

Exploring Relational Nursing with Canada's Aboriginal Peoples:
An Integrative Literature Review

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Abstract

This integrative literature review explores the positive and negative approaches to relational practice in health-care encounters which involves nurses, health professionals and Aboriginal patients. The findings are organized around three major themes. Two themes illustrate a positive relational approach: being present, and being familiar. The third theme, illustrates a negative approach: dishonoring and disempowering behavior. The negative approach appears to be associated with commonly found discourses stemming from colonization, residential-school history and negative assumptions often emerging in health encounters with Aboriginal people(s). The findings from the review highlight the importance for nurses and health-care professionals to employ a positive relational practice to develop therapeutic health encounters between Aboriginal people(s), nurses, and other health-care professionals; this will help to promote the health of Aboriginal people(s). A perceived gap in research in this field leads to recommendations for further research.

Key words: Aboriginal, Native, First Nations, Relational, Nursing

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"Productivity is never an accident. It is always the result of a commitment to excellence, intelligent planning, and focused effort."

— **Paul J. Meyer**

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Chapter 1: Area of Interest

Introduction

As a nine-year-old child in the rural community in which I lived, I witnessed an inebriated fifteen-year-old self-inflict a severe injury, lacerating the wrist area, which bled profusely. This was a traumatic and frightening experience for me. Despite my young age, I knew this was a serious injury and that we were a fair distance from emergency aid—the nearest hospital was reachable only by seaplane or motor boat, which needed to be specially summoned. Fortunately, the individual did reach medical aid and received the necessary medical treatment. The day this incident happened, I realized I wanted to be a nurse. Although it happened about forty-two years ago, this event remains etched in memory, still influencing my desire and commitment to work as a nurse and to strive towards promoting Aboriginal people's health.

As a Registered Nurse (RN) of Aboriginal ancestry, I have worked primarily in the area of Aboriginal health for the past fifteen years. For most of my life, I have lived in Aboriginal communities, although I attended a Residential School for two years. Currently, I work with an Aboriginal organization as a Home and Community Care (H&CC) Manager. I have enjoyed learning and working within an Aboriginal context as it offers experiences both challenging and rewarding at personal and professional levels.

That incident which set my childish feet on the path to nursing more than four decades ago was anything but an isolated event. Unfortunately, such incidents continue to happen in Aboriginal communities today. Moreover, scholars contend that Aboriginal people continue to

endure disproportionately higher rates of ill health, social suffering, morbidity and mortality rates than do non-Aboriginal people (Browne, 2007; Kurtz et al. 2008).

Background

In this project, I will use the term *Aboriginal*¹ to include the three recognized indigenous peoples of Canada: the First Nations (FNs), Métis, and Inuit, as defined by Aboriginal Affairs and Northern Development Canada. Bourque Bearskin (2011) points out there are more than 605 different Aboriginal nations in Canada; each nation has a unique history, language and set of cultural beliefs and practices (p. 549). Statistics Canada (2010) reports the Aboriginal population is one of the fastest growing populations in Canada and may reach 1.7 million by 2017.

Aboriginal peoples are resilient peoples who continue to strive for health promotion, independence, and self-governance—goals whose achievement has been impeded by colonialism, which the federal government reinforced upon Aboriginal peoples through the institution, by law, of the residential-school policy in the 20th century. Residential schools were in existence from 1892 to 1996 (Alfred, 2009; Degagne, 2007; Loppie Reading & Wien, 2009). The federal government collaborated with Christian churches, utilizing their organizations as a vehicle to enact the residential-school policy. These schools were mandated to educate Aboriginal people, to “assimilate” them and to deter Aboriginal people from their “savage” ways and “civilize” them (Milroy, 1999; Kurtz *et al.* 2008; Loppie Reading & Wien, 2009). The

¹ "Aboriginal peoples" is a collective name for the original peoples of North America and their descendants. The Canadian constitution recognizes three groups of Aboriginal people: Indians (commonly referred to as First Nations), Métis and Inuit. These are three distinct peoples with unique histories, languages, cultural practices and spiritual beliefs. More than one million people in Canada identify themselves as an Aboriginal person, according to the 2006 Census (<http://www.aadnc-aandc.gc.ca/eng/1100100013785/1304467449155>).

federal government enforced this policy by a law that Aboriginal children attend these schools (Degagne, 2007; Kurtz et al., 2008; Loppie Reading & Wien, 2009). Many former residential school students have reported the suffering and pain they endured in these schools in this sad chapter of history. Gray (2011) wrote that former residential school students were subject to acts of “sexual harassment, sexual assault, and rape; physical, emotional, spiritual, and intellectual torment; military and prison-style discipline; neglect, homicide, public humiliation, and punishment for cultural expression; and industrial training or indentured servitude instead of an edifying or nurturing pedagogy” (p. 10). Not all children who attended residential school suffered such acts; some have shared their positive experiences and the educational advancement they achieved. The majority of the former residential-school students, however, had negative experiences (Dion Stout & Kipling, 2003).

Atleo (1997) writes about how colonization of Aboriginals was advanced “through a centralized [Canadian] administrative structure based on laws developed and promoted through structural and policy initiatives; these included state-supported assaults on First Nations spirituality, culture, social organization, governance and economic activity” (p. 67). Atleo (1997) contends that “these initiatives served to subjugate First Nations by systemically alienating individuals from their history, politics, territory, family, traditions, material culture, and spiritual roots, [moreover, the *Indian Act* worked in concert to subjugate Aboriginal people]” (p. 67). In the light of the complex and challenging history endured by Aboriginal people, less than optimal health outcomes are hardly surprising.

Elias et al. (2012) contend that their research findings suggest that trauma, suicidal behavior, and related behaviors Aboriginal people display may be linked to residential schools

and that such behavior is believed to be passed on inter-generationally (p. 1560). Because of the residential-school legacy, many Aboriginal people have endured and continue to endure family violence, homelessness, family dysfunction and significantly lower health status in comparison to non-Aboriginal people (Kurtz et al., 2008).

Despite a plagued history, many Aboriginal people are reclaiming their culture and traditional practices, which, in some cases, they are willing to share with their non-Aboriginal counterparts (Ross 1992 as cited in Hunter et al., 2006). Historically, Aboriginal people have been rooted in relationships and connectedness—to one another, the Creator, and all things (Hunter et al., 2006), thus pointing to the idea that nurses who employ a relational-style nursing practice may find themselves in an optimal position to work collaboratively with their clients—particularly Aboriginal clients.

Smylie (2000, 2001) provides recommendations that she suggests may be helpful for nurses and health-care professionals in promoting effectiveness when working with Aboriginal peoples. The two suggestions most applicable to this project are that

- health professionals should have a basic understanding of the disruptive impact of *colonization*² (which led to *colonialism*³) on the health and well-being of Aboriginal peoples (Smylie, 2000, p. 5) and
- health professionals should recognize that the degree of ill health of Aboriginal populations is unacceptable and work with Aboriginal individuals and communities towards improved health outcomes (Smylie, 2001, p. 3).

² "Colonization" to establish a colony in or on. To settle in a colony" (*New Merriam-Webster Dictionary, ibid*).

³ "Colonialism" Control by one power over a dependent area or people. A policy advocating or based on such control. (*New Merriam-Webster Dictionary, ibid*).

The above recommendations point out that nurses and health-care workers who become knowledgeable about historical and government practices towards Aboriginal peoples may enhance their ability to engage effectively with their Aboriginal clients and promote their health.

Statement of the Problem

Significant documented past and present literature explicitly documents that Aboriginal people are vulnerable people who endure much social and health-care inequity. Little is known about Aboriginal clients' perspectives and experiences with health-care professionals, whether nurses or others. This lack of knowledge is compounded by health-care providers' limited understanding of Aboriginal people overall (Baker & Daigle, 2000, Browne, 2007, Kurtz et al., 2008). The Aboriginal Nurses Association of Canada (2009) contends Aboriginal people often choose not to seek necessary health care because they do not want to face stereotypical treatment. Nurses working with Aboriginal clients or contexts have voiced challenges and issues, such as the frustration of misinterpretations and misunderstandings which lead to various issues; in Aboriginal organizations, such issues often result in the vacating of nursing positions, which in turn means high staff turnover for Aboriginal organizations (Browne & Fiske, 2001; Habjan et al., 2012).

Over the fifteen years of my employment with Aboriginal organizations, what I have witnessed is similar to the issues documented in literature. Some nurses left their nursing roles in Aboriginal organizations when they felt that frustration and misunderstanding could not be resolved. Some felt that the challenges of misunderstanding and misinterpretation rendered

them incapable of developing meaningful nurse-client relationships to the extent necessary to engage the client.

Project Purpose

The goal of this project is to conduct an integrative literature review and critically appraise existing literature regarding the use of relational-nursing approach with Aboriginal people. It is my hope that the knowledge gained through this integrated literature-review project will identify ways in which a relational approach can enhance Advanced Practice Nurses' (APNs) ability to work with Aboriginal people. What negative and positive relational approaches in nursing practice are identified in the literature? Why is it important for nurses to be aware of how this influences the health of Aboriginal people?

Defining the Relational Nursing Approach

Scholars have argued that the development of a human-to human connection within the nurse-client relationship is critical; such a connection can evolve into a trusting and respectful nurse-client relationship. The College of Registered Nurses (CRNBC) (2012) defined relational practice as follows:

an inquiry that is guided by conscious participation with clients using a number of relational skills including listening, questioning, empathy, mutuality, reciprocity, self-observation, reflection, and a sensitivity to emotional contexts. Relational practice encompasses therapeutic nurse-client relationships and among [other] health care providers (Hartrick Doane & Varcoe, 2007, p. 34).

It is important to clarify that "relational describes the complex relational nature of human life, the world, and nursing" (Hartrick Doane & Varcoe, 2005). As nurses and health-care

professionals enact a relational approach, they are enabled to view clients from a holistic perspective, which may help them to understand and know their clients better (Hartrick Doane & Varcoe, 2005).

Effective use of the relational-nursing approach is complex and challenging—compounding busy schedules and adding complex Aboriginal clients or contexts augments the complexity and challenges of effective application of a relational-nursing approach. Although there is no cookie-cutter recipe for the cultivation of relational practice, Hartrick Doane and Varcoe (2005) recommend the following seven skills: letting be, listening, self-observation, questioning to look beyond the surface, intentionality, interrupting contextual constraints, and re-imaging. These are helpful for enhancing relational capacities (p. 200).

Research Question

How can engagement in Relational Nursing Practice by Advanced Practice Nurses (APNs) working with Aboriginal people help promote the health of Aboriginal people?

Chapter 2: Approach to Inquiry

Theoretical Perspectives on Relational Approach

Nursing is known as a profession that is committed to providing knowledgeable and compassionate health care in a holistic manner while prioritizing the dignity and uniqueness of client's they serve (Parker & Smith, 2010). Moreover, Hawthorne and Yukovich (1995) contend it is critical that nurses engage in a relational manner with their clients while providing health care. A relational approach in nursing care aligns with a paradigm of relation; the relationship between people are recognized as priority and one in which respect, honesty, authenticity, and compassion are prioritized. Engaging in a relational manner motivates nurses to be responsive to clients, to be intentional in nursing practice while being cognizant of nurse-client similarities and differences (Hartrick Doane & Varcoe, 2005). Thayer-Bacon (2003) contends:

making the similarities and differences transparent, [nurses] are better able to attend to issues of meaning, experience, race, history, culture, health, and sociopolitical systems; [moreover], as [nurses] relationally honor and attend to such differences the potential for growth, change and knowledge development is enhanced (as cited in Hartrick Doane & Varcoe, 2005, p. 9).

Therefore, it is assumed that nurse-client engagement prioritizing a relational approach seeks understanding, recognizes that there is no one truth and takes on the philosophical perspective of relational building. The desired outcome is that, when nurses develop positive relationships with clients and the health-care teams they are working with, they are better able to foster positive working relationships that promote ethical, safe, optimal health-promoting outcomes for their clients (Hartrick Doane & Varcoe, 2005).

Methodology Approach: An Integrated Literature Review

The method selected for this project is an integrative literature review methodology which employs the framework provided by Whittemore and Knafl (2005) and Cooper (1982). Integrative literature reviews are viewed as research of research and have been utilized for the last four decades (Whittemore and Knafl, 2005). This methodology allows researchers to explore and analyze diverse perspectives on a particular phenomenon to enhance nursing knowledge, practice, research and policy development (Whittemore & Knafl, 2005). The review framework Whittemore and Knafl (2005), specified, and modified particularly for integrative reviews, is Cooper's (1982) five stages which include (1) problem formulation/review of purpose, (2) literature search and data collection, (3) evaluation of data from primary sources, (4) data analysis, and (5) presentation of results (p.546). This framework can be used for both quantitative and qualitative methods. These five stages were used to guide me through the integrative-review process.

Problem formulation/review purpose

This initial stage, according to Whittemore and Knafl (2005), is where a clear problem identification and review purpose is important and allows the researcher to delineate focus and boundaries for the integrative review. The variables of interest, including the population, concepts, health problem, and sample being drawn on, determine the flow of the integrative review (Whittemore & Knafl, 2005). The purpose for this integrative review is to explore relational nursing practice with Aboriginal people. My goal was to explore and identify relational-nursing-approach skills that are facilitators and barriers to health-promotion effectiveness with Aboriginal people(s).

