them. There's nothing you can really put your finger on to say, why is this? It's hard, because you're wondering if that's a child who probably hasn't been physically abused, but is seeking love and attention. Whether it's neglect or whether someone's been whacking the child, you just don't know but there's nothing you can say. Sometimes you have a lot of questions that you can't find the answer to in your head, but you're not always sure you had the right answer during the home visit.

In this example, a seemingly innocuous cuddle from a child has invoked uneasiness and uncertainty. While there are times when a nurse's suspicions are substantiated, there are times when they are not, yet they linger. Mary noticed the mother being "a bit rough with the child"; however, it was the cuddle with the child that stayed with her and left her with

a lingering suspicion. Noticing is not only observational, it can be felt. Thus, by the child holding on for longer than Mary would expect or by resisting release from the cuddle, she not only noticed the mother's rough handling but also what was felt between her and the child.

Being with touch is to be in the world in a feeling way, with "a sense of being in contact" (Lemermeyer, 2022, p. 231). When using touch, nurses are feeling for something, such information so they can understand the body of whom they are touching (Lemermeyer, 2022) and it is a shared bodily experience. The meaning of touch and not "letting go" when Mary hugged the child is recognising the child's vulnerability. It is having an instant awareness of the touch/hug when according to Lemermeyer (2022), touch is not something that usually requires too much thought. However, sometimes touch practices incite feelings of discomfort for the nurse (Pedrazza, Berlanda, Trifiletti, & Minuzzo, 2018). At the point of not letting go, Mary becomes affected by the discomfort she feels. She senses that the information she feels from the hug warrants concern. Is the hug an emotional communication between her and the child? Does it ask for comfort or advocacy? Feeling as though you cannot "really put your finger on" what is happening creates unease and suspicion for Mary. The suspicion could mean that the child remains at risk in the absence of evidence to confirm it. Thus, in this story, touch engenders being with suspicion and living with lingering doubt. As Mary confirms, it is "hard" to give a child back to a parent when suspicion of abuse lingers.

During a home visit, Tania noticed behaviours that aroused suspicion about child safety. It was a child in the home who was not the primary reason for her visit that caused concern:

> *When visiting an older child, I became very aware of a 2-year old boy standing blankly in the background, not talking, not responding, not making eye contact. I asked the mother if the 2-year old was talking, and she said, "oh he says a few things". So I asked if she thought he could hear or if she was concerned about his hearing, because he should be vocalising and making words and sentences. She said, "oh, I don't know". I thought if we got his hearing tested we could get some speech language therapy happening. I was really concerned about the 2-year old's state of awareness. He was very much in the mode of looking and assessing, and watching what was happening very closely. But he had a deadpan face, no expression, and the older child had behaviour issues at school. There are many situations I've been involved in where it's not just physical abuse, it's family violence. Back at the office, I phoned Child, Youth and Family and found out there had been 48 notifications for family violence. I did a Note of Concern. There was no doubt this was affecting the children.*

Tania's story shows that paying attention to everyone in the home helps her to know when something is wrong. Noticing is the first part of the nurse's assessment (Tanner, 2006) and precedes intuition. Tania's use of intuition is evident by sensing something is wrong. Intuition is part of a nurse's interpretation (Nielsen, Stragnell, & Jester, 2007), and they are able to respond intuitively when they have already solicited the required knowledge from past experiences (Tanner, 2006). Thus, an historically effected consciousness is not only part of our understanding from the past, but is essential for informing new understanding—as long as the nurse is open to this.

While Tania initially wondered if the child had a hearing problem, it is by paying attention that she becomes suspicious about the children's safety. The 2-year old boy "standing blankly in the background" made Tania suspicious. Thus, the distrustful nature of suspicion meant that Tania continued to notice cues from and around the child being visited, such as his expressionless "deadpan face". Her concern is that the boy's behaviour is a consequence of more serious concerns. Back in the office, she finds out further information which helps her interpretation of the parts and the whole of his situation and is able to understand the risks to the children more fully.

When Suspicion Compels Action

At times, the level of suspicion and internal conflict is strong enough to compel nurses to act. Aroha recalls a situation which compelled action after noticing interactions between family members:

> *In the home there were an uncle and aunty, and my client's cousin – a little boy who looked about 3-years old and had quite a bit of bruising… I just had that feeling, it was the feeling from the aunty and uncle, that feeling where you just don't feel right… He had some bruising that I could see on his legs. Because of seeing the bruising and having that feeling… I called the police after I'd left and got a welfare check done on them. It turned out that my client and the 3-year old were being abused by the aunty and uncle, and my client told the police that she was scared… I made the right assessment and call. I made sure that not just my client was okay, but the younger child was okay as well. The result was that the children were taken away from the aunty and uncle so they wouldn't get hurt or killed.*

Knowing "you just don't feel right" is noticing what is out of the ordinary. While it is also noticing the more obvious signs of bruising, it is having "that feeling" or a suspicion these are not accidental and likely the result of physical abuse. Such feelings assist nurses to identify the salience of a situation while attempting to identify what is going on (Benner et

al., 2009). Even though she could not categorically prove the leg bruises were the result of abuse, the consequences of leaving children in a situation in which Aroha feared they could "get hurt or killed" compelled her to act.

It is the listening to suspicion that directs Aroha to request a welfare check. Thus, she is open to the "connection between feeling and listening" (Lashley et al., 1994, p. 193), a special type of listening Levin called hearkening. Hearkening is not listening as hearing. It is wanting to really hear, and to remain open to what one hears. It makes a claim on us and is a call to care, and a call to responsibility (Levin, 1989). Aroha hears the call to responsibility and acts to protect the children unable to protect themselves. Being with suspicion is to live with doubt and distrust while also worrying about the consequences of not acting.

Amy experiences frustration when she has a suspicion about the risks to a baby whose parents limited her access to the family home:

> *A mum and dad brought their 6-week old baby boy to see me for the immunisations. They had an older child with them, but mum was kind of all over the place and giggly, and told me CYFS were going to take her baby away. Clearly mum was on P at the time she came to see me, and I'm not sure whether dad was completely clean either. When we couldn't find the baby for the 3-month immunisations we did a home visit, and I don't [usually] do home visits. A colleague and I went because I was concerned about neglect and with mum being a P user, chances are there's going to be times when that baby is actually being neglected. Going for the immunisations was a way of getting in and checking. At the house, mum answered the door and held the 3-month old in front of her so we couldn't see what was happening inside. I would have done the immunisation on the doorstep but there was no chance she was letting us anywhere near the baby. So she said she'll come into the clinic this afternoon or next week and of course she didn't. We tried to contact and call her with no response. We sent another agency to the house and even they couldn't get in. So essentially it's now considered to be quite an unsafe house to go to.*

Amy's assessment of the parents' behaviour was the means to inform her assessment and her suspicion about the risks to the baby. Her suspicion of risk then became the means to act. It was not only the missed immunisations that concerned Amy. That and the suspected parental use of the drug P compelled Amy to do a home visit, even in the presence of potential risk to herself. She took a colleague with her, implying an awareness of risks to her own safety, particularly because P use is associated with behaviours such as aggression (Carney, Myers, Kline, Johnson, & Wechsberg, 2017) and violence (McKetin et al., 2014).

It was the baby as the Face of the Other which called Amy to feel responsibility. Levinas recognises this as a felt rather than cognitive or intellectual act (Bindeman, 2001). Amy's call to responsibility was to carry out a home visit under the guise of administering the immunisations, and thus being able to further establish the baby's safety. Her suspicions were further heightened when the mother blocked entry to the home and would not let her go "anywhere near the baby" to administer the immunisations, let alone be able to see inside the house. Failing to gain access to the baby compelled Amy to act further. Thus, Amy alerted another agency to the risks for the baby, the outcome of which was the house being considered "quite unsafe".

In the next story, Debbie recalls visiting a home where mistrust and suspicion compelled her to act:

> *I visited quite a few P houses and one of those visits was the scariest. The outside of the house was completely trashed, I'd never seen a house trashed that way. The smell in the house was horrendous, like a chemical with a disgusting bite in the back of your throat, and you could taste it. I thought it was probably P, but it was so strong that I sat on the porch and talked through the open front door to the man. All he wanted was his children back from CYFS care and he wanted to work out how I could be an advocate for that, and I thought, I'm the wrong person. We still had the conversation and he gave me permission to ring his lawyer, which I did, and we both agreed that under no circumstances were the children going back to that house. When I came out of that house and went down the street there were five police cars at the end of the street. So I rang the police, and they said yes, we had an armed offender's squad raid that day but there was a health car outside the house so we decided to wait until I'd left. They'd seen me enter and would have been watching me like a hawk while I was sitting on that porch. I wasn't safe.*

Arriving at the house and seeing it "completely trashed" and having one's senses subjected to the "disgusting bite" of a "horrendous" smell immediately creates mistrust and suspicion. Mistrust and fear are connected (Pelkmans, 2018) and Debbie describes this visit as "the scariest". She could have decided to leave, returning to the house with the relative safety of accompanying colleagues to mitigate some of the risks of visiting alone. Yet she trusted herself sufficiently to engage with the father.

Mistrust and suspicion can follow or precede each other (Pelkmans, 2018). It is therefore possible that upon approaching the home, Debbie could have initially felt suspicious followed by a sense of mistrust towards the occupants. Conversely, it is reasonable that the sight of the environment created an immediate sense of mistrust, followed by a suspicion about the safety of children connected to the family. Whichever came first, the

feeling of mistrust and suspicion compelled Debbie to continue with the visit, albeit staying at the front door and not entering the house. Propelled by a strong ethical obligation to protect children, Debbie is compelled to act in the interests of the children despite being unsure of the risk to herself.

While nurses attempt to be objective, according to Gadamer (Lawn & Keane, 2011), one's understanding is inextricably linked to their past experiences and knowledge. Debbie is remembering and comparing with other visits to homes where P is used. However, Gadamer argued that new knowledge can only be formed if past understandings are challenged through an attitude of openness and self-interrogation. Thus, Debbie is anticipating the consequences of not acting, and wondering about the risks to children in the house while standing on the porch. Being compelled to act continued after the visit, with Debbie phoning the police and the occupant's lawyer. It was only after leaving the house that Debbie's actions are justified by the presence of five police cars in the street and finding out about the raid which had been delayed by her presence.