Particular areas of concern, evident from my nursing practice experiences over the past several years, include (1) Aboriginal clients' choice to delay or not access necessary health-care service for diverse reasons related to prior negative experiences with health-care-service delivery; (2) a high turnover of nurses in Aboriginal organizations; and (3) nurses' frequent expression of frustration over inability to engage Aboriginal clients or peer health-care-team members within Aboriginal organizations in a meaningful way. The focus of this integrative-literature review is the exploration of health care and nurse-client health-care encounters with Aboriginal people(s) and the identification of documented barriers to, and facilitators of, working with Aboriginal people(s).

Literature search and data collection

The goal of this stage is to maximize the rigor of the integrated review and to obtain all relevant data and literature on the selected topic (Whittemore & Knafl, 2005). Computerized databases are accessible and effective but may yield only 50% of the eligible data or literature. To remedy this problem, Whittemore and Knafl (2005) recommend using more than one search method.

I first conducted a comprehensive, computer-based literature search using the Cumulative Index of Nursing and Allied Health (CINAHL), Google Scholar, and Summon databases. I also employed the ancestry search as well as hand-searching methods. In Google Scholar, I entered known authors who had published literature on my population of focus. Key search terms included (1) *relational*, (2) *Aboriginal*, (3) *indigenous*, (4) *American Indian*, (5) *Indian*, (6) *nurs** and (7) *health professionals*. The application of Boolean restrictions yielded four studies in CINAHL. Of the four, only one study proved useful. From that study, the ancestry

search was helpful in yielding names of authors to input into Google Scholar. One of the authors had published several studies on my topic. To preserve a broad perspective and to conform to the exclusion criteria of my study, only three of her research studies were included.

Inclusion and exclusion criteria

Clear inclusion and exclusion criteria to determine relevant literature sources are a necessity (Whittemore & Knafl, 2005). The inclusion criteria were (1) peer-reviewed primary research studies focused primarily on a relational approach, (2) studies published between 2000 to 2013, (3) studies about Aboriginal people, (4) studies by health-care professionals, medical doctors, occupational therapists, physiotherapists, psychologists, and social workers (to broaden the scope of the limited data found), (5) studies in diverse settings such as communities or hospitals and (6) studies available in full text. Initially, the focus was limited to articles written within the last five years to do with Canadian Aboriginal studies and relational practice but, because of the limited results, the search was extended to the year 2000 and broadened to include American Indian and indigenous Aboriginals. Various ways of searching in the computer-data-based systems, previously identified, were used. This lengthy search availed studies not strictly applicable to my project but did increase the number of studies I could employ for the ancestry-search process. This search, however, did not provide any studies that came within the criteria for this project.

The exclusion criteria were (1) studies not written in English, (2) studies that did not focus on Aboriginal people or vulnerable populations, (3) studies that were not peer-reviewed and, (3) two articles written by a single author from whom three studies were already included in this integrative review.

After application of the inclusion and exclusion criteria to the studies found, my search resulted in nine relevant articles. To conduct a full integrative review, I had set a goal between a minimum of eight and a maximum of ten relevant studies. I was disappointed to find that the literature available for selection for inclusion for this project was not more abundant; despite the meager results, however, I was pleased to include nine primary studies that were applicable for this integrative-literature review.

Data evaluation

This stage, the meaningful evaluation of diverse primary sources for quality, is complex (Whittemore and Knafl, 2005). To evaluate the quality of sources, Whittemore and Knafl (2005) suggest extraction of methodological elements using a quality-scoring system. The scoring is recommended to help evaluate the rigor of the primary source, rather than for the purpose of exclusion from the review; moreover, as Whittemore and Knafl (2005) point out, the score, whether high or low, can be used to measure the magnitude of the study in its analysis stage.

I adapted the qualitative-research-framework guide by Ryan et al. (2007) to evaluate meaningfully, and score, the nine primary sources for this review (see Appendix A). This framework was used to discover the elements affecting believability, which includes the author's credibility and writing style, as well as the elements affecting robustness, such as the study's literature review, theoretical framework, method, data collection, data analysis, and other elements.

I followed Whittemore and Knafl's (2005) recommendation and analyzed and scored each question in the framework. Each question was awarded a qualitative value from one to two-and-a-half; the score given each question was based on the ability of the primary research

source to answer the corresponding question in a meaningful way. Full points were granted to questions that appeared fully addressed within the primary source. Partial points were granted to questions partially answered. No points were granted to questions apparently not answered at all. A maximum of 20 points was attainable for each primary source. All nine primary sources proved acceptable for this review and scored from 14.5 to 19 out of the possible 20. The overall quality score awarded each study did not indicate the inclusion or exclusion of the primary source but was used as a variable in the analysis stage (Whittemore & Knafl, 2005, p. 550).

Data Analysis

In this stage, I again followed Whittemore and Knafl's (2005) recommendation by coding, categorizing, and summarizing the nine primary sources for this review in an orderly fashion. Data were summarized in table format as follows: (1) citation, (2) research type, ethical considerations, and strengths/limitations, (3) methodology description, (4) research methods, rigor in qualitative study, (5) relational framework—does the study explicate this? Are elements of relational approach included? If so, what are they? (6) Is the article relevant to inform Advanced Practice Nurses working with Aboriginal peoples or in Aboriginal contexts? Is the article succinct and well written? Is rigor of the study evident? (Appendix B). Miles and Huberman (1994) suggest a method which consists of data reduction, data display, data comparison, and conclusion drawing and verification (as cited in Whittemore & Knafl, 2005, p. 550).

Data reduction. Data reduction includes organizing included review sources into a logical system. Whittemore and Knafl (2005) suggest this stage includes the extraction and coding of included primary sources into a manageable system allowing for the simplification,

abstraction, focus and organization of the extracted data. For this stage, I summarized each included primary source into a one-page document and sought out elements of relational approach as defined by the College of Registered Nurses' CRNBC document (2012). The positive and negative aspects of relational approach were selected and became the focus of this integrated review.

Data display. This stage includes the development of a data display in an organized system, such as a graph, chart, table, or matrix (Whittemore & Knafl, 2005). I extracted common relational elements from each one-page summary to develop a table showing all nine studies. This table proved beneficial in identifying patterns, themes, and relationships within the included primary review sources.

Data comparison. This stage is described by Whittemore and Knafl (2005) as an iterative process that involves critically examining data displays, and is important for accuracy in identifying patterns, themes, and relationships. I conceptualized the data into the form of a *tree* to help make meaning out of the data as well as interpreting possible relationships as potential facilitation of, or obstruction to, a relational approach. The visual of a *tree* was essential to grounding me and remaining focused through the stages of data analysis, verification and the drawing of conclusions.

Conclusion drawing and verification. Whittemore and Knafl (2005) contend that this final phase of data analysis encompasses a shift from efforts to interpret the description of patterns and relationships to a greater level of abstraction, one allowing for generalization of the findings (p.551). This includes reviewing data, isolating patterns and processes, and identifying the commonalities and differences among the elements which highlight positive and

negative aspects of relational approaches of health-care encounters with Aboriginal people (Whittemore & Knafl, 2005). Miles and Huberman (1994) suggest this process is a gradual elaboration of a small set of generalizations that encompasses a subgroup of the integrated-review data in its entirety, allowing for the suggested continual revision of conclusions and development of a conceptualization model which helps ensure inclusion of as much data as possible (as cited in Whittemore & Knafl, 2005, p. 551). This stage included a process of validating the conclusions with the nine primary sources of my integrated review, to strive for accuracy (Miles & Huberman, 1994, as cited in Whittemore & Knafl (2005).

This final aspect of the data-comparison stage of my integrated review synthesizes the significant elements of the conclusions of each subgroup into an integrated summation of health-care encounters regarding relational approach with Aboriginal people in clinical practice (Whittemore & Knafl, 2005). The revised conceptual map which I developed (Appendix C) was helpful with focusing the process and provided a visible map to readers of this review of the vision of the outcomes, relative to negative and positive elements of relational approach with Aboriginal people(s).

Presentation of Findings

This final phase of the integrative review process included the presentation of the review findings, in the chapters dealing with findings and discussion. The conceptualization of relational approach with Aboriginal people(s) is presented in the form of a *tree*, based on the major themes which emerge from the primary review data. The tree is used to focus and help readers visualize how negative and positive elements of relational approach may create barriers to, or enhancement of, relational approach with Aboriginal clients, and may create better

understanding of the respective potential outcomes in nurse-client health-care encounters. The findings are presented based on the major themes emerging from the integrated review. A brief overview of the articles included in the integrative review is found below

Brief Overview of Articles

Author	Participants & Setting	Methodology & Study Location	Brief Overview
Browne, A. J. (2007)	Participants: N=35 14 RNs 14 FN women 12 LPNs 1 Native Liaison 4 FN key informants Hospital Setting	Ethnographic Study (9 month immersion) Location: a Western Canadian Hospital	Exploration and illustration about the sociopolitical context of nurses' encounters with First Nations (FNs) women. Four major themes were found: (1) relating across presumed "cultural differences" (2) constructing the other, (3) assumptions influencing clinical practice, (4) responding to routine patient requests. These themes illustrate relational factors which shaped nurses' encounters with FN women.
Browne, A. J., & Fiske, J. A. (2001).	10 FN women from a FN reserve Rural FN reserve, 20 kilometers from non-Native municipality, 125 kilometers from a regional city, and 1000 kilometers from an urban area.	Ethnographic Study FN reserve in the Northern region of a Western Canadian province.	To explore and understand the positive and negative health encounters from the perspective of the FN female participants. Findings were around two major themes: (1) invalidating encounters and, (2) validating encounters. The study points to several important factors that would benefit nurses to consider when engaging with Aboriginal clients.
Baker, C., & Cormier Daigle, M. (2000)	10 participants from Big Cove (hospitalized in a New Brunswick hospital within previous 3 years of the study. Big Cove Mi'kmaq community in New Brunswick	Interpretive Interactionalism Big Cove, New Brunswick	To explore the hospital experiences of study participants to understand the problem participants may face in the provincial health care system. Recurring themes in the study revolved around issues of misunderstanding, being misunderstood, and feeling understood. Study explicates the development process of relational approach (positive and negative).
Browne, A.J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, B., & O'Neil, J. (2011).	44 participants 25 male 18 female 1 transgendered (34 self-identified as FN). A large teaching hospital in Western Canadian city	Ethnographic Study (20 month immersion) Emergency Department (ED) in a large Canadian city.	To explore experiences of access to primary care service from Aboriginal participant perspectives. Three themes were around (1) anticipating providers' assumptions, (2) seeking help for chronic pain, and (3) use of the ED as a reflection of social suffering. Study illustrates how marginalization of Aboriginal clients may intentionally or

			unintentionally enter health encounters.
Herk, K. A.V., Smith, D., & Andrew, C. (2011).	5 purposively selected transcripts—and further examination of (n=21) transcripts for additional relevant data of a primary exploratory study interviews (p. 60). Community health and local public health unit settings.	Secondary analysis. Canadian city with a large and rapidly growing urban Aboriginal population (p. 59). Urban setting, study conducted with 2 partnering Aboriginal and 2 mainstream community health organizations (organizations provide preventative services for pregnant and parenting women).	To explore how perceptions of Aboriginal women's identities within health care encounters to understand how this impacts experience of care and future access of health care services. Four themes found include (1) Aboriginal mothering: The intersection of identities, (2) the imposition of the presumed superiority of Western models of mothering, (3) working it through with aboriginal mothers – giving care in a 'good way?', and (4) Aboriginal women leading and transforming care. Study illuminates how Aboriginal identity and being female influence health experiences and future access of health care.
Kurtz, D. L. M., Nyberg, J.C., Van Den Tillert, S., & Mills, B. (2008).	Both Aboriginal men and women participated in the study. This study highlights the experiences of n=13 Aboriginal women (p. 56). 3 urban Okanagan Valley Friendship Centers.	Participatory Action Research Okanagan Valley, British Columbia	To study and explore the barriers that urban Aboriginal people may face when they access mainstream health and social services. Exploring the reasons they seek out the services at Friendship Centers, and how colonial societal/political structures influence acts of structural violence, like racism, discrimination, and silencing of participants in health care encounters. Study explicates positive and negative elements of relational approach and how this may impact health outcomes for Aboriginal clients.
Porr, C., Drummond, J., & Olson, K. (2012).	Public Health Nurses (PHNs) n=15 Lower-income single mothers (LISMS) n=21—mixed ethnicity. Interviews conducted in respective participant homes, office setting of PHNs	Grounded Theory Location of study not provided.	The study was intended to develop theory grounded in data. A six stage model was developed from the study which explicates how the PHNs were able to develop therapeutic relationships with the LSMS in the study. The theory developed: Targeting Essence: Pragmatic Variation of the Therapeutic Relationship. This model is nicely laid out and may benefit nurses working with populations similar to those within this study.
Moules, N. J., Macleod, M. L.P., Thirsk, L. M., & Hanlon, N. (2010).	25 Public Health Nurses 32 High Priority Families (HPFs) Community settings of 14 different rural communities	Interpretive Hermeneutic Method Northern British Columbia	The findings for the study centred around: the process of relating and the substance and maintenance of relating. The article illustrates the complexity and skill necessary for developing therapeutic nurse-client relationships.
Gone, J. P. (2011).	Aboriginal participants n=19	Case Study	To explore the incorporation of FN cultural practices in a community-

	<p>2 Lodge administrators (current and former) 4 Lodge counsellors 11 former successful Lodge clients 1 Lodge Coordinator 1 program committee member</p> <p>Healing Lodge setting</p>	<p>Northern Algonquian Native reserve in Canada</p>	<p>controlled substance abuse treatment centre. The three themes: (1) orchestrating the therapeutic, (2) traditional ways, (3) healing discourse. With focus on community psychology, the study illustrates how cultural practice incorporated into service delivery may impact Aboriginal client outcomes.</p>
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Chapter 3: Findings

The findings within the literature reviewed for this project suggest that the nurse-client (Aboriginal) relationship is complex, with a likely interface of several challenges. The findings were organized around three themes. Two themes illustrate positive aspects of the nurses' relational approach of (1) being present and (2) being collaborative. The third theme, (3) dishonoring and disempowering behavior, illustrates the negative aspect of nurses' relational approach.

The theme of negative aspects of relational approach is discussed first, followed by the two positive themes. Although it is of value to note that there are times that the elements for both the negative and positive themes involve both nurse and client, this project focuses on how these elements are present in the nurse.

Dishonoring and Disempowering Behavior

The findings suggest that nurses and other health-care providers are influenced by the negative assumptions they make about Aboriginal clients, which in turn contribute to marginalization of Aboriginal people in health-care encounters. For example, nurses often find Aboriginal clients to be quiet, reticent, and passive (Browne, 2007; Browne & Fiske, 2001). Therefore, many nurses assume this is characteristic of Aboriginal clients. Such assumptions have potential for misinterpretation, misunderstanding, miscommunication, and sometimes dismissal of, or downplaying the health needs of Aboriginal patients seeking health care (Browne, 2007; Browne & Fiske, 2001). The authors of these articles contend that nurses may be incurious about their patients and fail to treat them as unique individuals, thus increasing

the potential for misunderstanding, miscommunication, misinterpretation, unmet patient needs, and frustration, which may influence both the nurse and the patient.

Another assumption discussed in the review articles was that Aboriginal patients are seen as needy, dependent patients, unworthy of their entitlement to a perceived abundance of free health-care benefits (Browne, 2007; Browne & Fiske, 2001; Browne et al., 2011). In Canada, Canadian Aboriginal people who are registered with the government as *Status Indians* are eligible for limited coverage of some health and medical-care benefits, which include some pharmaceuticals, dental care, physiotherapy, etc. These health benefits are known as non-insured health benefits, which are actually their medical-insurance coverage. (Browne et al., 2011; Kurtz et al., 2008). The existence of these benefits, when perceived as undeserved, creates negative feelings such as resentment and gives rise to an increased potential for disrespect, distrust, and judgment directed at Aboriginal people. (Browne et al., 2011; Browne & Fiske, 2001; Kurtz et al., 2008).

Browne (2007) noted that the concept of idealism is a common belief in health-care settings; idealism is the notion that everyone receives the same treatment, (Browne, 2007). This may be an inspirational goal to progress towards for nurses; however, the literature describes nurses' struggles with this way of being and highlights the resultant challenges they face as they care for their Aboriginal patients (Browne, 2007).

Such negativity can easily be enlarged when nurses and health professionals take on a stereotypical or racist view of Aboriginal patients. Findings from the literature suggest that stereotypical and racist attitudes of nurses or health-care professionals can negatively influence the health encounters of Aboriginal people. To illustrate from my practice, as an Aboriginal

Liaison Nurse (ALN), I worked with a two-year-old Aboriginal child who had been admitted to the hospital for severely infected impetigo. The child's mother, not yet twenty years old herself, had another child at home. Quiet and soft-spoken, she shared with me that she had very limited support and financial resources in managing her two children. She had obtained medication to treat her hospitalized child but was unsuccessful with clearing the impetigo. Following shift report, the nursing staff conversed among one another, about how this Aboriginal mom did not know how to clear the impetigo because "they" [Aboriginals] are not very clean people and thus it was not surprising that her child's condition was so severe.

Of particular concern is the labeling of Aboriginal women as unfit mothers. Fiske and Browne (2001) shared an example of a mother whose child was apprehended without warrant because of the notion that she was not caring for her child (p. 136). Herk et al. (2011) provide an example of an Inuit mother's child being apprehended because there appeared to be no food in her cupboard; Child Services had neglected to assess the situation correctly in failing to find this mother's freezer full of caribou meat. It appears that stereotypical and racist perspectives are intensified by lack of caregivers' knowledge or of awareness of Aboriginal people, their history and way of life. As an ALN, I have often been called when there were large numbers of Aboriginal family members presenting in the hospital for a loved one in critical condition. Many nurses and health professionals have conveyed compassion and understanding during these situations; others have displayed negative body language or voiced negative comments about the number of visitors and phone calls and about inappropriate use of the hospital patient and staff kitchen area. My role as an ALN to help mitigate racist attitudes and stereotypes has been to be available to the nursing staff to answer questions regarding the

cultural practices followed by the patient and their family and to be an advocate for Aboriginal patients. This has appeared to be helpful and beneficial for nurses as they seemed to be better able to understand and work with the patient and family members they interfaced with.

It appears from the literature that nurses and other health professionals may present themselves to Aboriginal patients in a manner which suggests a power imbalance. The imbalance is exacerbated for Aboriginal patients in institutional settings, where the imbalance can become startlingly visible with simple patient requests (Browne, 2007). For example, Browne (2007) observed how this was enacted upon a poverty-stricken Aboriginal patient accompanied by her nurse, who asked if her patient could use the hospital desk phone. This request was granted with hesitancy by the head nurse. Browne (2007), the researcher, witnessed a similar request from a non-Aboriginal patient on the same ward earlier on the same day: that person was cheerfully handed the phone as requested without any hesitation.

Findings from the literature suggest that power imbalances can be exacerbated for Aboriginal patients because of the legacy of the residential-school system and the colonization which they experienced historically and still suffer from at present. For example, when nurses and other health-care staff question Aboriginal patients as to why they have not sought medical attention sooner, the literature reveals that (1) the Aboriginal patients feel unsafe in seeking medical attention; (2) they are not taken seriously; (3) they are not listened to; or (4) they are not receiving treatment. (Browne, 2007; Browne & Fiske, 2001; Browne et al., 2011; Herk et al., 2011; Kurtz et al., 2008). Many of the participants in these studies shared or implied their belief that this treatment perhaps stemmed from stereotypical perspectives held by nurses or health professionals.

Moreover, during my role as Aboriginal Nurse Liaison in a hospital setting, similar responses were shared with me when I asked my patients why they had not sought medical attention sooner. For example, recently an elderly Aboriginal patient from the community I am currently working in presented to the emergency department with his wife. The patient was doubled over in pain. This patient's wife politely asked if there was anything that could be done to make the patient (her husband) more comfortable. The nurse at the desk angrily snapped at the family member, rudely stating that there were no beds available and pointing out that there were patients waiting even in the hall area. Meanwhile, two non-Aboriginal patients, presenting after the elderly Aboriginal patient, were seen in a timely manner. The family member further shared it had been difficult to persuade the patient to attend the emergency department because of previous similarly negative experiences. The nurse attempted to apologize prior to the doctor seeing this elderly patient stating that the busy emergency department was sometimes difficult to work in. This situation was documented by the patient's family and a complaint was lodged, resulting in the loss of the nurse's job.

In summary, the theme of dishonoring and disempowering behavior illustrates that in health encounters, nurses or health-care professionals may intentionally or unintentionally allow their negative assumptions to influence how they relate with Aboriginal patients. The findings in the literature and from my experiences as an advanced practice nurse support the notion that negative assumptions may potentially lead to stereotyping, misunderstanding, and silencing of this population. The findings also illustrate that despite the idealistic notion that everyone receives the same treatment, power imbalance is often visible in facility settings where nurses and other hospital staff may act in ways which convey dishonoring and

disempowering behavior that negatively impact the development of a therapeutic nurse-client relationship development.

Being Present

The findings suggest that a core element required by the nurse when interacting with Aboriginal clients is respect. Conveying respect, in the context of this review, includes politeness and consideration on the part of the nurse. Approaching Aboriginal patients in a caring and genuine manner and acknowledging them as legitimate patients is important. Nurses and health-care professionals who relate on a human-to-human level convey respect to clients and enhance their ability to understand the health issues and concerns most pressing for their patients.

Interestingly, the findings suggest that nurses and health professionals who engage with Aboriginal patients in a manner similar to their treatment of non-Aboriginal patients was appreciated. This appeared to be perceived as respectful, validating, and equal to non-Aboriginal patients (Baker & Daigle, 2000; Browne & Fiske, 2001; Browne et al., 2011; Herk et al., 2011; Kurtz et al, 2008; Porr et al., 2012; Moules et al., 2010).

The findings furthermore suggest that supportive care is an effective way for nurses to build trusting relationships with patients. Supportive care in the context of this review is illustrated by modeling a caring, kind, and empathetic attitude. Nurses who are attentive to providing care in this manner enhance their ability to develop positive and therapeutic nurse-patient relationships. This approach appears to be fundamental when working with Aboriginal patients with complex needs in busy health care environments. Supportive care is illustrated in two studies by health-care providers and public-health nurses who strive to provide safe care

and positive affirmation to poverty-stricken mothers, recognizing efforts the mothers were enacting despite the difficulties and challenges in caring for their babies (Herk et al., 2011; Porr et al., 2012).

In one of my roles as a community health nurse (CHN), I had an opportunity to work with several young mothers and families who faced various hardships with their finances, lifestyle choices, housing, and significant others. It was important to engage with the young mother and focus on positive aspects, such as a healthy thriving child, and the bond of love and affection shared between mother and child. Because I was aware that some families in this community experienced similar struggles, I asked one young mother who I was working with what she thought about starting children's clothing exchange at the health unit. I informed her I would happily contribute to this endeavor by providing several boxes of children's clothing that I possessed. I shared how this would be helpful to me and that I was happy to initiate the clothing-exchange program immediately.

This was a successful and useful program in which many young mothers and families participated; it was developed as a result of a trusting nurse-patient relationship in which the patient felt safe to share her concerns.

Findings also recommend that nurses employ intentional engagement in their nurse-patient health care encounters. Intentional engagement in the context of this review occurs when nurses and other health professionals intentionally engage in such a manner as to convey the existence of a balance of power and a sense of approaching health issues in a collaborative manner. Intentional engagement is most effective when the nurses are reflective about their professional practice and have the foresight to recognize the importance of engaging with

clients and skillfully learning from the individual patient what nurses need to know to provide optimal care. Moules et al. (2010) used the example of “coffee with a purpose” (p. 330). This example may readily arise with Aboriginal people. In my experience, a home visit with this population may include the client's offering the nurse tea or coffee. In some cases, if the nurse declines the offer, the refusal may be viewed as disrespectful. Acceptance of the offer, on the other hand, not only adjusts the balance of power and strengthens the relationship but also provides an opportunity for conversational exchange that may prove helpful in providing effective patient care.

The art of being an insightful nurse in the context of this review is illustrated when nurses are astute, perspicacious, intuitive, and understanding. Many of the studies highlight the complexity and challenges nurses face when working with Aboriginal peoples, pointing out that Aboriginal patients may present as quiet, reticent, or sometimes angry and resentful to non-Aboriginal people (Browne, 2007; Kurt et al., 2008). However the patient presents, the nurse who remains professional and understanding has been demonstrated to have increased success with meaningful engagement with their patients.

Several studies illustrate insightful nursing practice in health encounters where nurses intuitively balance their ethical duties along with astuteness and discernment, situations where a client conducts oneself in a manner which would normally call for drastic measures (Moules et al., 2010). When nurses face situations that create ethical dilemmas, they enhanced their nurse-patient relationships when they were able to make choices based on their insight about the least damaging and most probable long-term goal for their nurse-client relationship while

being mindful of the patient's future needs (Gone, 2011; Herk et al., 2011; Moules, et al, 2010; Porr et al., 2012).

The art of being present undoubtedly can be challenging for nurses, particularly within the ever-changing, busy health-care environments of the present day. Despite the current situation in health care, the findings of this review indicate that nurse-client encounters that are conducted in a respectful, supportive and caring manner, with the application of intentional engagement along with insightful nursing practice, are beneficial to both nurses and patients and positively influence health promotion for patients, including Aboriginal patients (Baker & Dailgle, 2000; Browne & Fiske, 2001; Gone, 2011; Moules et al., 2010; Porr et al., 2012).

Being Familiar

The findings recommend that nurses become knowledgeable about, and familiar with, Aboriginal history. One study in this review suggests that familiarity with Aboriginal history and Aboriginal ways of being may be helpful with refraining from categorizing and making negative assumptions about Aboriginal people (Browne, 2007). Moreover, being knowledgeable about Aboriginal people is found to instill nurse-client relationships with trust and respect that conveyed validation of, and appreciation for, Aboriginal peoples (Gone, 2011; Herk et al., 2011). Being familiar also encourages Aboriginal people to participate collaboratively in their health care. Interest in Aboriginal traditional practices and a holistic perspective can assist nurses and health-care professionals in providing culturally safe and respectful care (Browne & Fiske, 2001; Gone, 2011; Herk et al.,). For example, when I worked in an intermediate care facility, a new patient had been admitted while I was away on holidays. Staff informed me that we had a new Aboriginal patient and she was one who many staff considered impossible to work with for she

was described to be unpleasant and mean regardless of how gently and pleasantly staff approached her. This individual happened to be one of my patients for my shift. I entered the patient's room to provide her morning medications and remind inform her breakfast was being served in the dining room. The Aboriginal woman angrily took her pills and ordered me to leave her room. The patient did not recognize me but, I recognized her. In our (hers and mine) native tongue I asked her "Mary, why are you angry?" The patient startled, looked at me and said "who are you?" I told her who I was and who my parents were. This patient was shocked and pleased to have someone who she identified with and knew how to speak her dialect. This patient changed her attitude and behavior drastically. The patient verbalized her displeasure of being housed in the facility, however; she became accepting of being in the facility and did not continue her angry behavior to facility staff.