In the previous story there was time to decide how and when to act. Yet nurses can be thrust into situations without warning. Karen describes one such experience:

> *One time I went to do a 6-week baby check, the first visit. I put the baby on the floor to examine and dress the baby and as I'm kneeling down, I see a sawn-off shot gun under the sofa. Oh! So I did my bit and afterwards put in an incident form and talked to social services and police. The police told me they don't visit that house alone, they only go in twos!!*

Karen's trust in both her and the baby's safety has been shattered. Her first instinct is to leave the house as soon as possible. However, despite the overwhelming and immediate suspicion of risk, this has to wait. Before Karen is able to leave, she must remain watchful for any cues that signal further risk. She must also conceal her shock and outward awareness of risk to the occupant. Thus, Karen works hard to act as though nothing is amiss by projecting a sense of normalness while "doing her bit", before leaving. She is then compelled to act further by reporting the incident to the two agencies that manage such risk. Once again, it is only when she discovers that police only visit this house in pairs, that she understands the full extent of the risk.

Karen and Debbie's stories reveal the danger nurses experience when making home visits, particularly when child abuse is suspected. The danger that nurses can feel personally often signals that children are also at risk. Knowingly or not, nurses are constantly observing the environment for anything that arouses suspicion. They are always watching, looking behind, ahead, and out of the corners of their eyes. Thus, suspicion is

ever present irrespective of what is happening during a home visit. It was only through vigilant observation that Karen noticed the gun under the sofa. Her "Oh!" response indicates this was nonetheless a shock. "Oh!" signals Karen's understanding of a potential threat to her safety, and that of any children in the house. It is an intense feeling which derives from innate survival responses prompting either flight or fight, and is a natural part of the defence cascade of behaviours (Kozlowska, Walker, McLean, & Carrive, 2015).

The Relentless Nature of Suspicion

As mentioned earlier, whether nurses realise it or not, suspicion is always present during home visits. It is relentless, inescapable, and sometimes all-encompassing. Karen describes her conversations with children and youth, wherein suspicion of risk is ever present. She works carefully and skilfully to help them safely disclose abuse. She starts the conversation with asking "so who's at home?":

> *There are so many red flags around child abuse. They [children and youth] are just screaming out for help. If you ask the right questions you know they'll answer. But you need to support the conversation so you don't just go in and ask about anyone touching or hurting them in a way they don't like. It's about leading up to this, starting with "so who's at home"?, "who do you feel safe with?"…home can be a really hard place but mostly they're [children] happy to talk about home… I use a structured conversational framework to ask the questions to elicit the answer. It's not prompting them, it's using open ended questions so they have to answer, because if you use closed questions you'll only get a yes or no and that leaves you nowhere… When these kids came to see me at the intermediate school I was working with, probably every month I would get a disclosure of sexual abuse.*

To know children are "screaming out for help" is to understand they need the opportunity to disclose abuse. Karen's questions are structured to enable red flags to be revealed, thus she uses a framework that "they have to answer". To be ready with these questions is to carry suspicion into every encounter. While a suspicion may cause the nurse to make a referral to another agency, a disclosure provides proof that better enables children to be protected from further harm. Being with suspicion relentlessly compels Karen to do all she can to protect children from ongoing abuse. She continually tries to hold space for children she works with in the hope they will feel safe enough to make a disclosure to her.

Nurses hold space when they start to consider what is not able to be fully communicated through language and what may be excluded from language (Lashley et al., 1994). Karen thus holds space for children by voicing her questions and creating space for an answer

which is conversational rather than a yes or no response. The open-ended questions in her conversational framework avoid technical nursing language, ensuring children can understand and answer. This is what Lashley et al. (1994) call making space to "nurture listening and voicing" (p. 196). It invites the other person into the conversation. London, Bruck, Wright and Ceci (2008) found that most children do not disclose sexual abuse. Inviting them into conversation creates space for disclosure. Thus, being called to care is to make space for the Other, more so in the presence of a suspicion.

Nurses' sense of responsibility to safeguard children is heightened when met with a family's refusal to engage. Tania describes how she navigates these situations:

> *If families refuse a nurse's involvement, I want to know why. I try other ways to engage them, such as asking for an invitation to a school meeting with the parents where I can introduce myself and explain my role. I try to address the issues raised in a positive way and offer ways of supporting the family with their issue. I look at different ways I can engage with that family. If the family still say no, I will probably do a background check and find out more from the person who raised the concern, and find out why they think the family may have this particular issue or why they don't want my input.*

The relentless nature of suspicion suggests that everything visiting nurses encounter may appear to be hiding something. This is illustrated with Tania's assumption that something is hidden behind a family's refusal. She may be right, but until such time as her suspicion is supported by evidence, she continues to seek confirmation or refutation. This is particularly worrying when the attempts to engage with a family are based on a concern raised by someone else (i.e., a referral from a school). A community client's refusal to consent to nursing care is one of the two biggest dilemmas that community nurses face (Griffith & Tengnah, 2012). The consequence for the nurse having to employ multiple strategies to work with a family is likely to be a growing fear for the safety of the children.

The unrelenting suspicion becomes the means for taking action. The persistence in trying to achieve the end of visiting the family is evident in Tania's repeated attempts to negotiate a visit. Thus, a refusal becomes a new means to achieve the end of assessing the risk to children. Tania does a background check and goes back to the person who made the referral. She hopes to gain insights into why the family are refusing a visit. Typically, when clients refuse nursing care, nurses respond by giving information in the hope of persuading the client to change their mind (Aveyard, 2004). Thus, finding out what is happening behind the refusal becomes essential.

Like Tania, Abby develops a suspicion from certain cues. Abby describes becoming suspicious in chaotic and noisy environments:

> *You walk into a room and you just feel that it is chaotic and noisy and you think, what is it like for this child whose brain is developing in this environment. If I come out of a home and my head is spinning, I am a bit exhausted because it has been a noisy, difficult situation, I think, what has it been like for that child?... Sometimes you never know exactly what is going on, but you know something is because it is chaotic and noisy. You just know. It guides me to do extra visits and support the family.*

Abby is describing other impacts on the nurse. Her head spins and she feels exhausted after some visits. These are physical signs of exhaustion. But there is mental anguish too. The tension between not knowing exactly what is going on, yet knowing something is not right, compels her to do extra visits. Thus, to be with suspicion is to be constantly watchful and to risk exhaustion.

When "you just know" but you do not have proof, an element of uncertainty exists. To be faced with uncertainty is to be vulnerable and feel as though one is wounded (Lashley, 1994). Yet, it is only through being open to experiencing vulnerability and the associated tensions that the nurse is able to create new understandings and awareness (Lashley, 1994). Where past understandings meet with new, a fusion of horizons occurs (Gadamer, 1975/2013). Abby's vulnerability and the physical and mental suffering arise from being relentlessly suspicious. Being with suspicion is, therefore, to carry the burden of *knowing without proof* relentlessly until that suspicion is either confirmed or disproved. The extra visits, provision of support, surveillance, and ongoing assessment of risk can be exhausting.

Summary

In nursing, gut feelings are often something that require further investigation. Nurses experience a gut feeling based on the messages between the brain and their viscera, and are felt as a physical corporeal sensation. These significant bodily responses reveal what matters most to the nurse. They further inform suspicion even in the absence of proof. However, nurses try to hide their concerns when they realise they are feeling suspicious. Thus, there is a secret nature to being with suspicion. Once the cues noticed are sufficient and their suspicion is strong enough, nurses feel compelled to act. In some ways the compelling urge to act shows the distrustful nature of suspicion, whereby to act is showing a mistrust of parents/guardians to keep children safe. Despite wishing to remain open, the nurses in this study felt relentlessly suspicious. This chapter has alluded to, but not

directly focused upon, the toll that working with children who may have been abused or neglected has on nurses. The next chapter will describe what it is like to carry such a burden.

Chapter 7 – Carrying the Burden of Concern

The previous chapter described being with suspicion and how suspicion is an ever-present part of nurses' day to day work. This chapter describes the burden carried and the impact on the nurse.

To 'carry' and 'give birth' are the Indo-European etymological meanings for 'burden'. Old English interpretations include to 'bear', meaning both to carry a child and to carry a 'load' which is borne or carried such as a weight or a charge (Ayto, 1990/2011). Contemporary use of the word *burden* tends to describe a load, typically one which is hard to carry. It can also refer to a responsibility that may be hard to bear. Carrying the burden of concern in nursing is to live with a weight on one's shoulders, often with relatively little support. The emotionally demanding nature of their work and the sense of responsibility nurses feel when working with vulnerable children increases the burden.

There may be potentially unknown, but significant consequences for the children whom nurses suspect may be experiencing abuse and/or neglect. Recognising the impact on the child is the means for the nurse to form a judgment about what may be happening in the home, the consequences for the child, and the ends that prompt action. It is the nurse's knowledge of these consequences for the child that contributes to the burden they carry. There are also consequences for the nurse. Yet despite these consequences, most nurses do not waiver in their ability to continue this important work.

Carrying the Burden Alone

Nurses do not only visit families on their own, but they can also feel unsupported despite the presence of other agencies such as CYFS that may also be working with these families. When children miss health appointments, such as immunisations, they are rescheduled and new appointments are sent to the parents. This cycle can continue for up to a year or more depending on the health service. When a child continues to miss appointments and there is no response from the parents, the health service may eventually discharge the child. Although missing appointments may not, on the surface, mean that a child is at risk, Karen describes her concerns when this happens:

> *Nurses often see this as a health issue, because from a health perspective, it can be a precursor to poorer health outcomes if you don't get your child immunised. But it's also a precursor that someone in the house is not taking responsibility. A family may decline an appointment, which is different from just not showing up. But they're chaotic that they forget, so it's the chaos that's in the household. When nurses let*

> *CYFS know about missed appointments, they often won't activate a case until they have three hits [CYFS being contacted three times with concerns about a child at risk], at which stage they'll do something, so nurses hold on to that concern for a lot longer than anyone else and carry that. I don't think there's an environment of partnership.*

Nurses usually see families over a period of time. They are therefore well placed to know when and why visits are declined or, more importantly, missed altogether. Karen's understanding of the implications of missed visits comes from past experience and having observed negative outcomes with children. While she waits for CYFS to respond, the burden she carries accumulates. As previously described, the call to care draws Karen to feel responsible for the Other. She knows that even 'one hit' may mean increased risk for the child. Waiting for "three hits" contributes further to the emotional burden. It is the nurse's sense of responsibility which helps sustain their call to care (Berman, 1994b), even while carrying an emotional burden. Karen "hold[s] on to that concern" while waiting for CYFS to intervene.

Dewey's consequences and means-ends continuum help understanding of the burden which Karen carries. Dewey (1922/2007) argued that means and ends are series of acts within the same reality, just viewed at different stages. Means are actions in the present and can be controlled; however, ends are future possible actions that we cannot control (Visalberghi, 1953). The means, for Karen, is recognition that families "not showing up" for appointments is a sign of potential concern about a household. Her past experiences tell her that adverse outcomes for children are likely. Thus, although Karen's worry is imagined, it is one that she feels deeply. This draws her to make a judgement about what may be happening in the home environment and how safe or otherwise it is for children whose parental inaction could increase their risk for harm. It is knowledge of potential consequences for these children which creates a burden of concern for Karen.

Ends describe an event that have not yet happened, but one(s) we can foresee. Thus, they are hypothetically situated in the future, and are used to reorganise one's current actions (Visalberghi, 1953). Karen's knowledge of foreseen events are the ends that prompt her to ask what needs to be done. Hence, the previous experiences of consequence prompt action (Dewey, 1958); in this case, reporting one's concerns to CYFS.

Karen is reluctant to wait for three 'hits' because she worries the children will remain in an environment of risk. She knows that missed appointments are evidence of the struggles in the home environment, and that this struggle poses a potential risk for the children. Thus, she knows she needs to continue to work with families in the hope they will attend appointments. Carrying "that concern for a lot longer than anyone else"

reveals her belief (or perception) that the nature of her experience is different from that of the staff at CYFS. Karen spoke of CYFS as "dealing with a small percent *[of families]* at the end of the spectrum that have the highest needs", explaining that this small percent of families occupies much of CYFS' time. When most of their time is spent dealing with complex and high needs, the concerns nurses raise may be deemed less urgent by CYFS. Although Karen understands the pressure CYFS are under, she feels unsupported by the lack of partnership. The burden feels heavier because it is carried alone.

Like Karen, Amy becomes concerned when children miss health appointments. She recalls working with the health needs of a young child whose parents were suspected of being P users. The parents no longer brought their child to the clinic appointments and refused entry to the house when Amy tried to do a home visit. She was concerned about the safety of the child and attempted to get CYFS to investigate her concerns:

> *What do you do in that situation? We don't have formal case reviews in our practice, we just talk through it. So we have conversations about it, who else can I call, what can I do about this, have you got any other ideas? I talked to the clinical director and asked what to do. I say what I've done, so I've called CYFS twice and they're not really doing anything and I want them to do something. CYFS threshold of concern just seems to be higher than what we have. I can be really worried and want something done now, and they're like, it sounds kind of okay. And you think, no, it doesn't sound okay.*

Amy's concern about the risks for the young child continues to grow while trying to work with parents who are not engaging with her. Missing an appointment is an end, or the consequence of the home environment. However, it is also the means by which Amy's concern emerges. Her concerns about the safety of the child living with parents who are suspected P users is worrying enough. This concern, and the parents denying access to the child, not only leads to Amy's judgment about the level of risk and thus the consequences for the child, it also adds to the burden of concern which she carries. Amy can foresee the potential for neglect and lack of care for the child, meaning the potential ends prompt her to continue to try to get CYFS involved as well as trying to get support from her colleagues. Although helpful, Amy's colleagues are unable to do anything other than talk through this situation with her. There are no case reviews or guidelines to help her convince CYFS of the seriousness of her concerns.

Amy uses the term 'threshold', suggesting that she and CYFS have different levels of concern. There is a sense of frustration that she cannot convince CYFS of her concerns, along with a sense of conviction that she wants "them to do something" and to do it "now".

The sense of anguish gives meaning to the feelings of being caught between deep concern, powerlessness, and frustration.

Passion and human restlessness heighten the nurse's call to care (Berman, 1994b). Amy must continue to fight while she believes the family's situation puts the child at risk. However, in the absence of the type of proof that presents in physical abuse, Amy will struggle to get CYFS to intervene. Their threshold of concern is lower than that of CYFS. She does not imply that CYFS do not care. Rather, that they use most of their time working with the small percent of families with more complex needs, and they are not face-to-face with all children.

Amy is called to protect the children from harm and feels a sense of responsibility to any child at risk. CYFS have not been exposed to the call which the Face of the Other commands; thus, Levinas (Critchley, 2002) would refer to nurses' need to act as a struggle with the Other. Without assistance from CYFS, Amy feels as though she is carrying the burden alone.

Grace, too, feels unsupported, this time by family when working with a vulnerable teenager in a child Care and Protection residential setting. It was not until late into the 15-year old's admission into the unit that she disclosed her history of sexual abuse to Grace:

> *She had a global developmental delay, low IQ, quite volatile and impulsive, putting herself into dangerous situations. Most of those behaviours were sexualised, meeting up with older men, doing sexual favours and stuff like that. In the unit she'd talk a lot about sex, so for me it was figuring out where all this had come from. She didn't want a bar of me at first, so I was quite persistent meeting with her every day and saying "hey how are you doing?" She slowly opened up and talked about anxiety and that she was scared of what she was doing in our unit. A lot of the conversation with her mum was saying what I thought might have happened when her daughter was younger, which was really hard because as a mum, you feel like you've done the best you can. Mum kind of thought, oh well, I've always had a funny feeling that the relationship with her dad was a bit off. While that gave us an answer, I felt quite hurt for the child because she lived there for so long and we didn't know what he was doing or what she was exposed to, so it was quite hard.*

Grace knew she needed the mother to help work out why her daughter was displaying high risk sexualised behaviour. The mother's support was particularly crucial considering the girl's global delay and low IQ. Based on her experiences working with children, Grace understood such behaviours, but without confirmation from either the girl or her mother, there was little she could do other than be present and watchful. Grace carries the burden

alone until the mother opens up to her. She tries to avoid blaming the girl's mother for not being able to prevent the abuse but is distressed because it has continued undetected for so long. Carrying the burden alone is compounded by her prior understanding that a mother's job includes doing their best to protect their children.

To be human is to be vulnerable, and to be vulnerable is to open oneself up to feeling a range of emotions (Lashley, 1994). To open oneself to feeling the hurt and pain of others is the consequence of not only being human, but remaining so when working alongside vulnerable children with traumatic backgrounds. According to Levinas, "suffering discloses the burden of being" (Edelglass, 2006, p. 43). Forming a relationship with the girl is Grace's means to the ends of getting a disclosure; however, these means also open her to vulnerability. Grace experiences an unintended, but perhaps inevitable, transference of emotion. According to A. Jones (2005), the transference that Grace experiences is linked to attachment. It occurs unconsciously when feelings from a client are transferred to the nurse (Swatton, 2011). The ability to attune oneself to the feelings of another is an empathic skill at the core of nursing (Hawkins & Shohet, 2006). Thus, working in more emotionally distressing situations such as Grace's workplace make transference more likely. At times, the risks and discomfort experienced from rendering oneself vulnerable may lead to questioning whether being vulnerable is worth the risk (Lashley, 1994). Having given herself to vulnerability, Grace encounters the emotional toll of enabling the girl to disclose her past abuse.

This situation was "hard" because Grace carried the burden alone. This can become overwhelming. Berman (1994a) asked: "how does one become immersed in suffering and yet not drown?" (p. 175). 'Staying afloat' while suffering is to show one's vulnerability. Grace's willingness to be vulnerable and open herself to the suffering of the girl facilitates disclosure of the abuse. Thus, Grace's call to care lies in her openness to vulnerability, even when experiencing this burden alone.

The Nature of the Burden

The burden of working with families with complex needs also has inherent legal implications. Megan describes the stresses and fears she experiences:

> *It's stressful work. I did find I got very stressed sometimes, some cases I was just so pleased to see the back of because they were just so complex. There are a lot of cool families out there who are really grateful for all your help. Actually probably 90% of them were really good, not easy, but pretty straightforward. I really struggled with the complex cases, I didn't trust my own ability around risk assessment and felt very*

stressed and used to fear I was going to be held accountable for something going wrong. I was always thinking, what if this was the case that ended up in court? Have I got good rationales for what I did?

Megan is worried about the vulnerable children with whom she works, and fearful of being held accountable if something goes wrong. Getting something wrong does not only have adverse outcomes for children. It may also mean having to defend oneself, as a nurse, in court. The nature of the burden implies she is "always thinking" about this possibility. It sits on her shoulders as a load almost as if she is waiting "for something to go wrong". Feeling inadequate, Megan doubts her "own ability around risk assessment". Although Megan describes 90% of the families she works with as "not easy, but pretty straightforward", it is the 10% of complex cases that increase her fear and stress. It is the smaller percentage of cases and their complexity that add to the weight of the burden she carries.

Many of the job demands to which nurses are exposed create extraordinary levels of stress (Roberts & Grubb, 2014). This is exacerbated when contending with the suffering of others (McNeely, 2005). Megan's struggle with the burden exacted by 10% of complex cases is heightened by the fact that she is working alone in the community. She does initial risk assessments and makes decisions alone before seeking advice from colleagues back in the office. Dewey (1920/1986) argued that people face the consequences of their actions. Working in a stressful environment, particularly one where she sees the suffering of others, highlights the deeply felt impact for Megan, and thus the emotions she experiences. Furthermore, the consequence of experiencing her work environment alone is the heightened fear of getting it wrong. The consequence of acting creates a connection between doing and suffering, leading to continual transformation (Dewey, 1920/1986). In Megan's case, the level of suffering resulted in her resignation after only 12-months of employment. After our interview had concluded, she disclosed that she was not offered professional supervision or any other form of assistance. She also said that she never asked for it, because having to do so only exacerbated her feelings of inadequacy.

Megan believed it was her workplace's responsibility to provide supervision. When the workplace constrains nurses' ability to carry out their responsibilities, they often experience moral distress (Jameton, 1984) and there is a clear correlation between nurses who experience moral distress and their intention to leave nursing (Bong, 2019; Laurs, Blaževičienė, Capezuti, & Milonas, 2019).

The following story illustrates the nature of the burden as one which is sometimes experienced as heavy. This is in response to a disclosure made in the nurse drop-in clinic within an intermediate school (children approximately 11-12 years of age). The clinic ran

one day per week, and children could drop-in without an appointment if they wanted to see the nurse for any reason. Karen's approach was to use a HEEADSSS[9] assessment with children visiting the clinic. One student in particular, who was previously unknown to Karen, stood out for her:

> *I asked one girl who else lived in her house, and she said she was living in a boarding house with mum and all these other men. You also ask how they're getting on at school, and she said she couldn't concentrate because she kept seeing rape things. She was having PTSD flashbacks and night terrors… she'd wake up and see red blood and black and awful things. She'd been sexually abused living in that boarding house with her mum, who couldn't protect her. It turns out the mum had a bad history of trauma and sexual abuse herself. So mum would send the daughter to stay out of town with family and was sexually abused when she was there by a family member, the same one who sexually abused the mother…. It's making me feel like ugh because this was a particularly nasty one.*

Karen feels the full weight of her emotions when recalling this account from a child. Months later, she still feels 'ugh' when recounting this "particularly nasty" story. "Ugh" describes a bodily response to ghastly details. It also reveals conflicting emotions ranging from deep empathy to abhorrence, the former for the child and the latter towards the perpetrator(s). Understanding the seriousness of the girl's situation arises not only from what Karen hears and sees, which in itself is powerful, but also from the way it makes her feel physically. According to Merleau-Ponty (1962/1999) our body is "the vehicle of being in the world" (1962/, p. 82).