Interestingly, some of the studies indicate it is important to be knowledgeable about the individual client (Browne & Fiske, 2001; Porr et al., 2012). In some cases remembering the patients name and being knowledgeable about their health issue was important. Moreover, the majority of the review studies appear to demonstrate the importance of nurses and other health care providers treating their Aboriginal patient as *regular* sick people, similar to their non-Aboriginal patients—this appears to be beneficial for developing positive relationships with patients. For example, one participant in one of the studies shared "the hospital care I got was the same as everyone else there...As far as I could see we were all treated equally and that is the way it should be" (Baker & Daigle, 2000, p. 20). A recommendation made in one study by participants in one study shared "Everybody should be treated equal...Doctors should wear

colored glasses so everybody looks the same....so everyone could be treated the same and so the individual is an individual, not categorized, not assumed" (Kurtz et al., 2008, p. 59).

The findings suggest nurses and health-care providers practice mindfulness and provide care in a manner that conveys sensitivity to context (Baker & Daigle, 2000; Browne & Fiske, 2001; Gone, 2010; Herk et al, 2011; Moules et al., 2010). Sensitivity to context within this review means awareness of the patients' individual situation and circumstances, for example, when an Aboriginal patient is late for an appointment or misses an appointment; when a patient is uncomfortable with exposing the body; when the patient is quiet and reticent, and so forth (Browne, 2007; Browne & Fiske, 2001; Kurtz et al., 2008). Nurses and health professionals may enhance their ability to provide optimal care by exercising sensitivity and flexibility during patient care. To be flexible in this context entails moving beyond black-and-white rules to analyze each situation and health encounter critically, while considering the desired outcome in order to arrive at the best decision for the situation at hand (Moules et al., 2010).

In summary, there is little doubt about the complexity nurses and health-care encounters professionals face on a regular basis. It appears that familiarity with, and knowledge about Aboriginal people is beneficial and therefore recommended. The goal is to heighten familiarity with Aboriginal people and awareness of the need for sensitivity to context. Flexibility is also important: at times, circumstances must be critically analyzed without losing sight of the goal of building positive nurse-client relationships for the purpose of health promotion among Aboriginal people.

Chapter 4: Discussion

Summary of Findings

This integrative literature review illuminates the nexus of the manner in which nurses and health-care professionals approach their patients and their ability to engage Aboriginal clients effectively. The overarching premise is that the conscious use of CRNBC (2012) relational practice as a guide during all nurse-patient health-care encounters including Aboriginal patients can positively influence nurses and other health-care providers to engage Aboriginal patients successfully, thus promoting their health. Of importance is an awareness of how stereotypical perceptions can influence the treatment and care provided to Aboriginal patients.

Findings highlight that nurses and other health professionals may slip, intentionally or unintentionally, into dishonoring and disempowering roles which may lead to power imbalance, marginalization of Aboriginal patients, and negative assumptions that can potentiate misunderstanding, miscommunication, misinterpretation, and unmet patient care. In contrast, when nurses and health professionals consciously engage by being present with each patient and being familiar with Aboriginal history and context, they are actively employing positive relational skills of intentional engagement, respect, supportive care, and insightfulness. These skills signal that the nurse is interested in the patient and recognizes the uniqueness of each individual, regardless of ethnicity or such misfortunes as poverty or addiction issues. By enhancing understanding and promoting therapeutic relationships, a positive relational approach enlarges the ability of health-care workers and nurses to promote the health of Aboriginal clients. The use of a relational approach in encounters with Aboriginal peoples can be beneficial for patients as well as for nurses and health-care professionals themselves.

My experience of working with Aboriginal peoples in diverse settings supports the findings of this integrated review. As an ALN in a hospital setting, I worked with diverse Aboriginal peoples from Inuit and various Aboriginal nations. Each group held beliefs and practices unique to that nation. Thus each case entailed a fresh relational approach in order to achieve familiarity with the patient's culture and history and to develop a sensitive awareness of the patient's context. My role involved developing a respectful therapeutic relationship with the patient and the family, meeting them where they were and progressing towards a trusting relationship that enabled me to work collaboratively with each patient and family to promote health and optimize health outcomes.

Application of positive relational skills as illuminated in this review may be helpful with successfully engaging Aboriginal patients in health-care encounters and promoting the health of this population. Active commitment to, and application of, positive relational skills increases the likelihood that attitudes and perceptions in the health-care community will gradually become more positive. It is my hope and dream that nurses, along with the larger community, will commit to the practice of genuine respect, honor, and caring—for themselves and others. May this way of being grow and develop an impact for the betterment of Aboriginals and all peoples.

Significance of Findings for Nursing Education

The College of Registered Nurses of British Columbia (CRNBC) has identified the relational-nursing approach as a critical aspect of nursing-care delivery. The Aboriginal Nurses Association of Canada (ANAC) (2008), the Canadian Nurses Association (CNA) and the Canadian Association of Schools of Nursing (CASN) have collaboratively developed a best-practices

framework to support Aboriginal nursing students in university, as well as providing education about culturally safe care for Aboriginal people of Canada. The first core competency identified in this framework emphasizes the importance of the nurses' ability to demonstrate and provide relationship-centered care with Aboriginal people. The collaborative efforts of these entities (CRNBC, ANAC, CNA, and CASN) affirm the importance of nurses' providing health care in a manner conducive to engagement by Aboriginal people.

The ANAC (2008) framework suggests that it is important for nurses to be aware of the colonial history of Aboriginal people. Although this is not new information, it appears that there is still much work that nursing education can contribute to meet the recommended requirements of the ANAC (2008) framework. One recommendation that I would suggest is that nurse educators offer an Aboriginal Nursing course for both Aboriginal and non-Aboriginal undergraduate students. This would add to the knowledge base for all nursing students about how best to provide relationship centered care to Aboriginal peoples. As a nursing student, I took an optional undergraduate course on Aboriginal nursing. I was surprised to learn that many of my fellow students had minimal understanding about the history of Aboriginal people. Having witnessed this, I realized that my views on what I perceived to be stereotypical and racist behavior exhibited by nurses and other health professionals needed further consideration. What I originally perceived to be offensive nurse and health professional behavior needed a wider perspective: I realized that, in some cases, such behaviors may actually be oblivious, unintentional mannerisms displayed by nurses and other health-care

professionals that could be attributed to a lack of knowledge and awareness about Aboriginal people and their history of colonization and residential school experiences.

Increasing my awareness was important for widening my personal perspective; it helped me to recognize the importance of how this essential lack of knowledge leads to nursing bias when providing care to Aboriginal people. Relating this to nursing education and the ability of nurses to 'know' how to reflect on their practice, provide care from a patient centered perspective, and enter into meaningful relationships with Aboriginal patients became the question of this paper.

Significance of Findings for Advanced Practice Nursing

Advanced-practice nurses (APNs) are equipped with the advanced skills, education, expertise, and knowledge necessary to work within challenging environments as well as with complex patients (Canadian Nurses Association, 2008). Review findings highlighted difficulties nurses may encounter when working with Aboriginal people and contexts. Findings suggest that nurses working with this population would benefit with advanced education and knowledge, when working and engaging with Aboriginal people to effectively and meaningfully promote the health of this population. Moreover, because of the APNs advanced skills, knowledge and leadership skills, they may find themselves in optimal positions to model the skills of positive relational approach of being present (respectful, supportive care, insightful, intentional engagement) and being familiar (knowledgeable about Aboriginal history, sensitivity to context, flexible) within nursing practice.

The foundational Code of Ethics describes seven core values and ethical responsibilities that all nurses must strive to uphold within their professional practice. The review findings of

this project appear to suggest all of the Code of Ethics primary values are important; however, the values of: (1) providing safe, compassionate, competent and ethical care, (2) preserving dignity, and (3) promoting justice, appear to be of particular importance (Code of Ethics for Registered Nurses, 2008). These aforementioned values align with the identified elements of the theme *being present* and *being familiar* which are further detailed in Appendix C. While APNs provide service to all of their patients (including Aboriginal patients) in this manner, they are role modeling a positive relational approach style of nursing for their colleagues and other health care professionals.

My personal nursing practice of working with Aboriginal people(s) and/or Aboriginal contexts aligns with the review findings. For example, I have found that it is critical to consistently convey respect to Aboriginal patients—this has been of particular importance when working with patients who are visibly impoverished. I was critically aware of my verbal and body language congruency. For example, being present meant being mindful of how I communicated. My patients watched how I presented as a nurse—did I introduce myself and sincerely listen to what their issue and concern was; did I appear to care and make the brain to heart connection; did I actively listen with my ears without interrupting; did I take the necessary time, particularly when patients were critically ill; did I engage with family and support them effectively? These are a few elements within my nursing practice that I strived to be mindful of upon all contact with my patients and their families. In some nurse-patient health encounters, this style of nursing was instantly successful and facilitated open and honest

communication. In some cases, it was a process, the patient needed time to build confidence and trust in the relationship.

To influence and promote trust building, I found that *being familiar* was important. To engage a patient in the relationship, I often began with actively listening. Although I had experienced some similar experiences as my patients, it is embedded in my practice to not assume to think it was the same. For example, I attended residential school for a brief period. I found it was critical to be sensitive to the context of the patient, to hear and understand how this impacted them as a unique individual rather than offering my version, and assuming that because of this I would 'know' their version. The ethics and art of active listening is a skill that I have had to focus on, and which I have had the most success. This can be challenging when personal experience has illuminated aspects that were personally important for healing and health promotion for me as a nurse and as an Aboriginal woman. I think the ability for the nurse to be able to reflectively consider the ethics of how ones personal experiences contribute to the relationship with the patient is key to successful nurse-patient relationships.

In some cases, I was challenged by some patients who had previous life and nurse-patient experiences that were less than optimal. For example, my ethical responsibility of ensuring the safety of a child required involving Child Social Services. The mother of the child felt I was being unreasonable and that I was abusing my power and penalizing her and her child. I stayed focused on the situation at hand and assured the mother that when she was ready, I and other staff would help her find the required support to enable her to have her child back in her home. Thankfully, this mother made the decision to change her lifestyle and did obtain the required support that enabled her child to return to a safe home environment. This example

demonstrates the importance of having a relationship with the patient that enabled me to successfully do what was necessary while continuing to engage the patient and supporting her to healthier outcomes.

Project findings along with my nursing experience point to potential benefits for nurses and other professionals to engage Aboriginal individuals, communities, and organizations with a positive relational approach. The findings from this perspective which parallels Hunter et al. (2010) and their notion that nurses are instruments of the healing journey for their clients. This indicates that as nurses work with their clients, it is important to do so in a culturally safe and relational manner.

Linking of Findings to Theoretical Knowledge

Throughout this integrative review, the link between findings and theoretical knowledge about relational approach in nursing has been demonstrated. The connection between the elements of relational-nursing theory and these review findings illustrate a theory-to-practice link by using Whittemore and Knaff's (2005) five stage process to critically analyze the data. The CRNBC (2012) relational approach definition was critical to guide and focus my approach to the data. The elements of relational approach, which describes the nurse-client approach to be one that is a collaborative and conscious process which includes: effective listening, inquiry, respect and empathy, mutuality, reciprocity while being mindful of self-observation. This process facilitated the systematic organization of the data in a meaningful way throughout the review process. The findings of the review clearly outline both barriers to, and facilitators of, the relational approach. These were illustrated through the use of a visual representation

(Appendix C). This review has effectively illustrated why it is important for nurses to consciously endeavor to employ a positive therapeutic relational approach with all of their patients, including Aboriginal patients.

Recommendations for Future Research

A gap in the literature relating to the experience of Aboriginal people and their health-care encounters has been identified. I recommend further primary research into relational approach from the perspective of nurses. This literature review shows that the scant literature on the topic to date points in the direction a need to strengthen awareness of how relational approach with Aboriginal people(s) may impact outcomes. This may be beneficial to help increase and illuminate the importance of the impact a relational approach may have on outcomes for Aboriginal people(s).

Conclusion

This integrative-review project critically appraised the available health-care encounter literature regarding the use of a relational-nursing approach with Aboriginal people, and its potential impact to meaningfully engage and promote the health of this population. The findings point to Aboriginal history of colonization and residential school as a primary factor in discourses about Aboriginal people. These discourses potentiated nurses and other health care professionals to unwittingly engage in relationships based on common negative assumptions about Aboriginal clients. This not only becomes an ethical issue for the healthcare professional, but sadly may lead to dishonoring and disempowering behaviors that create barriers to engaging and promoting the health of Aboriginal patients.

Positive relational approaches that include the elements of being present and being familiar, conveyed by nurses and health-care professionals within health encounters create and enhance the potential for meaningful engagement with Aboriginal patients.

The findings of this integrative review indicate that relational approach in nursing practice, that includes the elements of the CRNBC (2012) definition, can potentiate the development of ethical therapeutic environments, thus creating positive and meaningful engagement with Aboriginal patients, which in turn lead to improved health outcomes for Aboriginal people.