Thus, for Karen, the nature of the burden from this situation is one that feels heavy, both bodily and emotionally. The burden of her concern which she has carried all this time attunes with how she feels when retelling this story. While suspecting child abuse is known to cause nurses distress (Dahlbo et al., 2017), one can only imagine Karen's distress upon hearing such a disclosure from a vulnerable child. Sundler, Whilson, Darcy, and Larsson (2021) recommends that nurses who work in schools need to be prepared to encounter child abuse. Yet little can prepare for the immediate physical sensation and response in our body when hearing such disclosures, and their accumulative effect is likely to increase this burden.

[9] HEEADSSS is an acronym for a comprehensive adolescent psychosocial assessment used to identify risks, health and protective factors and stands for: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/depression, Safety (Starship Child Health, 2022).

The burden nurses experience also comes from having empathy and compassion for others. Yvonne remembers working with a 14-year old boy. She had noticed there was little or no food in the cupboards. The mother did not know the boy's whereabouts nor that he was often missing school:

> *As the last question of the HEEADSSS assessment, I asked him, "Who loves you and how do you know they love you." I always ask this. He said "nobody." It just broke my heart. I said "okay, so can you tell me in the last week or two weeks, has anyone done something nice for you." He said, "Oh yes, the teachers, they feed me." "So the teachers must care about you." He goes, "Oh yeah, they do, they feed me." So what can you say? You just realise that he doesn't have anything, he doesn't have the resiliency, he doesn't have any confidence in himself and he doesn't have anybody who cares about him. He was one that really stuck in my mind because I didn't think I had done enough really to help him. Maybe not just me, but all the people who were working around him. So I told the social workers "you need to uplift him". He is not doing well mentally. It can be quite a disappointing way to work.*

The nature of the burden Yvonne carries is one of heartbreak, the depth of which was palpable during the interview. The disclosure that nobody loved him deeply impacted Yvonne. She relived the concern she felt as she was describing this situation. It was one that had stayed with her—"really stuck in my mind". Yvonne was further burdened by the fact that neither she nor others were able to address this neglect. Seeing the boy feeling unloved and neglected broke her heart. Her knowledge about the potential consequences of this neglect adds to her burden. Yvonne carries a sense of guilt: "I didn't really think I'd done enough to help him".

According to Dewey, our actions are determined by inquiry and reflection on the significance of consequences of past actions (Stark, 2014). Thus, the potential consequences for the boy of living in an unloving environment is the means for Yvonne to ask the social worker to uplift the boy. Yvonne's compassion for the boy enables her to provide what Hall (2013) described as a depth of care beyond that of simple nurse–client relationship. Yvonne's concern encompasses the compassion she had for the boy. According to Levinas (1985), compassion is the highest level of being ethical. Yet there are consequences of continually giving of oneself and experiencing the disappointments that Yvonne describes.

This assessment includes awareness of the long-term impact of neglect and, while perhaps not an immediate threat to life, is the means to future trauma as the boy grows into an adult. Yvonne knows that neglect is hard to recognise because it is more about omissions

than actions (Polnay, 2001). For the same reason, it can also be hard to prove and to address. Perhaps this contributed to the feeling that she had not done enough.

Coping With the Burden of Concern

While some nurses (e.g., Megan) find the burden too heavy and walk away, the nature of the concern compels others to carry on. The Face of the Other (Levinas, 1985), as explained previously, calls nurses to stay. Many try to reduce their burden by seeking support and developing coping strategies. Debbie, describes how she sought ways to enable her to carry on:

> *…as the nurse I only had supervision from CYFS, not from my own organisation, so I felt that I carried those children as my weight. I think I had what I believe is professional love, no one talks about it but I do believe that I developed a compassion and a love for these children, so I loved them. I think I'm very reflective and I reflected deeply on all the work I did and sought to learn and develop my own strategies. I'm not a religious person, but I strongly believe in the power of connection, and I think my connection to my staunch strong base and with the children was really important. When I would visit CYFS, the social worker would often not be in the office, so I would sit down with this admin woman and we would talk about the case together then she would run the plan past the social workers. I knew I was working with an admin woman, but she had skills, experience, and internal knowledge, so I was never concerned about her not being a true social worker. If you put it all together, the school, the classroom teacher, the psychologist, the CYFS admin woman, the theme is relationships. I think it was about constantly talking. You know, even since I've explained all that, I now feel lighter. I was quite overwhelmed when you asked how I manage, but now that I've talked, I think I've used varying forms of supervision about how to navigate this space and complexity.*

Debbie talks about the children being her weight. She knows she carries the weight of the children whom she has not been able to help. Nursing is known to be more stressful than many jobs, and of all healthcare professionals nurses are reported to have one of the highest levels of job stress (Bourbonnais, Comeau, Vezina, & Dion, 1998). Debbie feels the human suffering of children who are at risk. They rely on Debbie to notice, speak for them, and provide practical support. This stress remains even as she tries to find ways to reduce the burden.

Learning from her experiences by reflecting on-action (Schön, 1983) helps Debbie to consider ways to reduce the burden she carries. Reflection is a means to develop new

approaches to situations which occur in practice (Benner et al., 2008). The strategies Debbie develops to help reduce the burden are ones she can employ in future situations. Thus, her historically effected consciousness becomes part of reflecting on-action, from which her thinking informs the present, and helps her with the anticipation of future situations. Reflecting on-action enables Debbie to reconsider her actions and their effect, forming new understanding by a fusion of horizons (Gadamer, 1975/2013).

A level of professional love is central to enabling Debbie in being able to carry the children she has worked with, even years later. Professional love describes the depth of care nurses feel for many of the families they work with. It is a close relationship that still maintains professional boundaries. Slunt (1994b) speaks of healing love as that which can be developed by 'being present' and being alongside clients. Rollings (2008) suggested that having professional love for a client is an exceptional quality. It can attract love back from the client, thus enhancing the therapeutic relationship.

Debbie implies that the "power of connection" helps to sustain her practice. Trust and attachment are developed when nurses connect with others in an authentic way (Slunt, 1994b). However, these burdens are hard to relinquish. Debbie uses the power of connection to try and relieve the suffering of the children she carries but, in doing so, takes on the burden of grief. There is grief for the children who have suffered even when she can help them, and grief for the children she is unable to help.

Debbie seeks others who can help her reduce this grief and sadness. At the same time, she hopes these 'connections' will indirectly help the children's predicaments. Unsupported by a relative lack of professional supervision, she utilises the supervision offered by CYFS. "As the nurse", Debbie "only had supervision from CYFS" rather than her "own organisation". She implies this contributed to the feeling that she carried "the children as her weight". It raises questions about the adequacy of what support, if any, is provided to nurses by their profession. Debbie draws on different strategies to help her cope. While the ability to find ways to cope with difficult situations and emotions is a hallmark of resilience (Block & Block, 1980), at what cost is this to both individual nurses and to the profession as a whole?

In the next excerpt, Abby puts herself into a kind of "lockdown" to focus her response and manage her emotions. The disclosure from the mother was that her 4-year old boy had been hit by the uncle in her family home. When Abby explained to the mother that this was child abuse and would need to be reported to CYFS, the mother tried bargaining to stop this happening because it would divide the family. Abby eventually found out that the abuse related to dual ethnicity. The boy had stated he was Niuean when he was of mixed

Tongan and Niuean heritage. The uncle was Tongan and wanted the boy to identify with his Tongan heritage. Abby describes her distress upon learning this:

> *You kind of go into lock-down yourself because you have a focus and you know what it is you have to do and you kind of have to stay calm and repeat yourself a lot to the parents or the family members, particularly if they are bargaining with you not to keep going through. So, I guess you put any emotions you might have aside. When things are sorted and you have a good outcome and the families are now in a safe place, or the child is in a safer family functioning way. That particular child, when I found out why he was hit, I did have a good cry on a Friday night with a glass of wine. He was probably one of two children of my 10 years of working in this role where I had a cry. I guess it is just because we are human. To think a child could get hurt based on ethnicity. I just think that is probably what got me the most.*

Even though Abby is distressed by the reason for the abuse, she cannot think about this until the boy's safety is assured. Stepping back from the immediacy of the situation helps Abby to reflect and reconsider. Reflection on-action is an important way to help move thoughts from a situation and connect with deeper understanding (Perry, 2000; Schön, 1983). Furthermore, reflection on one's practice is an effective strategy in developing moral courage (Gibson, 2019). The high emotional costs of nursing emphasise the importance of reflective practice (Knight, 2015). Being able to have a glass of wine at the end of the working week also enables Abby to release her feelings. Although not the ideal solution, it helps her to cry. She is reducing her burden in the best way she knows.

The individuality of nurses and the differing nature of their burdens leads them to find different ways of reducing the burdens they carry. Abby feels caught in the middle of the parents and the child. Thus, she recognises she needs to "stay calm" while "putting her emotions aside". She wants to protect the child but must also consider what is best for the family as a whole. Nurses' work is grounded in both ethical standards and moral obligations. Situations which have an ethical dimension, wherein nurses' professional values are challenged, create moral distress (Mealer & Moss, 2016). Abby feels the burden of being in the middle of a pleading parent and what she feels morally obliged to do to protect the child. Complex decisions make it easy for nurses to have feelings of guilt, more so when the nurse carries the burden of a life or death outcome (Hyde & Coggan, 1958). Regardless of the decision she makes, Abby knows there will be repercussions for the family. She needs to step back to avoid becoming compromised by the parents' emotions. She understands the family's distress but has to balance this with knowing that abuse of the child could escalate. She also knows she faces the ramifications of not reporting abuse, as set out in New Zealand legislation (1961). Action based on the knowledge of

consequences involves knowing what may happen from past experience, from observing the current situation, and putting these together to form a judgement (Dewey, 1938). Dewey described this as the significance of consequences resulting in purpose. Thus, Abby's actions are based on the consequences of her professional knowledge, of which the purpose is to safeguard the boy. However, having to choose which expectation to meet, and being unable to satisfy everyone can contribute to feelings of guilt (Hyde & Coggan, 1958) and thus, once again, to the nurses' burden.