References

- Alfred, T. A. (2009). Colonialism and state dependency. *Journal of Aboriginal Health, 5*(1), 42-60.
- Andelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health, 96*(2), S45-S61.
- Atleo, M. R. (1997). First nations healing: Dominance or health. *The Canadian Journal for The Study of Adult Education, 11*(2), 63-67.
- Baker, C., & Cormier Daigle, M. (2000). Cross-cultural hospital care as experienced by mi'kmaq. *Western Journal of Nursing Research, 22*(1), 8-28. doi:10.1177/01939450022044241
- Brascoupe, S., & Waters, C. (2009). Cultural safety exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health, 5*(2), 6-41.
- Bourque Bearskin, L. R. (2011). A critical lens on culture in nursing practice. *Nursing Ethics, 18*(4), 548-559.
- Broad, G., Boyer, S., & Chataway, C. (2006). We are still the Anishnaabe nation: Embracing culture and identity in Batchewana first nation. *Canadian Journal of Communication, 31*(1), 35-58.
- Broome, B., & Broome, R. (2007). Native Americans: Traditional healing. *Urologic Nursing, 27*(2), 161-163.
- Browne, A. (2007). Discourses influencing nurses' perceptions of first nations patients. *CJNR, 37*(4), 62-87.
- Browne, A. J., & Fiske, J. A. (2001). First nations women's encounters with mainstream health

care services. *Western Journal of Nursing Research*, 23(2), 126-147.

doi:10.1177/019394590102300203

Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, B., & O'Neil, J. (2011). Access to primary care from the perspective of aboriginal patients at an urban emergency department. *Qualitative Health Research*, 21(3), 333-348.

Browne, A., Varcoe, C., Smye., Reimer-Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy*, 10, 167-179.

Canadian Nurses Association. (2008). *Advanced nursing practice a national framework*.

Ottawa: Author. Retrieved on January 2013 from: www.cna-aiic.ca

College of Registered Nurses of British Columbia (2012). Boundaries in the nurse-client relationship, retrieved on August 25, 2013 from

<https://www.crnbc.ca/Standards/Lists/StandardResources/432NurseClientRelationshipsPracStd.pdf>

Cox, S., & Austin, J. (2013). Genetics and identity: Diagnosis, management, and prevention of health concerns. In J.L Storch, P. Rodney, & R. Starzomski (2nd Ed.), *Toward a moral horizon: Nursing ethics for leadership and practice* (pp. 491-508). Toronto On: Pearson.

Degagne, M. (2007). Toward an Aboriginal paradigm of healing: Addressing the legacy of residential schools. *Australian Psychiatry*, 15 September, 49-53.

Dion Stout, M., & Kipling, G. (2003). Aboriginal people, resilience and residential school legacy. *Aboriginal Healing Foundation*. Retrieved from:

<http://www.ahf.ca/downloads/resilience.pdf>

Dobbelsyeyn, J. L. (2006). Nursing in first nations and Inuit communities in Atlantic Canada.

Canadian Nurse, 102(4), 32-35.

Douglas, V. (2013). Introduction to Aboriginal health and health care in Canada bridging health and healing. Springer Publishing Company, New York NY.

Douglas, K. S. (2012). Navajo public health nurses inspire thoughts on health care reform. *Nursing Economics*, 30(4), 227-229.

Elias, B., Mignone, J., Hall, M., Hong, S. P., Hart, L., & Sareen, J. (2012). Trauma and suicide behaviour histories among a Canadian indigenous population: An empirical exploration of the potential role of Canada's residential school system. *Social Science & Medicine*, 74, 1560-1569.

Gray, R. R. R. (2011). Visualizing pedagogy and power with urban native youth: Exposing the legacy of the Indian residential school system. *Canadian Journal of Native Education*, 34(1), 9-27.

Gone, J. P. (2011). The red road to wellness: Cultural reclamation in a native first nations community treatment center. *American Journal of Community Psychology*, 47(1-2), 187-202.

Green, B. L. (2010). Culture is treatment. *Journal of Psychosocial Nursing*, 48(7), 27-34.

Habjan, S., Prince, H., & Kelley, M. L. (2012). Caregiving for elders in first nations communities: Social system perspective on barriers and challenges. *Canadian Journal of Aging*, 31(2), 209-222.

Hartrick, G. (1997). Relational capacity: the foundation for interpersonal nursing space. *Journal of Advanced Nursing*, 26, 523-528.

Hartrick Doane, G., & Varcoe, C. (2005). *Family nursing as relational inquiry developing health-promoting practice*. Philadelphia: Lippincott.

- Hartrick Doane, G., & Varcoe, C. (2007). Relational practice and nursing obligation. *Advances in Nursing Science*, 30(3), 192-205.
- Hawthorne, D. L., & Yurkovich, N. I. (1995). Science, technology, caring and the professions: are they compatible? *Journal of Advanced Nursing*, 21, 1087-1091.
- Herk, K. A. V., Smith, D., & Andrew, C. (2010). Identity matters: Aboriginal mothers' experiences of accessing health care. *Contemporary Nurse*, 37(1), 57-68.
- Hunter, L. M., Logan, J., Goulet, J., & Barton, S. (2006). *Aboriginal healing: Regaining balance and culture*. *Journal of Transcultural Nursing*, 17(1), 13-22.
- Kleffel, D. (1996). Environmental paradigms: Moving toward an ecocentric perspective, *Advances in Nursing Practice* 18(14), 1-10.
- Kurtz, D.M., Nyberg, J. C., Van Den Tillaart, S., & Mills, B. (2008). Silencing of voice: An act of structural violence. *Journal of Aboriginal Health*, January, 53-63.
- Kovach, M. (2010). *Indigenous Methodologies Characteristics, Conversations, and Contexts*. University of Toronto Press, Toronto Buffalo London.
- Lavoie, J. G., Forget, E. L., & Browne, A. J. (2010). Caught at the crossroad: First Nations, health care, and the legacy of the *Indian Act*. *Pimatisiwin: A Journal of Aboriginal and indigenous Community Health*, 8(1), 83-99.
- Loppie Reading, C., & Wien, F. (2009). Health inequalities and social determinants of Aboriginal peoples' health, National Collaborating Centre for Aboriginal Health retrieved from http://ahrnets.ca/files/2011/02/NCCAH-Loppie-Wien_Report.pdf, 1-41.
- Macaulay, A. C. (2009). Improving aboriginal health. *Canadian Family Physician*, 55 April, 334-336.

Mackinnon, M. (2005). A first nations voice in the present creates healing in the future.

Canadian Journal of Public Health, 96(1), s13-s16.

McCabe, G. (2008). Mind, body, emotions and spirit: Reaching to the ancestors for healing.

Counselling Psychology Quarterly, 21(2), 143-152.

McEvoy, P., Escott, D., & Bee, P. (2010). Case management for high-intensity service users:

Towards a relational approach to care co-ordination. *Health and Social Care in the Community, 19(1), 60-69.*

Milloy, J. (2009). *A national crime: The Canadian government and the residential school*

system, 1879 to 1986. Winnipeg: University of Manitoba Press.

Moules, N. J., MacLeod, M. L. P., Thirsk, L.M., & Hanlon, N. (2010). "And then you'll see her in

the grocery store": The working relationships of public health nurses and high-priority families in northern Canadian communities. *Journal of Pediatric Nursing, 25(5), 327-334.*

O'Connell, E. (2008). Therapeutic relationships in critical care nursing: a reflection on practice.

Journal Compilation British Association of Critical Care Nursing, 13(3), 138-143.

Parker, M. E., & Smith, M. C. (2010). *Nursing theories and nursing practice* (3rd ed.).

Philadelphia: F. A. Davis Company.

Porr, C., Drummond, J., & Olson, K. (2012). Establishing therapeutic relationships with

vulnerable and potentially stigmatized clients. *Qualitative Health Research, 22(3), 384-396.*

Royal Commission on Aboriginal Peoples. (1996). *Volume 3: Gathering strength, 223-224.*

- Ottawa: Author. Retrieved June 14, 2013 from Statistics Canada. (2010). *Aboriginal Peoples of Canada: Population growth*. Retrieved from <http://www.statcan.gc.ca/pub/89-645-x/2010001/growth-pop-croissance-eng.htm>
http://www.ainc-gc.ca/ch/rcap/rpt/index_e.html
- Racine, L., & Petruckla, P. (2009). Enhancing decolonization and knowledge transfer in nursing research with non-western populations: Examining the congruence between primary healthcare and postcolonial feminist approaches. *Nursing Inquiry* 18(1), 12-20.
- Ryan, F., Coughlan, M., & Cronin, P. (2007). Step by-step guide to critiquing research. Part 2: Qualitative research. *British Journal of Nursing*, 16(12), 738-744.
- Smylie, J. (2000). A guide for health professionals working with Aboriginal peoples: The sociocultural context of Aboriginal peoples in Canada. *Journal of the Society of Obstetricians & Gynaecologists of Canada, Policy Statement No. 100*, Dec. 2000, 1-12.
- Smylie, J. (2001). A guide for health professionals working with Aboriginal peoples: Cross cultural understanding. *Journal of the Society of Obstetricians & Gynaecologists of Canada, Policy Statement No. 100*, Feb. 2001, 1-11.
- Star, M., Whyte, N., Dundan, S., & Brown, J. (2011). It takes a community to raise a nurse: Educating for culturally safe practice with Aboriginal peoples. *International Journal of Nursing Education and Scholarship*, 8(1), 1-13.
- Tang, S. Y., & Browne, A. J. (2008). 'Race matters: Racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context, *Ethnicity & Health*, 13(2), 109-127.
- Tuckett, A. (2005). Part II: Rigour in qualitative research-complexities and solutions. *Nurse*

Researcher, 13(1), 29-42.

Vogel, L. (2011). BC first nations to run own health system. *CMAJ, 183(17), E1227-E1228.*

Whittemore, R., & Knaf, K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing, 52(5), 546-553.*

Appendix A

Qualitative Evidence Review Framework

Guidelines for critiquing a qualitative research study--score is based on how well each question is addressed in the article being critiqued.

Elements influencing believability of the research			
Elements	Questions	Comments	Score
Writing style	Is the report well written-- concise, grammatically correct, avoiding the use of jargon? Is it well laid out and organized?		/1
Author	Do the qualifications and position(s) of the researcher(s) indicate an appropriate degree of knowledge? In this field?		/1
Report Title	Is the title clear, accurate, and unambiguous		/1
Abstract	Does the abstract offer a clear overview of the study, including the research problem, sample, methodology, findings and recommendations?		/1
Elements influencing robustness of the research			
Statement of the phenomenon of interest	Are the phenomena of interest to, and consistent with, the research question? Is the phenomenon to be studied clearly identified?		/1
Study Purpose	Is the purpose of the study/ research question consistent throughout? Are the phenomena to be studied clearly identified?		/1
Literature Review	Does the literature meet the philosophical underpinnings of the study? Does the review of the literature fulfill the objectives of the study?		/1
Theoretical framework	Has a conceptual or theoretical framework been identified? Is the framework adequately described? Is the framework adequate to the research problem?		/1
Method and philosophical underpinnings	Have the philosophical approach and underpinnings been identified? Is the framework adequately described? Is the framework adequate to the research question?		/1.5
Sample	Are the sampling methods and sample size identified? Is the sampling method appropriate? Were the participants suitable for informing the research?		/1.5
Ethical considerations	Were the participants fully informed about the nature of the research? Were concepts of autonomy and confidentiality addressed? What protections from harm were put in place for the subjects? Was ethical permission granted and recorded?		/1
Data collection/data analysis	Are the data-collection strategies described? Are data-analysis strategies described? Did the researcher follow the steps of the data analysis method identified? Was data saturation achieved?		/1
Rigour	Does the researcher discuss how rigor was assured? Was credibility, dependability, transferability, or goodness discussed?		/2
Findings/ Discussions	Are the findings presented appropriately? Has the report been placed in the context of what was already known of the phenomenon? Is the original purpose of the study been adequately addressed?		/1
Conclusions/ Implications and recommendations. References	Are the importance and implications of the findings identified? Do recommendations suggest how research findings can be used in relational nursing? Are all the books, journals, and other media alluded to in the study referenced accurately?		/1.5
Relational Approach	Is there evidence of nurses consciously using a number of relational skills with clients including : (1) listening, (2) questioning, (3) empathy, (4) mutuality, (5) reciprocity, (6) self-observation, (7) reflection, and (8) sensitivity to emotional contexts? Is there evidence of nurses' inclusion of therapeutic nurse-client relationships and relationships among health care providers?		/2.5
Total			/20

Adapted from Ryan, F., Coughlan, M., & Cronin, P. (2007). Step by-step guide t critiquing research. Part 2: Qualitative research. *British Journal of Nursing*, 16(12), 738-744

Appendix B

Summary of Overall Critique Analysis for Integrative Review Articles

Relational Nursing And Aboriginal People(s)					
Qualitative Research Studies					
Citation	Research Type Ethical considerations and Strengths/ Limitations	Methodology Description	Research Methods Rigor in Qualitative Study	Relational Framework—Does study explicate this? Are elements of relational approach included? If so, what are they?	Is article relevant to inform advanced practice nurses when they work with Aboriginal people(s) or Aboriginal contexts? Is the article succinct and well written? Is rigor of the study evident?
<p>#1</p> <p>Browne, A. J. (2007).</p> <p>Clinical encounters between nurses and First Nations women in a Western Canadian hospital.</p> <p><i>Social Science & Medicine</i></p>	<p>Qualitative</p> <p>University and hospital ethics board provided approval for this study. Also, two FN organizations responsible for providing leadership in health care in the region provided written endorsement for the study (p.</p>	<p>Ethnographic study design.</p> <p>Study Purpose: “were to (a) examine patterns of interaction between nurses and First Nations (FNs) women in the hospital, and (b) analyze these interactions within a wider sociopolitical context to better understand how these contexts shape relations between nurses and FN women” (p. 2167).</p>	<p>Data Collection:</p> <p>“Immersion in the research setting involved visits to the hospital at least twice a week over the course of 9 months” (p. 2168). Data collection included nurse-patient encounters and the researcher recorded observed data on field notes. Reflexive analysis was employed by the researcher to assess if researcher presence altered the nurse-client interaction. Following the observational sessions, 1-2 hour in-depth interviews were conducted with individual nurses to discuss the nurses’ experience. Follow-up interviews were conducted for clarification. Interviews with the FN participants was initiated with an informal visit</p>	<p>Relational Framework:</p> <p>This article describes an approach that nurses may use intentionally or unintentionally—one that is not focused on a relational nursing approach. The four themes included: “relating across presumed “cultural differences”; constructing the Other; assumptions</p>	<p>Relevance to APN’s</p> <p>This study by Browne (2007) is one that can inform advanced practice nurses when working with Aboriginal people(s) or Aboriginal contexts. APNs have the ability to be “advocates for individuals, families, groups and communities in relation to health</p>

<p>64(10), 2165-2176.</p> <p>Believability and Robustness Score: 17.5/20</p>	<p>2167).</p> <p>The researcher was immersed in the research setting over a nine month period. The researcher’s repeated presence in the hospital facilitated the process of naturalistic inquiry as relationships were developed with nurses, other staff, and patients over time (p. 2168).</p> <p>Ethical Considerations: The questions asked in the interview are not provided. The purpose of the study is clear. There is no mention of explaining the purpose of the study to the participants. Written consent</p>	<p>Sample population: Purposeful sampling was employed. There were 35 participants (n=35), 14 registered nurses (RNs), two licensed practical nurses (LPNs), all worked in the same hospital; one Native liaison worker (for the hospital), four FNs key informants with expertise in Aboriginal health (including 2 RNs, a community health representative (CHR), a health administrator responsible for FN health in the region. All were women (p. 2167). Four of the hospital participant’s self-identified as FNs and most of the staff was employed at the hospital for long periods of time. The 14FNs women (patients) all spoke English. Eight resided in the local city; six lived in the FNs reserves in the surrounding region. They were from the Cree, Slave (Dene-thah), Babine, Witsuwit’ en, Dakelh (Carrier), and Gitskan nations (p. 2168).</p> <p>Setting: The setting is in a Western Canadian</p>	<p>in the hospital and a more formal interview was conducted in the participant’s home following discharge from the hospital when the researcher visited the women in their home community to conduct in-depth interviews. All interviews were audio-taped and transcribed for analysis (p. 2168).</p> <p>Data Analysis: “Interpretive thematic analysis was completed using processes described for qualitatively derived data” (p. 2168). Interviews and field notes were reread repeatedly to identify recurring and contradictory data patterns, preliminary concepts and themes, and possible linkages to theory—this enhanced study credibility. The data underwent a process of coding categories being collapsed, expanded, and refined. Nurses in the study reviewed the data as well as four key informants who concurred that the data resonated with the range of issues they encountered and experienced. (p. 2169)—this indicates dependability of the study.</p> <p>Trustworthiness: techniques for establishing credibility included: prolonged engagement within study environment, persistent observation, triangulation, negative case analysis, and member checking. Transferability was established by providing a thick description—research setting, information of participants, in-context data, and the researcher explains credible interpretation was affirmed by key informants (p. 2169). Conformability was established as the researcher employed reflexivity on field notes to examine if researcher presence impacted the behavior of the nurse during observational</p>	<p>influencing clinical practice; and responding to routine patient requests” (p. 2165). This paper discusses and illustrates how discourses and assumptions may shape how professionals view particular populations—the paper shows how this can be case for Aboriginal women in this study. The author asserts that, “this paper illustrates how discourses and assumptions about Aboriginal people, women, culture and presumed differences became interwoven into routine clinical encounters” (p. 2174).</p>	<p>promotion, health equity, health services, and policy decisions that affect health and quality of life” (Nura 518 C.—1). As a skilled nurse leader, the APN can role model using a relational approach in nursing care with Aboriginal people(s) and contexts by actively using excellent listening skills, being empathetic, caring, and respectful to all clients they service, particularly those of Aboriginal descent.</p> <p>The article is well written, the author is a nurse who appears to be familiar with the topic she is researching. The language within the study avoids the use of jargon and wordiness. All main aspects of the paper are clearly described and written. The article is well laid</p>
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	<p>is obtained from participants prior to observations (p. 2168).</p> <p>Strengths: Data obtained was based on the experience of participants (p. 2168).</p> <p>Limitations: The sample size was small thus limiting generalizability of the study.</p>	<p>hospital (p. 2167).</p>	<p>sessions (p. 2168).</p>		<p>and presents the findings nicely and provides excerpts to clarify rationale for themes.</p>
Citation	<p>Research Type</p> <p>Ethical considerations and Strengths/ Limitations</p>	<p>Methodology Description</p>	<p>Research Methods</p> <p>Rigor in Qualitative Study</p>	<p>Relational Framework—Does study explicate this? Are elements of relational approach included? If so, what are they?</p>	<p>Is article relevant to inform advanced practice nurses when they work with Aboriginal people(s) or Aboriginal contexts?</p> <p>Is the article succinct and well written? Is rigor of the study evident?</p>
<p>#2</p> <p>Browne, A. J., & Fiske, J. A. (2001).</p> <p>First nation’s</p>	<p>Qualitative</p> <p>The researcher’s state the Royal Commission on Aboriginal Peoples’ (1993)</p>	<p>Ethnographic Design</p> <p>Study Purpose: to examine mainstream health care encounters from the viewpoint of FNs women and to</p>	<p>Data Collection:</p> <p>Each participant underwent two in-depth interviews for 1 to 2 hours. Each woman was interviewed separately and was conducted by one member of the research team. Interviews were taped and transcribed verbatim. Each</p>	<p>Relational Framework:</p> <p>This article described the invalidating and affirming encounters of the 10 FNs women participating in the</p>	<p>Relevance to APN’s</p> <p>This article is relevant to inform APNs when they work with Aboriginal people(s) or contexts.</p>

<p>women’s encounters with mainstream health care services.</p> <p><i>Western Journal of Nursing Research, 23(2), 126-147.</i></p> <p>Believability and Robustness Score: 18.5/20</p>	<p>guidelines for ethical research with FNs communities was followed (p. 132). Informed consent was obtained from participants.. There is no mention of ethical permission for the study being granted. A memorandum of understanding (MOU) with the FN community outlined the shared control of the project and the findings (p. 132).</p> <p>Strengths: data obtained was based on participant’s experiences.</p> <p>Weaknesses: Sample size was small (10) thus, study is not generalizable.</p> <p>Lobiondo-Wood and Haber (2009)</p>	<p>understand how these encounters are shaped by social, political, and economic factors –thus, recognition and acknowledgement of the barriers are made so that government supported and collaborative efforts can be made to eliminate them (p. 127).</p> <p>Sample Population: 10 First Nations women, fluent in English from a reserve community in a rural area in northwestern Canada (p.127). Purposive and snowballing procedures were used with the input of community leaders, elders and the research team. Purposive sampling may be used when researchers have a particular question they wish to answer. Snowballing uses the approach of gaining further participants at the recommendation of other participants who know others that may be informative of the study (p. 132).</p> <p>There is no description provided about the</p>	<p>participant was asked to describe both a “model case” and “contrary case” of their health experience s. Field notes were recorded as part of the reflexive process (p. 132).</p> <p>Data Analysis: The research team met regularly to discuss the interview process, issues of rapport, potential biases, blind spots, and interpretive issues. Interpretive thematic analysis was completed in stages: the narrative text was reviewed as a whole by the research team; the text was read repeatedly to identify patterns of regularities, recurring ideas, and experiences that linked participants’ perspectives. Through this, categories and conceptual themes were formulated and reformulated. Researchers consistently worked at establishing an auditable decision-trail (p. 133).</p> <p>Trustworthiness: Techniques to enhance credibility and dependability of the study included peer debriefing as a research team to discuss the interviews, issues of rapport, potential biases, blind spots, and interpretive issues (p. 132). Negative case analysis was used, and member checking-- the participants were asked to critique, modify, and validate the analyses, interpretations, and themes to enhance both credibility and conformability (p. 132). Transferability was established as the researchers provide a thick description of the participants and setting of the study (p127). Conformability was enhanced as the researchers employed triangulation methods such as audio recording, transcript auditing, and thematic log in interviews (p. 132). Also, field</p>	<p>study. The affirming experiences described by the participants explicate relational approach. The relational elements are described in broad themes as follows:</p> <p>Actively participating in health care decisions—ability to speak openly and participate in their health care decisions, good communication relationship that incorporates the sharing of knowledge and power between professional that includes empowerment of participant’s, health care provider showing interest and concern for the health of the participant’s, not being constrained by time, ability to exercise self-determination, respect and caring attitude conveyed to participants, professional conducting them self in a genuine manner and including their</p>	<p>The researchers point out the importance of critically analyzing the unique social, political, economic, and historical factors influencing health care encounters at individual and institutional levels— with Aboriginal clients. This article describes both the positive and negative experiences for participants and their health care experiences. This may be helpful to heighten awareness for APNs and provide opportunity to reflect on the descriptions provided by participants and critically consider how relational approach can be beneficial in their nursing practice and help them to promote the health of Aboriginal people(s).</p>
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	<p>point out that reader must approach the study findings with caution.</p>	<p>participants. Setting: A FN reserve (did not want to be named) in the northern region of a Western Canadian province.</p>	<p>notes and reflexivity were practiced consistently which enhanced conformability of findings (p. 132). The use of purposive sampling is to obtain participants that are similar or from a specific cultural group thus enhancing transferability of findings to other similar environments and populations.(p. 132).</p>	<p>family, being treated like a “regular person”, unexpected acts of kindness such as support in particularly difficult times for participants, taking interest in knowing the participant, building trusting relationships, demonstration of sensitivity to emotional contexts. Affirmation of personal and cultural identity—recognition of traditional healing knowledge, acceptance of this knowledge as legitimate, acceptance of patients’ use of traditional medicines, affirmation of the value of traditional medicine by the mainstream system, expression of interest in cultural identity of participant’s, support given to grieving family members, doing home visit to fatally ill participant’s and/or family members. Development of a</p>	
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				positive, long-term relationships with a health provider—long-term positive relationships with doctors and nurses was important to participants, having a stable health care provider was noted as important for this enabled continuity of care and the building of relationships grounded in mutual respect and trust.	
Citation	Research Type Ethical considerations and Strengths/ Limitations	Methodology Description	Research Methods	Relational Framework—Does study explicate this? Are elements of relational approach included? If so, what are they?	Is article relevant to inform advanced practice nurses when they work with Aboriginal people(s) or Aboriginal contexts? Is the article succinct and well written? Is rigor of the study evident?
#3 Baker, C, & Cormier Daigle, M. (2000). Cross-cultural hospital care as	Qualitative Participants and interviewer signed informed consents. The interviewer checked the data	Interpretive Interactionism (II) Study Purpose: the study explores the hospital experiences of study participants to provide authentic understanding of the problem	Data Collection: Denzin’s (1989) five steps of interpretation—deconstruction, capture, bracketing, construction, and contextualization were used for this study (p. 11). A Mi’kmaq nurse (fluent in the Mi’kmaq language and who worked in the FN	Relational Framework: The study explicitly describes the development of negative and positive relationships between the participants and	Relevance to APN’s The findings in the study indicated that “understanding” between the caregivers and participants were

<p>experienced by Mi’kmaq clients</p> <p><i>Western Journal of Nursing Research, 22(1), 8-28.</i></p> <p>Believability and Robustness Score: 18/20</p>	<p>provided in the Table describing participants in grouped format to enhance anonymity of participants. Signed consent explained study and guaranteed anonymity and confidentiality completed. Interviewer signed same consent as participants (p. 14).</p> <p>Strengths: The data obtained was based on participant’s experiences. Open ended interview schedule was used thus interviews were not restricted to specific questions and had ability to be redirected according to participant information (p. 14).</p>	<p>participant’s face—their need to access health care services in a non-Aboriginal provincial health care system (p. 10). The goal was to increase the responsiveness of health care professionals to clients from minority cultural communities (p. 9).</p> <p>Sample Population: non-probabilistic, purposive sample of 10 Mi’kmaq individuals from the Big Cove reserve in New Brunswick—the participants had been hospitalized within three years of the study (p.11).</p> <p>Setting: The Big Cove Mi’kmaq FN community in New Brunswick (p. 11).</p>	<p>community) received training for interviewing techniques. An open-ended interview schedule was used (p. 14). All participants interviewed were only known by the interviewer (as per participant request), sessions were approximately 2 hours each, all sessions were audio taped in the Mi’kmaq language and they were transcribed by the same nurse (p. 12).</p> <p>Data Analysis: Data analysis began with bracketing—“in II, identification of the essential elements of the phenomenon being investigated” (p. 13). The process involved identifying problematic experiences and epiphanies in the text as well as key phrases thus leading to continued reviewing and revisions for identification of themes, construction and contextualization complete the analysis process (p. 11).</p> <p>Trustworthiness: The author notes that several strategies were used to establish credibility and dependability: the investigators presented the findings, first to the interviewer (who was a member of the Mi’kmaq Nation being studied), second, to a small sample of the Nation band council and elders, and then to the Nation personnel of the Health Center at Big Cove. These groups confirmed the interpretations fit their understanding of the experience investigated (p. 15). Research strategies enhancing rigor included: audio recording, transcript auditing, and thematic log. Operational techniques enhancing rigor included: atypical case samples, member checking, and triangulation strategies:</p>	<p>caregivers.</p> <p>Elements of relational approach are included and the participants describe optimal experiences were when participants felt understood.—this included: empathy and caregiver genuineness, taking the time to talk with participants, showing compassion and conveying kindness—responding with empathy from a human level and across cultural differences, being treated as equals, acceptance of family visitors.</p>	<p>often a problematic area—this may stem from nurses lack of understanding of communicating across differences. The authors point out that for nurses to effectively promote the health of minorities, including FN populations, “it is important for nurses to understand the phenomenon of receiving care in an unfamiliar culture” (p. 8). Therefore, I believe this study is relevant to inform APNs when they are working with Aboriginal people(s) and contexts.</p> <p>This article is succinct and well written. The authors use a methodology that is suitable for this type of study and they provide adequate background information to help readers understand the phenomenon being studied.</p>
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	<p>Limitations: Study uses a qualitative methodology and small sample sizes, therefore, generalizability of the findings are limited. Because of anonymity concerns the participants did not review and findings.</p>		<p>interviews, audio taping, thick description, and peer review. The authors point out that rigor is decreased due to inability to confirm results with study participants—however, they use several other acceptable approaches to increase the rigor of this study (p. 15).</p>		
Citation	<p>Research Type</p> <p>Ethical considerations and Strengths/ Limitations</p>	Methodology Description	Research Methods	<p>Relational Framework—Does study explicate this? Are elements of relational approach included? If so, what are they?</p>	<p>Is article relevant to inform advanced practice nurses (APNs) when they work with Aboriginal people(s) or Aboriginal contexts?</p> <p>Is the article succinct and well written?</p>
<p>#4</p> <p>Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, B., & O’Neil, J. (2011).</p>	<p>Qualitative</p> <p>Participants signed informed consents. The study was a collaborative research endeavor with the university</p>	<p>Ethnographic design</p> <p>Study Purpose: To understand the experience of study participants experiences accessing health care within the particular contexts of their lives (p. 337).</p>	<p>Data Collection:</p> <p>Data was collected over a 20-month period of immersion in the ED using (a) individual in-depth interviews with 44 patients triaged as stable and non-urgent, (b) individual in-depth interviews with 38 ED staff, including nurses, doctors, social workers, and admitting clerks; and (c) participant observation in the ED to observe clinical encounters between patients</p>	<p>Relational Framework:</p> <p>The study explains how marginalization is entrenched in the history of relations between Aboriginal people and the nation state. The elements of</p>	<p>Relevance to APN’s</p> <p>This article is relevant to inform APNs when they work with Aboriginal people or Aboriginal contexts. The article provides useful background information about</p>