Debbie describes the way she copes with the burden of carrying concern while awaiting CYFS' intervention:

> *My threshold of concern was much lower than the threshold of CYFS, so I would refer issues to CYFS if I was concerned. They may make a decision that no intervention was needed, but it didn't feel to me as if the issues were alleviated. I would manage this by putting my hand to my knee and I would say that I carry the children of concern from here, and then I'd put my hand above my head, and the children above my head would be taken by CYFS. So the children who ended up in neuro intensive care from head injuries would be taken by CYFS, but the child with blood in their knickers where no one could prove they had been sexually assaulted, I felt I carried that. I would meet weekly and just chat with children who had blood in their knickers, because I thought if they developed a relationship with me and trusted me, they might tell me what was going on...*

Debbie's way of indicating the burden she carries is by physically placing her hand on her knee to indicate where she would intervene, and then raising her hand above her head to demonstrate the level of abuse/concern when CYFS would act. The statement: "I felt I carried that" refers to her juggling the different thresholds of concern while trying to build enough trust to enable the children to disclose "what was going on". Perhaps with 78,000 reports of concern in 2021 and 1,835 front line social workers (Oranga Tamariki, 2021), Oranga Tamariki need to triage and thus prioritise reports which suggest immediate threat to the child. Yet, being with families in their homes suggests that nurses cumulatively understand that long term emotional and mental disability/illness are significant. Debbie must be the keeper of these concerns until they meet CYFS' threshold. She carries the burden of concern until this threshold is met. At the foundation of nursing is the duty to care (Dunsford, 2022), thus the willingness to take on the pain of others is a consequence of the call to care. Acting on what we see, hear, and touch results in consequences that form our purpose and thus creates meaning (Dewey, 1938). It is difficult for Debbie to witness the suffering and pain of others. The inability to protect others or to preserve life weighs heavily on those who are called to care (Lashley, 1994).

While all nurses learn to develop personal strategies to reduce the burdens they carry (Abbasi, Ghafari, Shahriari, & Shahgholian, 2019; Cheval et al., 2021; Saver, 2021), workplace support is absolutely essential (Wolf et al., 2016). Karen recalls a time when she felt burnt out from her work and how she sought help to cope:

> *I felt burnt out for a while, but you have to recognise it. I had supervision at the time. When I first came to NZ the first thing I asked for was supervision and was told, oh no, you can't have that. The policy was changed and we got supervision, albeit in groups. Then some staff got trained to be supervisors but not your line manager – it can never be your line manager. When you're working in a stressful environment you do need to look after yourself. Working with complex families on a daily basis takes a toll. There's a whole transference thing, like I stopped working with babies when I had my own babies because it's really hard to separate when you get home. I think people underestimate the impact of our work. I think quite often people see supervision as just going to talk about things, but I think people need to be challenged about what they're doing and how they're doing it. You know, asking what made you behave this way or not behave that way. How are you going to cope if you hear this again? It's building strategies to cope and manage, and recognise when it's time to move on. I don't think many of us have had good supervisors. I change supervisors regularly because you get comfortable and complacent as a relationship together and you need someone who will challenge you and ask the questions.*

Providing unconditional emotional support and facing the challenges of "complex families on a daily basis" wears Karen down. Such experiences contribute to moral distress, which, in turn, lead to burnout (Wolf et al., 2016). This is further illustrated based on the strong link between nurses' psychological distress, having limited control over decisions in high demand roles and emotional exhaustion (Bourbonnais et al., 1998). To be burnt out is to feel emotionally exhausted (Sun, Lin, Zhang, Li, & Cao, 2017). Burnout is a serious work-related side effect of occupational stress and has an associated human cost including real damage to their health, reduced mental health, and feeling demoralised (Peate, 2015). Karen recognises that the emotional burden of her work with at-risk children has resulted in burnout. It is a personal toll based on her understanding of the consequences for children who remain at risk. Burnout is also a result of working in a "stressful environment" which "takes a toll". Dewey believed that reacting to the consequences of one's actions creates meaning (Polkinghorne, 2004). Thus, Karen knows you need to "look after yourself" in a stressful working environment. She reacts to being burnt out by seeking supervision and, when necessary, changing her workplace. The potential

significance of this is that the support needed to help nurses reduce their burdens is underestimated. While it is important that nurses themselves recognise the emotions that traumatic events create (Tingberg, Bredlov, & Ygge, 2008), it is also crucial that workplaces assist nurses to cope, both in the short and long term. Karen is human. She cannot switch off the concerns that she carries but she can be proactive. Having the confidence and ability to challenge access to supervision is important (Yip, 2006) and Karen, who has come from the UK to New Zealand, seems to have been a catalyst for a policy change to implement supervision in her new workplace.

Research by Tingberg et al. (2008), supports nurses' needs for formal counselling to help them cope with their work with children who have been abused. Seeking to further reduce the burden she carries, Karen devises other ways of coping. Knowing "when it's time to move on" is important, especially when she has her own babies and worries about transference of her emotions to her own family. Over time, she has come to know what helps to alleviate the burden she carries.

Summary

Working with vulnerable children and complex families burdens nurses significantly. They carry this burden because they care. Its toll is primarily emotional but is also physical and legal in nature. The responsibility of working with children whom they suspect are being neglected and/or abused invokes feelings of sadness, helplessness, guilt and grief. Furthermore, nurses often feel as if they are carrying these burdens alone. This may be due to a lack of support from other agencies and perhaps from the families whom they are trying to help. The fear of getting something wrong, feeling inadequate, and/or powerless to bridge the differing thresholds of concern is part of their everyday life. Feelings of inadequacy and vulnerability arise from the failure of being able to help someone in need (Slunt, 1994a). The 'carrying' feels like a weight that sits on their shoulders while the tensions within the burden are ongoing. Despite the burden of concern nurses carry, many continue this work. They are drawn to the children, the Face of the Other, by a force that commands their responsibility for the Other.

Many of the stories in this chapter relate to potential neglect of the child. The difficulty proving neglect is a significant contributor to the burden experienced. Yet, feeling compelled to act, the nurses find ways of coping. They also seek support, although not always successfully, from their workplace. The nurses in this study needed support beyond that which was offered, seeking to be sustained and thus to reduce the burdens

carried. The next chapter will discuss the findings as a whole and offers recommendations for practice, education, and further research.

Chapter 8 – Discussion of Findings, Recommendations, and Limitations

Introduction

A summary of the thesis findings will be presented in this chapter. What this study offers and the implications for practice, education, and research will then be discussed, followed by discussion of the limitations of the study.

Summary of Findings

The findings chapters have described and interpreted the experiences of nurses as they work with families in the community. This study has shown that nurses who suspect children may be being abused and/or neglected experience uncertainty about what the consequences will be for children at risk, their families, and also for themselves personally and professionally. Their stories have shown that a consequence of this concern prompts action. While in the midst of trying to build and nurture relationships, they face uncertainty as to whether they will be able to form a relationship. When suspicious about the risk to children, in the absence of proof, they worry about whether their suspicions will be believed. When recognising the consequences vulnerable children may experience, nurses also worry about whether they will be supported, and thus often carry a burden of concern. All the while, they remain focused on reaching an outcome which both keeps children safe from harm and supports their families.

The concerns of the nurses in this study and how they felt about them are intertwined with their interpretations of the situations in which they found themselves. This concern drives their ethical responsibility and their need to act when they suspect abuse or neglect. Nurses know that relationships are important and work hard to build a relationship and gain trust. Amidst the complexities and challenges of nurturing a relationship, they do not know if the family will allow them to help. It is the ethical call to action which compels them to continue amidst barriers they may face.

Nurses develop ways of nurturing relationships based on past experiences of what has proven effective. However, no two families are the same. Each new family requires new ways of working. A family's lack of trust in other agencies may make it challenging for the nurse to build and nurture a relationship, particularly if children are at risk. Similarly, it may take longer to build and nurture relationships with children who have traumatic backgrounds. Including an explanation about limited confidentiality is an important part of nurturing relationships because the latter has the potential to break trust. However,

there are times when the nurse has to find other ways to keep children safe because they feel as though other agencies may not fully trust their assessment of risk. Thus, building and nurturing a relationship with other health professionals and agencies is crucial for the nurse to support a family.

Feelings of suspicion invariably arise for the nurse in relation to risks that may exist for a child. The feeling that something is wrong begins with a visceral gut feeling based on the subtle and/or more obvious cues noticed. Sometimes nuanced cues engender a sense of unease. At other times, a particularly horrific disclosure of abuse leads to an awful feeling whereby the nurse stays alert and more vigilant. However, nurses experience conflict between feeling suspicious and remaining open, not wanting to suspect. Suspicion is ever present and at times all-encompassing. To be ready to receive a disclosure or to notice risk is to always be suspicious. It is relentless and inescapable.

The emotionally demanding nature of this work leads to the nurse carrying the burden of concern. Sometimes this concern is carried alone when a lack of partnership contributes to the nurse not feeling supported with regards to their assessment of risk. The lack of partnership may be with the family of the child whom the nurse suspects have experienced abuse and/or neglect, or from other agencies who are dealing with the smallest but highest percentage of at-risk families. Nurses feel ill-equipped to deal with the complexity of some family situations. There is a sense of powerlessness accompanied by the fear of either not noticing or being wrong in their judgements. Nurses try to find ways to cope with the burden they carry. Some walk away. One nurse in this study left because the burden become too overwhelming. Others feel compelled to carry on. Another nurse in this study experienced concern regarding the adequacy of documented information available to them, and felt at times she needed more information. These are serious issues impacting the primary health nurse workforce. Burnout and depletion of this essential workforce is a very real risk. Thus, along with developing personal coping strategies, nurses need organisational support and professional supervision.

The findings of this study are important because they provide a deeper insight as to what these experiences are like for primary health nurses in New Zealand, and how they feel about these experiences. My research has highlighted significant concerns for nurses who work with children whom they suspect are being abused or neglected. There is cause for everyone who works alongside nurses in the community to be concerned about their experiences. This is because nurses do not work in isolation. Rather, they work in multidisciplinary teams. Therefore, it is imperative that those who work alongside nurses such as social workers, GPs, teachers, dental technicians and managers of nurses in the

community know what these experiences are like. They need to know that relationships with children and their families are critical for nurses, and that there are unique nuances and complexities when building and nurturing these relationships when the nurse suspects a child is being abused or neglected. The suspicion nurses feel is often felt as a gut feeling, and is a bodily response which tells the nurse what really matters. In the absence of proof, this suspicion is relentless. Without support, the concern nurses feel is often experienced as a burden, one which is emotional, physical and legal. This research has shown that these nurses often carry this burden alone. Therefore, the burden these nurses carry is a significant finding. It is only through understanding these experiences that change is possible. Prior to this study, these experiences were often hidden. We now have a deeper understanding of what these experiences are like and the impact on primary health nurses. To fail to act with urgency would not only deepen the burden nurses carry, but raise the real potential for nurses to leave this very important work.