<p>Access to primary care from the perspective of aboriginal patients at an urban emergency department.</p> <p><i>Qualitative Health Research, 21(3), 333-348.</i></p> <p>Believability and Robustness Score: 17.5/20</p>	<p>researchers and community based leaders in Aboriginal health and was guided by guidelines for ethical research with Aboriginal people.</p> <p>Strengths: The data obtained was based on participant’s experiences.</p> <p>Limitations: Only six participants participated in second interviews—these were challenging for many participants lived in temporary or transitional housing and people moved frequently.</p>	<p>Sample Population: Purposive sampling was used to recruit patients who were triaged in the ED as stable and non-urgent (p. 337). Patients who participated in the study (n= 44) included 25 men, 18 women, and one transgendered person (age range 20to 62 years). Of the 44 patients, 34 self-identified as Aboriginal (p. 336). Most were living in poverty and residing in the inner city of where the study was conducted (p. 336).</p> <p>Setting: An emergency department located in a large teaching hospital in Western Canada (p. 336).</p>	<p>and staff, and the general ED environment for contextual information (p. 336).</p> <p>Data Analysis: An interpretive thematic analysis was conducted using procedures for qualitatively derived data. Interview transcripts and observational notes were repeatedly read to identify recurring and contradictory patterns in the data, and possible linkages to theoretical perspectives. NVivo software was used to organize and code the narrative data. The analysis discussed in this study draws primarily on interviews with patients who identified as Aboriginal (p. 337).</p> <p>Trustworthiness: Researchers continuously evaluated and discussed credibility of analysis amongst their team and with leaders, and experts in Aboriginal health, ED clinicians, and health care administrators in primary care as well as university-based researchers. Triangulation of patient, staff, and observational data contributed to rigor and trustworthiness. Researchers regularly discussed the emerging themes with different groups of stakeholders –who concurred that the themes reflected in the data accurately resonated with their experiences and interpretations of these experiences. An audit trail of analytical insights and decisions was maintained (p. 337). Research strategies to enhance rigor included: audio recording, transcript auditing, and thematic log in interviews, and prolonged engagement (p.337). Operational techniques to enhance rigor included: atypical cases, member checking, triangulation methods, thick description and peer review (p. 337).</p>	<p>relational approach that are apparent in this study include health professionals being guided by conscious participation with clients that included listening, questioning, genuineness, and empathy. There was evidence of using sensitivity to emotional contexts.</p> <p>Specific examples included: Participants were acknowledged in some way; they were offered a snack or drink while in the ED; they felt listened to in an attentive manner; they were asked how they were feeling; you are treated like a human being; It was important to be treated like a regular person.</p>	<p>the Aboriginal people and discussed the long standing inequities endured by many Aboriginal people stemming from the systemic racism, discrimination, intergenerational effects of residential schools, welfare colonialism, and economic marginalization. This information is necessary for readers to understand and particularly important for APNs to be aware of to help them understand the importance of relational approach when working with Aboriginal people(s).</p> <p>The article is well written, the author is a nurse who appears to be familiar with the topic she is researching. The language within the study avoids jargon and wordiness. All main aspects of the</p>
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					paper are clearly described and written
Citation	Research Type Ethical considerations and Strengths/ Limitations	Methodology Description	Research Methods Rigor in Qualitative Study	Relational Framework—Does study explicate this? Are elements of relational approach included? If so, what are they?	Is article relevant to inform advanced practice nurses (APNs) when they work with Aboriginal people(s) or Aboriginal contexts? Is the article succinct and well written? Is rigor of the study evident?
<p>#5</p> <p>Herk, K. A. V., Smith, D., & Andrew, C. (2011)</p> <p>Identity matters: Aboriginal mothers' experiences of accessing health care.</p> <p><i>Contemporary Nurse, 37</i>(1), 57-68.</p>	<p>Qualitative</p> <p>There is no mention of obtaining informed consent for the secondary analysis study. The study was supported by two Aboriginal organizations and the Aboriginal Access Center involved with the primary research study and Ethics approval was granted from a Research Ethics Board for the</p>	<p>Secondary Analysis— intersectionality method</p> <p>Study Purpose: This study will focus on how perceptions of Aboriginal women’s identities within care encounters affects women’s experience s of care and thus influences their access to health care (p.58).</p> <p>Sample Population: While the researcher was immersed in the data for the primary study the initial step was the purposive selection of five transcripts. Following analysis of the first five transcripts, the larger</p>	<p>Data Collection:</p> <p>Data was collected from purposively selected transcripts of exploratory interviews with aboriginal women. (p. 57). While the researcher was immersed in the research data for the primary study, the first step in the secondary analysis was to the selection of five transcripts. After completing an analysis of the first five transcripts the larger body of interviews transcripts (n=21) was examined to identify additional relevant data. (p. 60).</p> <p>Data Analysis: Thematic narrative analyses was used to code all the transcripts for themes to identify how interrelated systems of domination/oppression play out and are experienced in the everyday lives of Aboriginal women (p. 60).</p>	<p>Relational Framework:</p> <p>This study uses a postcolonial feminist lens to explore how identity and the care for Aboriginal women impact the access for this population. This lens facilitates in-depth understanding of the phenomenon of study with regard to relationships of health care professionals, particularly nurses with the Aboriginal population. One theme in the study: working it through with</p>	<p>Relevance to APN’s</p> <p>This is an excellent article to inform APNs when they work with Aboriginal people or within Aboriginal contexts. The article provides examples of when relational approach is employed by nurse and includes conscious participation with clients and incorporation of relational skills of listening, questioning, empathy, mutuality,</p>

<p>Believability and Robustness Score: 17.5/20</p>	<p>study (p. 60).</p> <p>Strengths: A secondary analysis is useful in studying a sub topic such as this study (p. 60).</p> <p>Limitations: this secondary analysis did not avail opportunity to talk with women about how they thought service providers’ perceptions of their identity impacted their care experience during the primary interviews. Researchers note that one must consider this study as an initial step for informing future research where participants would have greater opportunity to discuss the implications of the meaning</p>	<p>body of interview transcripts (n=21) was examined to identify additional relevant data (p. 60).</p> <p>Setting: The primary study was conducted in a Canadian city with a large and rapidly growing urban population (p. 59).</p>	<p>Trustworthiness: Credibility for study was enhanced by researchers focusing on doing research collaboratively with Aboriginal participants in their approach (p. 59). Dependability was enhanced as preliminary results were shared to verify findings with the participating Aboriginal organization and three Aboriginal women—there were revisions made based on discussions (p. 61). Research strategies to enhance rigor included: field notes and thematic log process. Operational techniques that enhanced rigor included: atypical case, thick description, peer review of data where preliminary results were shared to verify results (p. 61). The authors note: this secondary analysis did not avail opportunity to talk with participants because it was a secondary analysis (p. 61).</p>	<p>Aboriginal mothers – ‘giving care in a good way?’ explicated a relational approach. This was evident with the positive acknowledgement of Aboriginal identity of participants, recognition and sensitivity to their unique history and experiences, recognition of the context of the participants, providing necessary support and care leading to the development of trusting relationships, empowering clients, taking the time to listen and work through complex situations, respect, and provision of optimal care from the client’s perspective.</p>	<p>and respect and trust building with clients is beneficial to nurses and may be helpful in promoting the health of Aboriginal clients.</p> <p>The overall article is well written, clear, and succinct. The author does not use jargon in their writing and provide necessary definitions to help readers clearly understand their study.</p>
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	attached to their identity in health care encounters. (p. 61)				
Citation	Research Type Ethical considerations and Strengths/ Limitations	Methodology Description	Research Methods Rigor in Qualitative Study	Relational Framework—Does study explicate this? Are elements of relational approach included? If so, what are they?	Is article relevant to inform advanced practice nurses when they work with Aboriginal people(s) or Aboriginal contexts? Is the article succinct and well written? Is rigor of the study evident?
#6 Kurtz, D. L. M., Nyberg, J. C, Van Den Tillert, S., & Mills, B. (2008). Silencing of voice: An act of structural violence urban Aboriginal women speak out about their experiences with health care.	Qualitative There is no mention of informed consent within this study. The study is a partnership between three Okanagan Friendship Centers and various departments at the University of British Columbia, there is no mention of an Ethics Board	Participatory research Study Purpose: The study explores the barriers that urban Aboriginal people face when they access mainstream health and social services and the reasons why they are increasingly seeking out the Friendship Center services. Sample Population: The sample is identified as 13 urban Aboriginal women. Setting: The setting is described to be with	Data Collection: Data collection included discussion forums and interviews and drew on participant insights from stories and narratives that had been documented to this stage of this ongoing study. The strategies used to analyze the data are not described. This participatory study provides excerpts from participant voices. Data Analysis: The report does not detail the data analysis process used. Trustworthiness: The researchers do not provide information about how rigor of their study was achieved. Two of the researcher are of Aboriginal descent, which may enhance the rigor of this study..	Relational Framework: This study focused on the voice of the Aboriginal women participants in the study. Relational framework is not clearly explicated in this study. The elements of relational approach included in the study occurred when participants described feeling supported and cared for. The service provider treated them nice and took the time	Relevance to APN’s The study included both negative and a few positive encounters shared by the participants of the study. The main elements of structural violence experienced by the participants in the study were racism, discrimination, and the silencing of voice. This study highlights the impact colonization has had and in some cases

<p><i>Journal of Aboriginal Health</i>, 4(1), 53-63.</p> <p>Believability and Robustness Score: 14.25/20</p>	<p>approval.</p> <p>Strengths: this study is a partnership between three Okanagan FCs and various University of British Columbia Okanagan, thus inclusive of several different perspectives relative to the phenomenon being studied.</p> <p>Limitations: The sample size is small (n=13), therefore, the study is not generalizable.</p>	<p>three urban Okanagan Valley Friendship Centers in British Columbia.</p>		<p>to listen and hear them as well as willingness to service beyond the minimum requirement. The service provider availed a safe environment and they fostered the development of trusting relationships.</p>	<p>continues to persist in the health care encounters of Aboriginal peoples. The author's contend it is important for health care providers to be aware of the legacy of colonization; awareness may help facilitate increased understanding about Aboriginal people as well as an increased awareness of how female Aboriginal individuals may face greater challenges when accessing health care services. APN's may benefit from reading this study to better understand how structural violence may be present in current nurse-client health encounters.</p> <p>This article is not written with great clarity and succinctness for it appears to be a bit wordy.</p>
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Citation	Research Type Ethical considerations and Strengths/ Limitations	Methodology Description	Research Methods Rigor in Qualitative Study	Relational Framework—Does study explicate this? Are elements of relational approach included? If so, what are they?	Is article relevant to inform advanced practice nurses when they work with Aboriginal people(s) or Aboriginal contexts? Is the article succinct and well written? Is rigor of the study evident?
<p>#7</p> <p>Porr, C., Drummond, J., & Olson, K. (2012). Establishing therapeutic relationships with vulnerable and potentially stigmatized clients. <i>Qualitative Health Research</i> 22(3), 384-396.</p> <p>Believability</p>	<p>Qualitative</p> <p>Ethical approval was granted from the University Health Research Ethics Board following approval from the regional health authority operational approval (p. 385). The participants signed an informed consent following the researchers explaining the study, inviting questions, and participant’s ability to withdraw from</p>	<p>Grounded Theory Methodology</p> <p>Study Purpose: The purpose of the study was “to elucidate how public health nurses (PHNs) develop therapeutic relationships with vulnerable and potentially stigmatized clients, specifically, single mothers living in low-income situations” (p.384).</p> <p>Sample Population: Purposive sampling of PHNs (N=15) and LISMS (N=21). The PHNs were White Canadians with a minimum of 1 year work experience and the LISMS were of mixed ethnicity from 22 to 40 years with</p>	<p>Data Collection:</p> <p>Face-to-face interview meetings lasting 60 to 90 minutes were audio taped. Broad semi structured questions were used to focus participants. PHN interviews were conducted in the privacy of their office while the interviews with the mothers were conducted in their respective homes. Nonverbal data by observing interactional behaviors of 14 dyads involving 4 PHNs and 14 mothers (7 mothers of low-income status and 7 mothers of high-income status) (p.386).</p> <p>Data Analysis: Interview transcripts were examined from a macroscopic view then substantive coding took place, the researchers used in vivo codes that depicted relevant perspectives, behaviors, gestures, attitudes, or key experiences. Core issues evident between PHN and LISMS relative to the development of therapeutic relationship. Theoretical coding was also used, this process helped produce the interrelation of conceptual categories and</p>	<p>Relational Framework:</p> <p>Relational approach is apparent in this study. The theoretical model that emerged in the study was named Targeting Essence: Pragmatic Variation of the Therapeutic Relationship. This model consists of six stages. Stage one: projecting optimism consists of 2 subthemes: engaging positively and offering verbal commendations. Stage two: Child as mediating presence consists of the subthemes: child as focal point, evaluating</p>	<p>Relevance to APN’s</p> <p>This article is an excellent article to inform advance practice nurses when they work with Aboriginal people or within Aboriginal contexts. The model developed provides a framework to help focus APNs in the development of therapeutic and relational practice.</p> <p>This article is nicely written. The authors provide clear and succinct descriptions about how APNs can establish therapeutic relationships with</p>