Aroha's Story Exemplifies the Whole

The following story illustrates the complex nature of what it is like to work with children whom the nurse suspects is being abused and/or neglected. It shows the interconnecting themes presented in the three findings chapters:

> *She was a strong looking wahine Māori [female Māori] [14-years old]. It took me about 4-5 visits to build trust with her, and, after about 3 months, she told me she'd been sexually abused by a male member of the family. I suspected she had been sexually abused before she told me. She also said that her mother and others in the family had been sexually abused by the same person. Two weeks later the parents came back [from overseas] and requested an urgent meeting with me, my manager, and the psychiatrist. They thought their daughter had built too good a relationship with me, so they discharged her against medical advice. So, this girl who had built resilience over time, got it shot back down again because the parents took her away from the service just as she was starting to open up. The girl trusted me. The trust she had with me gave her the resilience to open up. After she was discharged she would ring me on the free-phone number from outside my [work] building and say she knew she couldn't come in, but asked me to come outside and see her. I'd have to say I couldn't [the family did not want their daughter to have any contact with Aroha] which was the hardest thing. It was horrible, it was absolutely horrible. It was real gut wrenching. She would ring me and tell me she was taking two pills, then four pills, then six pills. She was calling out for me to continue to work with her, but I couldn't go outside my boundaries. I couldn't do anything. I ended up moving away*

from that job because it became too much for me. It really put me off working with rangatahi [Māori youth] and mental health. About 7 weeks after I left she attempted suicide. It was horrible. All that hard work and the relationship I built. All the resilience she built to go against her family. It was all for nothing. It was very hard. She just needed a bit of love, support, and guidance, and I couldn't do that.

Aroha knows how to work with youth towards trusting relationships. The Face of the Other, a "strong looking wahine Māori" [female Māori] called Aroha to be patient. Aroha knew this was particularly important because the girl had tried to commit suicide prior to meeting her, thus she needed to be guided by when she was ready to form a relationship. In doing so, Aroha was answering the ethical call to action by persevering for as long as it takes to build a relationship and trust.

Aroha suspected the girl had been sexually abused. Working with children with complex needs is not linear, and building a relationship does not necessarily happen in isolation to developing a suspicion. A suspicion can develop before a relationship is established, prompting the need to build a relationship to enable sufficient trust for a disclosure. While Aroha's suspicion shows the importance of forming trusting relationships with children, reflection on-action shows the precariousness of trust when relationships have not yet been developed with parents. Thus, her visits are the means to noticing anything either confirming or refuting her suspicion. She lives with an ongoing uncertainty which lingers until her suspicion is confirmed.

Aroha waited "about 3 months" until the girl felt safe enough to disclose the history of sexual abuse by her grandfather. She is thus acting upon what Levinas (2003) described as one's responsibility to the Other by building a relationship and continuing to nurture it until the girl felt safe enough to disclose the abuse.

The burden nurses carry is always present while developing and nurturing a relationship, and feeling suspicious. Nurses feel a burden of concern because they are called to care (Lashley et al., 1994). The paradox of this situation is that the consequences of having gained the trust required for self-disclosure, Aroha must vicariously endure her pain and hurt. Nonetheless, Aroha values her ability to establish and strengthen trust in relationships because she knows without this the client–nurse relationship will not develop.

The call to act ethically based on the Face of the Other (Levinas, 2003) led to unbearable tension for Aroha. The NZNO (2012) state that nurses must uphold the ethical values of beneficence and non-maleficence. Beneficence is described as doing acts which lead to worthwhile outcomes and is the notion of doing good; whereas non-maleficence is

described as the avoidance or prevention of harm (NZNO, 2019). Aroha knew she needed to uphold her professional responsibilities, thus maintaining ethical practice. However, she also knew this meant she was unable to act in a way that led to beneficence or positive outcomes for the girl, and was, sadly, unable to prevent harm and thus support non-maleficence. The girl's need to maintain a relationship with Aroha contributed to an enormous sense of guilt, forcing her to prioritise her professional boundaries over the consequence of risk of harm to the girl. The ethical tension of protecting herself but being left unable to protect the girl was a life changing experience for Aroha: "It was horrible" and "became too much".

The emotional toll became a burden she could not carry. The pain and hurt endured contributed to Aroha leaving the workplace as a way of coping. The deep care, concern, and disappointment were ongoing.

What This Study Offers

This is the first study in New Zealand that has asked a range of primary health nurses who work with children across all age groups, what it is like to suspect a child is at risk of abuse or neglect. One small study in New Zealand explored Plunket nurses' experiences when making decisions on child abuse and neglect, however, Plunket nurses work with children who are exclusively under the age of 5 years (Carter, 2010).

In my interpretation of the stories in this study, I have sought to give voice to experiences that they tend not to speak about. Understanding such experiences is crucial if changes are to be implemented to support the work of primary health nurses. This study builds on what was previously known and revealed in the literature.

The literature review revealed a scarcity of research and thus understanding about primary nurses' experiences when working with children whom they suspect may be being abused and/or neglected. The nurses in this study gained valuable insights about the risks to children from a variety of settings such as homes, nurse clinics, and State residential facilities. Most of their understanding was acquired in face to face interactions with clients and families. The literature showed that primary health nurses play a role in protecting children because they are well placed to detect and thus respond to concerns (Dahlbo et al., 2017; Lines, Hutton, & Grant, 2020a; Nayda, 2004). In addition, the importance of home visits by primary health nurses was highlighted as central to child protection. Their experiences building and nurturing relationships during home visits was central to being able to assess risks of abuse and neglect.

The findings in this study, particularly Karen's experiences in Chapter 6, support Kraft and Eriksson's (2015) finding that school nurses rely heavily on intuition when identifying students they believe are being abused. This study found that nurses working in schools prepare for the potential of receiving a disclosure before they are alerted by their intuition. They therefore create an environment that enables a child to disclose abuse when they are ready. Nurses in schools experience suspicion relentlessly.

In all the three findings chapters there are disclosures of abuse to primary health nurses. Corlett and Taylor (2009) asserted that the nurse's role assisting with child safeguarding is crucial. Furthermore, their study found that nurses in the community have a critical role in recognising and responding to child safety concerns, particularly as they are face-to-face with children before most other allied or health professionals.

The study findings have extended understanding of primary health nursing by describing the challenges nurses face when building and nurturing relationships in the context of suspected child abuse or neglect. They live constantly with the uncertainty of whether they will be able to sustain the relationship. The nuances of these challenges and the ever present and secret nature of suspecting that a child may be at risk has not previously been discussed in the literature. This study has shed light on the nature of nurses' gut feelings and signs they notice that create suspicion. It has also revealed the ways in which suspicion compels action. Previously unrecognised was the significant burden of concern carried when nursing vulnerable children and complex families. The burden is one that is exacerbated by the nurses' knowledge of the consequences for children whom they suspect are at risk of harm. Nurses experience feelings of deep concern, sadness, grief, guilt, and, at times, helplessness. Moreover, they often feel they carry this burden alone. Another important finding is that the support provisioned for nurses in New Zealand does not adequately meet their needs. This has significant implications for nursing in terms of practice, education, and research.

Implications for Practice

This study sought to describe what it is like for the nurse to work with children they suspect may be experiencing abuse or neglect. The findings have revealed the heavy toll this work has on nurses in primary health care. It has clearly demonstrated the need for better support for these nurses. One recommendation for practice is that professional supervision is available for every primary health nurse who works with at-risk children. This responsibility is with the employer/workplace to ensure this is not only offered as a regular support, but is a mandatory part of nurses' workplace professional development.

Rafferty and Coleman (2001) found there are aspects of professional supervision that are generally agreed upon by nursing researchers. Those most relevant to this study include having the space for discussion of problems associated with nursing care and enabling learning and encouragement between colleagues, thus reducing stress, emotional strain, and feeling isolated. Research has shown that workplace initiation of an invitation for professional supervision is the cornerstone for participation by clinicians (Hemberg & Sjoblom, 2018). Thus, organisations need to ensure nurses know supervision is readily available and extend invitations to participate, avoiding the need for nurses to independently seek this out. While professional supervision for nurses in Australia and New Zealand is becoming embedded in mental health workplaces, there are efforts to extend this into general nursing areas (Brunero & Stein-Parbury, 2008). To date, efforts to extend supervision have not yet been embedded.

A supportive supervision environment provides reassurance and validation through sharing and understanding (Brunero & Stein-Parbury, 2008; J. Jones, 2005), and would help nurses alleviate the burden they carry. Janíková and Bužgová's (2021) research showed a significant correlation between nurses' job satisfaction and the satisfaction with clinical supervision and prevention of burnout. This puts the responsibility on employers for offering supervision to nurses, and ensuring the quality and effectiveness of that supervision.

Another recommendation is that employers and workplaces need to include nurses from the primary health sector in discussions about the support they deem helpful. The importance of preventing burnout, promoting self-care, and reducing the burdens nurses carry cannot be underestimated. Being part of this discussion will enable nurses to convey what has and has not assisted their efforts to find support and/or self-manage their burdens.

Oranga Tamariki (2022b) statistics show that Māori children/tamariki are not only more likely to be subject to a Report of Concern than non-Māori, but are more likely to be disproportionately represented across the entire flow within the Care and Protection system. Inequality and unemployment amongst Pacific populations contributes to the high rates of abuse of Pacific children (Sheehan, 2021). Thus, while increasing the Māori and Pacific nursing workforce has the potential to improve child outcomes, employers and workplaces must ensure all primary health nurses are able to better support Māori, Pacific, and vulnerable populations. Some of the ways this support can be embedded within Māori health and wellbeing are highlighted in a literature review by Wilson, Moloney, Parr, Aspinall, and Slark (2021). They conclude that Māori navigating the healthcare system benefit when whānau provide emotional and practical support, and that

there is benefit when healthcare practitioners acknowledge a person's wairua (spirit) and join whānau in karakia (Māori prayer).

Implications for Education

Primary health nurses' skill in identifying and responding to a suspicion that a child is at-risk develops mainly through experience. Primary health nurses who work in areas such as public health often work alone, even though they may meet with a wider team at the end of a day, or at some other time. This situation points to the importance of education/theory and how it underpins and supports practice.

Child health is a compulsory component within New Zealand nursing education (NCNZ, 2017b). However, as discussed in the literature review, there is no requirement to include child protection and/or specific assessment of suspected child abuse in the undergraduate nursing curriculum. With a cost of over $2 billion per year (New Zealand Family Violence Clearinghouse, 2011) and rated fifth worse of 31 OECD countries (Child Matters, n.d.), child abuse and neglect are more than worthy of mandatory inclusion in undergraduate and graduate entry nursing programmes in New Zealand. New graduate nurses encounter this topic for the first time when starting work for a DHB as part of their orientation. My challenge is for the NCNZ to implement this mandate. In the absence of a mandate, the challenge is for schools of nursing in New Zealand to incorporate education in undergraduate programmes on all types of abuse, including child abuse and Intimate Partner Violence.