<p>and Robustness Score: 19/20</p>	<p>the study at any point (386).</p> <p>Strengths: the data obtained from the study is powerful for it was based on the human experiences of the participants and it was intended for the discovery of theory grounded in data as opposed to the verification of extant theory (Glaser & Straus, 1967) (p. 385). Questions were broad structured, mainly to focus interview (p. 385).</p> <p>.</p> <p>Limitations: It is difficult to know if the researcher’s presence influenced or impacted the study. The research quality appears to be dependent on</p>	<p>at least one child under 5 years old.</p> <p>Setting: the setting and location for the research study is not provided.</p>	<p>properties that elaborated them. The interpretive framework employed for the study was symbolic interactionism as well as communication theory.</p> <p>Trustworthiness: The researchers note that “criteria for rigor include fit, relevance, work, and modifiability, as developed by the cooriginators”(Glaser and Straus, 1967). The researcher’s state “fit was maintained by ensuring that we did not force data to conform to predetermined ideas or “pet” theories” (p. 391). “Relevance was evident by the fact that our discovery of the relationship building issues (e.g. time constraints) resonated with the PHNs’ everyday practice realities...after presenting [the model] to a group of PHNs, it was confirmed that we had passed the criterion for work—we were able to validate that the model could explain and interpret (Glaser, 1978) the interpersonal dynamics between the PHN and the LISM” (p. 391). The PHNs agreed that the model developed was feasible. Modifiability was attained as the researchers assert they approached the data with openness and flexibility (p. 391). Credibility and dependability was demonstrated when the PHNs agreed that the model Targeting Essence: Pragmatic Variation o the Therapeutic Relationship was comprehensive and merited practical value and application (p. 391). A technique for establishing transferability included a thick description of participants (p. 385). Triangulation of methodology included observations and interviews. Observation included observing dyad interactional behaviors</p>	<p>the practitioner’s approach, and attributing advanced child sensitivity. Stage three: Ascertaining motives consisted of the subtheme to trust or mistrust and the litmus test. Stage four: exercising social facility consisted of the subthemes empathic accuracy, responding and strategically. Stage five: Concerted intentionality consisted of the subthemes painting a new canvas and building capacity. Stage six: Redrawing professional boundaries consisted of the subthemes assuming pseudo roles and fulfilling surrogate social support. Each of these stages provided examples of the PHNs developing relational practice with their clients.</p>	<p>vulnerable and potentially stigmatized clients which describe the way many Aboriginal people have shared about how they have been treated.</p>
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	the skills of researcher.		(p. 385).		
Citation	Research Type Ethical considerations and Strengths/ Limitations	Methodology Description	Research Methods Rigor in Qualitative Study	Relational Framework—Does study explicate this? Are elements of relational approach included? If so, what are they?	Is article relevant to inform advanced practice nurses when they work with Aboriginal people(s) or Aboriginal contexts? Is the article succinct and well written? Is rigor of the study evident?
#8 Moules, N. J., Macleod, M. L.P., Thirsk, L. M., & Hanlon, N. (2010). “ And then you’ll see her in the grocery store”: The working relationships of public health nurses and high-priority families in northern Canadian communities.	Qualitative The researchers note that criteria for selection and recruitment process are detailed in other publications arising from this study (p. 329). Ethical approval was received from the research ethics boards of the University of Northern British Columbia, University of Victoria, University of	Interpretive Hermeneutic Inquiry method Study Purpose: The purpose of this study is to examine and articulate the working relationships of public health nurses (PHNs) and high-priority families (HPFs) in northern communities with the intent of informing practice, education, and policy at the community, regional and national levels (p. 328). Sample Population: The study includes 25 PHNs who have at least one	Data Collection: Data was collected from July 2005 to July 2006. Five PHNs were trained for the completion of interviews with families outside of their region of practice. The second author completed 18 individual and 4 group interviews with PHNs. All interviews were audio taped and transcribed verbatim. Data was also collected through participant observation of six PHN during their everyday work with families (p.329). Data Analysis: The researchers completed individual and group sessions of systematically reviewing all interview transcripts. Interpretive notes of transcripts, subsequent meetings were used to interpret similarities and differences to extend the researchers interpretations (p. 329). The researchers were careful to ensure that the findings emerged from the data obtained from participants as opposed to any previous	Relational Framework: Relational framework is apparent in this study. This study affirms that the nurse-client relationship is vital to PHNs for establishing trusting relationships to facilitate their ability to effectively work with HPFs. The process of relating, engaging and entering into relationships heading provides the following major themes: A “weigh” in the door, coffee with a purpose, and doors	Relevance to APN’s I believe this article is relevant to inform the nursing practice of APNs as they work within Aboriginal contexts or with Aboriginal people. The researchers contend “by examining the relationships of nurses and families in context, new possibilities can be seen for ways in which to support HPFs and enhance PHN practice” (p. 328).

<p><i>Journal of Pediatric Nursing</i> 25(5), 327-334.</p> <p>Believability and Robustness Score: 17.5/20</p>	<p>Calgary, University of British Columbia, and the Research Review Board of Northern Health (p. 329).</p> <p>Strengths: The data is from the participants and was collected over an entire year (p. 329) thus demonstrating the data is derived from human experience of the participant’s of the study.</p> <p>Limitations: The researchers note that this study did not match families with nurses and thus cannot validate that each participant’s perception of a “good relationship” was shared by the participant (p. 333).</p>	<p>year of work experience and 32 HPFs who have at least one child under five and that have been supported by the PHN within the year of initiating the study (329).</p> <p>Setting: The study was conducted in northern British Columbia with 14 communities. The region of this study is home to a relatively large proportion of Aboriginal people. (p. 328).</p>	<p>theories (p. p. 329).</p> <p>Trustworthiness: The authors employ several strategies to enhance rigor of this study. Research strategies included transcript auditing “researchers individually and as a group systematically reviewed all of the interview transcripts. Each wrote interpretive notes about the transcripts” (p. 329). Credibility, dependability and conformability are demonstrated as they note “there is no attempt to achieve a truth that is equated with frequency, reoccurrence, and or control nor is there an attempt to achieve what is known in the natural sciences of objectivity” (p 329). Moreover, PHNs agree that findings resonate and are familiar within their practice and understandings (p. 329).</p>	<p>and questions. These subthemes provide excerpts of the ingenuity PHNs employ to enable them to work effectively with HPFs. The aspects of respect, listening, empathy, caring, mutuality, reciprocity, and sensitivity to contexts are apparent throughout the study findings.</p> <p>These provide clear descriptions of relational approach between the PHN and HPFs in the study.</p>	<p>This article is nicely written and is clear, concise, reader friendly, and free of jargon.</p>
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<p>#9</p> <p>Gone, J. P. (2011).</p> <p>The red road to wellness: Cultural reclamation in a native First Nations community treatment Center.</p> <p><i>American Journal Community Psychology</i> 47, 187-202.</p> <p>Believability and Robustness Score: 17/20</p>	<p>Qualitative</p> <p>The researcher had community approval for conducting the research study. Ethical approval to conduct the study was obtained from the controlling Institutional Review Board. Participants signed informed consent to participate in the study.</p> <p>Strengths: The researcher employed semi structured, open-ended interviews</p>	<p>Case Study</p> <p>Study Purpose: The study was conducted “ to explore how Aboriginal cultural practices were incorporated into an outpatient counseling program to illustrate how cultural analysis—i.e. the critical engagement of empirically observed phenomena that is oriented by interest in cultural matters—might enhance inquiry within community psychology more generally” (p. 188)</p> <p>Sample Population: There were 19 Aboriginal participants (n=19) that included the current and former Lodge administrator (n=2),</p>	<p>Data Collection:</p> <p>Data collection included interviewing participants. Interviews were 30 minutes to 3.5hours in length using an open-ended fashion relative to a host of informal questions arising during the study and were audio-taped. Copies of documents and records associated with the counseling program were retrieved by the researcher (p. 190).</p> <p>Data Analysis: The audio-tape recordings were transcribed by research helpers and the researcher analyzed data for accuracy (p. 190). Thematic content analysis was used for theme finding. The qualitative data analysis software program NVivo8 was used by the researcher. A thorough descriptive report was drafted and provided to Lodge administrators and program staff for review and feedback. An early version of this article was provided to program staff to review and they gave an affirmative response (p. 190).</p> <p>Trustworthiness:</p>	<p>Relational Framework:</p> <p>This article explores how Native American cultural practices were incorporated into an Aboriginal run Healing Lodge that had been in existence since 1989. The mission statement of the Lodge focused on the Aboriginal healing perspective that incorporated the Medicine Wheel which involves a holistic approach. The Western approaches of healing were also used to augment the healing process of the clients using the Lodge.</p> <p>The elements of</p>	<p>Relevance to APN’s</p> <p>This article is an excellent article that may be helpful to advance APNs when they are working with Aboriginal people(s) or Aboriginal contexts. As nurses intentionally increase their awareness of relational nursing approach in their nursing practice this has the potential to enhance their nurse-client relationships which may enhance their ability to facilitate, promote, and optimize the health of their clients in diverse practice</p>

	<p>therefore, was not restricted to specific questions guided by the interviewer (p. 190).</p> <p>Limitations: The author point out “one key limitation of the official report was its crafting in response to an overtly descriptive mandated of the Aboriginal Healing Foundation” (AHF) (p. 190). The staff were more adept than the clients at discussing treatment approaches, thus, data was heavily derived from the staff interview responses (p. 191).</p>	<p>counselors (n=4), lodge clients that had completed the program (n=11), counseling program coordinator (n=1), and the counseling programs oversight committee member (n=1). Nine participants were male and ten were male (p.189).</p> <p>Setting: A Healing Lodge located in a northern Algonquian Native reserve in Canada (p. 189).</p>	<p>Techniques for establishing credibility included: participant observation, interviews, and member checking (p. 190). To establish transferability, a thick description of the participants and setting is provided (p. 189). Dependability is demonstrated as the researcher employs an inquiry audit on the transcribed data from assistants (p. 190). Conformability of study is demonstrated for the researcher used several sources to obtain data: participants, data from documents and records associated with the counseling program—thus study is shaped and derived from the study participants (p. 190).</p>	<p>relational approach used in the Lodge include: active listening skills that allowed the staff to take time necessary to assist clients. Participants noted that if staff used “banker hours” this would have negatively impacted the healing process. Staff conveyed patience, understanding, caring, and empathy which facilitated the development of trusting and open relationships. Spirituality was a focus on ceremonial practices such as sweat lodge ceremony, traditional healers, smudging, and pipe ceremonies. Mutuality was evident—many of the staff had experienced historical and present day issues of racism and stereotypical treatment. The report indicates that many Lodge staff conveys a connectedness to their clients.</p>	<p>settings, particularly those including Aboriginal people(s) and Aboriginal contexts.</p> <p>This article is grammatically correct and well written. The article is nicely presented with clear headings. There are areas that the researcher may have used simpler words and phrases to help readers better understand the report. However, this article is well written and can be helpful to inform the practice of nurses and other health care workers.</p>
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				<p>This article includes many of the relational approach elements necessary to develop positive client and health care professional relationships that can be helpful in promoting the health of clients.</p>	
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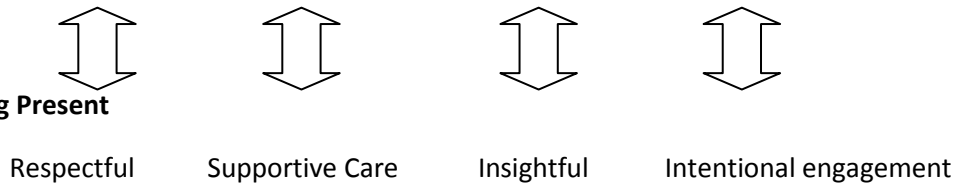
Appendix C

Conceptualization of Relational Approach with Aboriginal People

Tree: Being familiar



Roots: Being Present



Lightning Bolts: Dishonoring and Disempowering Behavior