In New Zealand, recognising and responding to child abuse are two key aspects included in literature across many organisations when encountering actual or suspected child abuse (Child Matters, 2017; Ministry of Education, 2022a; NZNO, 2013). These are aimed at guiding a range of people including the general public and health professionals. The findings of this research, together with my role as a nurse educator, have led to the identification of three key components recommended for inclusion in nursing educational programmes: recognise, report, and protect. Terms such as identify/recognise/respond/report are often used in documents aimed at educating the public or staff in organisations who may come across vulnerable children both in New Zealand and internationally (Bunker, 2015; Ministry of Education, 2022a; National Council for Voluntary Organisations, 2021). The three key areas below are aimed at public education. I believe they could be useful for nursing education programmes:

Recognise

- Definition of child abuse and neglect

- What is 'at-risk'?
- At risk of what?
- Confidentiality, limited confidentiality in relation to children, youth, and parents
- Disclosing the 'three harms' and that this is never negotiable (harm to self, harm to others, others harming you)
- Assessment is key – HEEADSSS assessment or Hearts and Heads conversational assessment (assessing a person's risk and resilience)
- Observe for behaviours that alert the nurse to further assess the child's risk and environment
- What do these alerts 'look' like? – physical signs, atypical age/stage behaviours, risk taking behaviours, chaos, not attending health appointments; property neglect
- Never make assumptions. Alerts are prompts to further assess, not a confirmation of potential or actual child abuse/neglect

Report

- Report to whom?
- Check workplace policy on reporting
- Know legislative reporting requirements and obligations
- Never work in isolation – always discuss concerns with a colleague
- Transparency with families and children when reporting a concern
- What information is needed when reporting?
- What happens once you have reported a concern to Oranga Tamariki?

Protect

- Protect the most vulnerable – the child(ren)
  - Is a child at risk of imminent harm?
- Protect and self-care for the nurse
  - Know your obligations (workplace policy and legislation on reporting)
  - Risk from others towards the nurse
  - Burnout
  - Strategies for coping
  - Workplace support.

There is also very little offered in New Zealand at postgraduate level that focuses on child protection or safeguarding. An example is the paper at Otago University 'Promoting Children's Participation and Protection' as part of their Postgraduate Certificate in Children's Issues (Otago University, 2022). The Child Matters organisation runs a New Zealand Qualifications Authority (NZQA) accredited Diploma in Child Protection Studies (Child Matters, 2022); however, this is a Level 5 programme which, in New Zealand, is equivalent to the level of the first year of a Bachelor's degree programme. Safeguarding Children (n.d.) based in Nelson offer online training and seminars for those wishing to know more about working with at-risk children.

Nursing students' training and work preparation is better when strengthened by educational programmes with classroom based learning and practice because it allows implementation of learnt skills (Berndtsson, Dahlborg, & Pennbrant, 2020). There is merit in the development of an interdisciplinary postgraduate, university-based child protection qualification for practitioners in order to better support their knowledge and practice. The implication for university education is the development of not just one paper, but a qualification of a postgraduate certificate in child protection/safeguarding. Nurse education relating to aspects of working with at-risk children such as navigating uncertainty and building resilience would support nurses in their work in the community. Mandating supervision in place for primary health nurses would encourage uptake of postgraduate papers pertaining to clinical supervision for health professionals and would better support nurses in their roles.

Implications for Research

Nurses who work in the community, work where the population resides and thus encounter different challenges to those in inpatient settings. While most international research focusses on the inpatient setting, studies in Sweden (Dahlbo et al., 2017) and Canada (Jack et al., 2021) explored the challenges primary health nurses encountered when working with at-risk children. Further research could focus on primary health nurses' thoughts on what more can be done within and outside of primary health nursing to better support nurses' work with at-risk children, with the focus on what nurses say they need from their employers. Collaboration with nurses in the primary sector is crucial to addressing the emotional toll of this work. Survey research would help to capture a large number of respondents and thus provide substantive data.

Research focused on collaboration between nurses and social workers concluded that greater collaboration between practitioners could be fostered by interprofessional education at undergraduate tertiary level (Bennett, Hauck, Radford, & Bindahneem, 2016). My findings also support the value of interprofessional approaches in order to enhance outcomes with children and families. Interacting with other professionals, such as social workers, is of particular importance to nurses when caring for children with suspected abuse as it provides more comprehensive care and enables more needs of the child to be met (Ciuffo, Rodrigues, & Tocantins, 2014). Thus, research contextualised to the New Zealand environment would be useful for establishing the effectiveness of interprofessional collaboration.

A recent study investigated how suspicion of child abuse arises with GPs and what actions they take as follow-up (Stolper, Verdenius, Dinant, & van de Wiel, 2020). Following from my study, it would be valuable to gain greater understanding about nurses' suspicion of child abuse, how it arises, and what they do as follow-up. Replicating this study in the primary health nursing population could assist with the recognition of child abuse and preventive actions.

An historical document analysis of child abuse cases may help reveal to what extent nurses are involved, and how different agencies work together. The notions of Bourdieu (1997) with respect to structural constraints and power would be useful in such a study.

My Reflections

Throughout this study I found myself reflecting in-action, being with my thoughts while I mulled over the nurses' stories. I now find myself looking back and reflecting on-action on the findings that have emerged from this study. The nurses who so generously entrusted me with their stories do their job because they care deeply. This is a calling that compels action. For most children who are at risk of abuse and/or neglect, the nurse is more likely to be the first health professional they come into contact with, highlighting both the importance of the nurse's role in primary health and the face-to-face contact they have with children and their families. As nurses in this study shared their stories, I often felt 'my hair stand on end', leaving me in awe of what they do and their dedication. I felt extremely privileged to have been part of such heartfelt conversations. Now, I feel a responsibility to ensure their stories are heard.

Limitations

The findings from this study provide important insights and understanding of nurses' experiences suspecting child abuse/neglect. I am fully aware that the findings presented and discussed are mine alone. Readers may have different understandings, yet they should be able to understand how I came to the interpretations made.

Another limitation is the absence of primary health nurses who did not participate. There were no participants from Plunket (an organisation that does pre-school anticipatory checks) and secondary schools. In addition, there was only one nurse who worked as a practice nurse and there were no male nurses. There are, therefore, many untold stories that could further inform the findings from this study.

The participants were primary health nurses from Western, Māori, and Pacific cultures. However, Auckland, is described as 'superdiverse' (Goh, 2019), whereby more than 25% of the population are migrants or where there are more than 100 resident nationalities (Chen, cited in Goh, 2019). Participation by nurses from other cultures represented in Auckland's diversity may have added further culture specific experiences to the stories told.

Conclusion

This study recognised a dearth of understanding about primary health nurses' experiences when working with children they suspect may be abused and/or neglected. It has contributed to understanding of a little known aspect of practice. I believe the findings will help nurses reflect on their practice, and assist them to voice their experiences and concerns. Encouraging nurses to talk with colleagues will open the dialogue necessary for change. However, change will only occur if the recommendations in this study are implemented. The importance of this research cannot be understated. The urgency with which these findings need to be addressed cannot be undertaken fast enough. This study has raised serious concerns about the welfare of the primary health nursing workforce and the burdens they carry every working day.

The nurses' commitment and persistence in building and maintaining relationships illustrates their sense of needing to advocate for vulnerable children. Their determination to either confirm or refute a suspicion stays with them, even amidst potential risk to themselves, or until external factors force them to stop working with the child.

Most of the nurses who participated in this study continue to give selflessly despite the toll on themselves. Their need for greater support is clear. Not only will this assist them in understanding and learning more about their practice and their wellbeing, it will help sustain an essential future workforce.

Nurses are called

and face whatever comes,

whether it be a child potentially at risk,

a difficult conversation,

risks to themselves,

And/or the grief of a child harmed.

Nurses show up every day, despite the toll to themselves.

Selfless, courageous, brave.

But sometimes broken.

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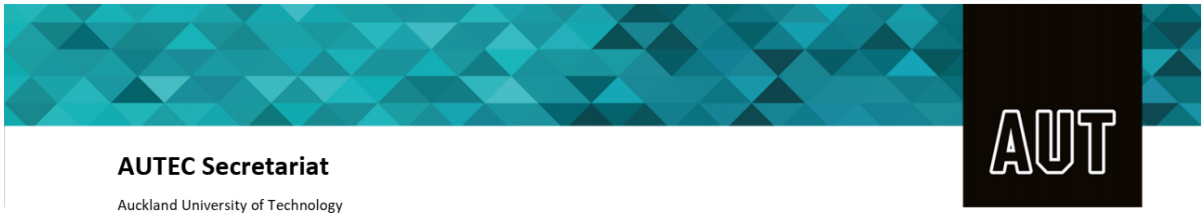
Appendices

Appendix A: AUTEC Approval



AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

27 September 2016

Deb Spence
Faculty of Health and Environmental Sciences

Dear Deb

Re Ethics Application: **16/317 What are the experiences of primary health nurses working with children who may have been abused or neglected?**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 27 September 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 27 September 2019;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 27 September 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Susan Platt; Shelaine Zambas

Appendix B: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

27/09/2016

Project Title

What are primary health nurses experiences working with children who may have been abused or neglected?

An Invitation

Greetings, my name is Susan Platt and I am an AUT staff member and also a student enrolled in the Doctor of Health Science (DHSc). The research I am conducting will contribute to my thesis/DHSc qualification which I am doing at AUT University. I would like to invite you to participate in the research I am conducting on the experiences of primary health nurses working with children who may have been abused or neglected. I am interested in finding out about your experiences as a primary health nurse working with children whom you suspect as having been abused or neglected.

What is the purpose of this research?

I am wanting to do this research because I am passionate about the care of children who may have been abused or neglected. There is much work that nurses do with these children which is not widely known, and I am wanting to give this work a voice. This research will inform nursing practice for those who work with children. NZ has the fifth worst child abuse rates out of 31 OECD countries and is therefore a significant concern. It is expected there will be a presentation and journal publication based on the research findings.

How was I identified and why am I being invited to participate in this research?

Primary health nurses with at least one-year practice experience who have worked with children whom you suspect as having been abused or neglected are invited to participate in this research. You have received this because you've responded to the flyer about this research. Primary health nurses who have worked with children who may have been abused or neglected are invited to participate in this research.

You have been invited because you have the experience and you are the expert!

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You will need to contact the researcher to enquire further. If you decide to participate you will need to sign a Consent Form.

You are able to withdraw from the study at any time for any reason. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Being involved in this research will mean attending an interview with myself, the researcher (Susan Platt). It is anticipated that interviews will be approximately 1.5-2 hours duration. Once the interviews have been transcribed, they will be sent back to you for reviewing, whereby you are invited to make corrections/changes. Interviews will be audio recorded and transcribed by a person who has signed a Confidentiality Agreement. I will be using the data from your interview to inform this research project for the purpose of the DHSc qualification I am enrolled in, for academic publications, conference presentations and journal articles.

What are the discomforts and risks?

There is a possibility you may recall events of working with abused or neglected children that cause you distress. This may include either the recall of the child's experience that causes you distress, or it may eventuate that talking about your experiences of not reporting child abuse causes you distress.

The Crimes Act 1961 s195A states that a person who has frequent contact with a child or vulnerable adult and who knows that the child or adult is at risk of death, grievous bodily harm or sexual assault may be liable to imprisonment if they do not take reasonable steps to protect the victim from that risk. What this means for participants of this study who are hospital or institution staff members, if you disclose practice (such as non-reporting) that has not

protected a child from the risks described in s195A, the researcher may be obliged to refer this to an external agency. All participants will be informed and reminded of this at the beginning of the interview.

How will these discomforts and risks be alleviated?

The interview can be stopped at any time, and you do not have to answer any questions that cause distress.

If participating in this research causes emotional upset or distress, free counselling is available at AUT drop in counselling services open Monday to Friday 9am – 4pm. City campus Wellesley St, Auckland, buildings WB219 or phone (09) 9219992; North Campus Akoranga Drive, Northcote building AS104 or phone (09)9219998.

What are the benefits?

For participants, this research is an opportunity to talk about your work. It may provide a space for you to reflect upon your practice and enable learning and growth from this. It is expected that those in receipt of nursing care will benefit from the recommendations arising from this research. The benefit to the researcher will be the achievement of a DHSc.

How will my privacy be protected?

If you decided to participate in this research, your name and place of work will be protected and will remain confidential. You will be given a pseudonym should quotes be used in the published thesis of this research or any publications resulting from this research. Any quotes used will have any potential identifiers removed. All data collected will be stored in a locked cupboard in a locked office at AUT University. All electronic data will be password protected.

What are the costs of participating in this research?

Costs incurred by participants are the transportation to the interview, the time taken to attend the interview of approximately 1.5-2 hours, and the time to read your transcript.

What opportunity do I have to consider this invitation?

From receiving this Information Sheet, there are two weeks for you to consider participating in this research.

Will I receive feedback on the results of this research?

All participants will be informed where the thesis will be located, and they will be informed about any publications resulting from this research. Unless you indicate otherwise, I will send out a 1-2 page summary of the findings.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Dr Deb Spence. Email dspence@aut.ac.nz, or 09 921 9999 ext 9392.*

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Researcher: Susan Platt, splatt@aut.ac.nz or phone 09 921 9999 Ext 7132

Project Supervisor Contact Details:

Primary Supervisor: Dr Deb Spence, dspence@aut.ac.nz or phone 09 921 9999 Ext 9392

Secondary Supervisor: Dr Shelaine Zambas, szambas@aut.ac.nz or phone 09 921 9999 Ext 7865

Approved by the Auckland University of Technology Ethics Committee on 27th September 2016, AUTEC Reference number 16/317.

Appendix C: Advisor Confidentiality Agreement

Confidentiality Agreement

For Transcriber to Susan Platt

Project title: *What are primary health nurses experiences working with children who may have been abused or neglected?*

Project Supervisor: ***Dr Deb Spence***

Researcher: ***Susan Platt***

✓ I understand that all materials and conversations are confidential.

✓ I understand that any materials or the content of any conversations can only be discussed with the researchers.

Advisor's signature: .....

Advisor's name: .....Cherry Campbell.....

Advisor's Contact Details (if appropriate):

Email: cherry.campbell@lakesdhb.govt.nz

.....

.....

.....

Date: 8th May 2017

Project Supervisor's Contact Details (if appropriate):

.....deb.spence@aut.ac.nz.....

.....Ph 09 9219999 ext 9392.....

.....

.....

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number 16/317*

Appendix D: Consent Form

Consent Form

For use when interviews are involved.

Project title: *What are primary health nurses experiences working with children who may have been abused or neglected?*

Project Supervisor: ***Dr Deb Spence***

Researcher: ***Susan Platt***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 27 Sept 2016.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I am aware that if I disclose practice that has not protected a child from death, grievous bodily harm or sexual assault (such as non-reporting), the researcher may be obliged to refer this to an external agency. This is in relation to the Crimes Act s195A that applies to hospital or institution staff members.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 27th September 2016, AUTEC Reference number16/317.

Appendix E: Transcriber Confidentiality Agreement

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title: *What are primary health nurses experiences working with children who may have been abused or neglected?*

Project Supervisor: ***Dr Deb Spence***

Researcher: ***Susan Platt***

- ☑ I understand that all the material I will be asked to transcribe is confidential.
- ☑ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☑ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ..... Plank

Transcriber's name: .....Deborah Plank.....

Transcriber's Contact Details (if appropriate):

P.O Box 89229
Torbay
Auckland 0742
ph 0274458895

Date:

Project Supervisor's Contact Details (if appropriate):

.....deb.spence@aut.ac.nz.....

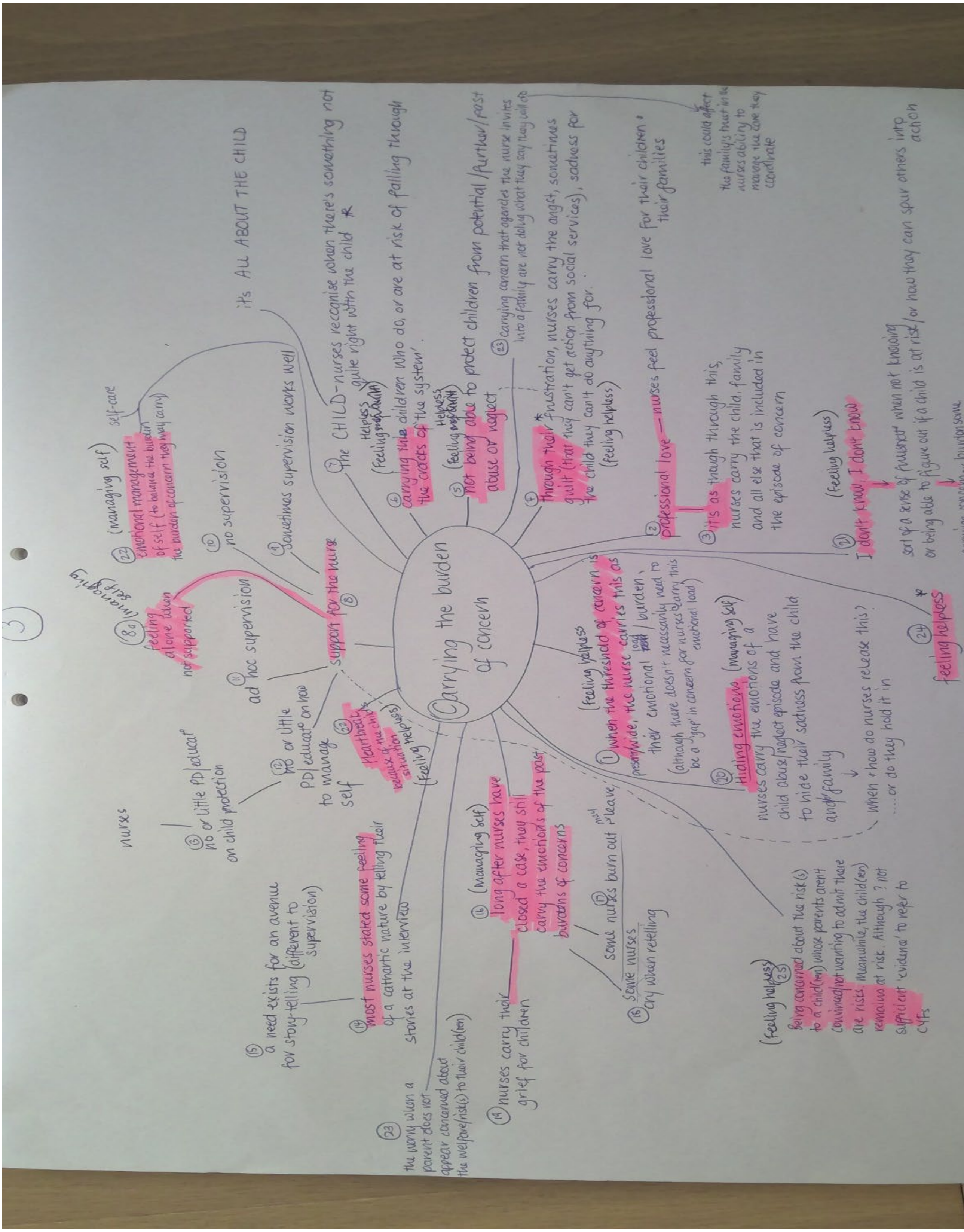
.....Ph 09 9219999 ext 9392.....

.....

.....

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number*

Appendix F: Mind Mapping Example



3
Carrying the burden of concern
nurses
13 no or little PD/educat° on child protection
12 no or little PD/educat° on how to manage self
11 ad hoc supervision
8a (managing self) feeling alone when not supported
22 (managing self) emotional management of self (to balance the burden of concern they may carry)
self-care
10 no supervision
9 Sometimes supervision works well
support for the nurse 8
it's ALL ABOUT THE CHILD
7 The CHILD - nurses recognise when there's something not quite right with the child
6 carrying the children who do, or are at risk of falling through the cracks of 'the system'.
5 not being able to protect children from potential/further/past abuse or neglect
23 carrying concern that agencies the nurse invites into a family are not doing what they say they will do
4 through their frustration, nurses carry the angst, sometimes guilt (that they can't get action from social services), sadness for the child they can't do anything for.
(feeling helpless)
2 professional love — nurses feel professional love for their children + their families
3 it's as though through this, nurses carry the child, family and all else that is included in the episode of concern
this could affect the family's trust in the nurses ability to manage the care they coordinate
21 (feeling helpless) I don't know, I don't know
sort of a sense of frustrat° when not knowing or being able to figure out if a child is at risk/or how they can spur others into action
24 feeling helpless
1 (feeling helpless) when the threshold of concern is wide, the nurse carries this as their emotional load/burden, (although there doesn't necessarily need to be a 'gap' in concern for nurses to carry this emotional load)
20 Hiding emotions (managing self) nurses carry the emotions of a child abuse/neglect episode and have to hide their sadness from the child and family
when + how do nurses release this? ... or do they hold it in
25 (feeling helpless) Being concerned about the risk(s) to a child(ren) whose parents aren't convinced/not wanting to admit there are risks. Meanwhile, the child(ren) remains at risk. Although ? not sufficient 'evidence' to refer to CYFs
15 a need exists for an avenue for story-telling (different to supervision)
19 most nurses stated some feeling of a cathartic nature by telling their stories at the interview
22 Heartbreak because of the child's situation (feeling helpless)
23 the worry when a parent does not appear concerned about the welfare/risk(s) to their child(ren)
14 nurses carry their grief for children
16 (managing self) long after nurses have closed a case, they still carry the emotions of the past burdens of concerns
17 some nurses burn out + most leave
18 some nurses cry when retelling