Changes in Awareness and Care Practices on the part of Public Health Nurses through Participation in an Action Research-based Case Study Group on Child Abuse and Neglect

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Key Words :
child abuse and neglect
public health nurse
case study group
action research
family support

ABSTRACT

Purpose: To establish a case study group composed of public health nurses and describe changes in awareness and support on the part of the nurses participating in the group, with the aim of making public health nurses deal with child abuse and neglect cases.

Method: Utilizing action research, the author established a case study group, described the changes noted in 11 public health nurses and analyzed the result.

Result: The study proceeded as follows:

1. Proposal to establish a case study group;
2. Pre-establishment publicity and implementation; and
3. Evaluation and feedback.

In the course of expressing themselves in the case study group participants became able to tackle their tasks in advanced ways. They changed their way of looking at the family and the content of their support by shifting the focus of their attention from "problems" to "strengths", thereby strengthening the prevention of abuse and neglect and promoting the spread of the support network.

Discussion: The above changes resulted from the author's role as facilitator, listening closely to each participant's thoughts, promoting interactions among the participants and supporting each individual participant by promoting the changes in their thinking so as to enable them to focus more closely on "strengths".

I. Introduction

Dr. Kempe, an American pediatrician, and his colleagues defined child abuse and neglect as "a condition having to do with those children who have been deliberately injured by physical assault" by parents, guardians, or caregivers[1)]. The most tragic and worst result of child abuse and neglect is "death." Even the cases not ending in death can cause physical or emotional harm to children, and leave them severely impaired, cause mental retardation, or evoke emotional or personality disturbance during the course of their growth. Child abuse and neglect is a life-threatening issue for children; at the same time it physically and emotionally hurts children and sometimes causes irreparable developmental disorder or disability. Also, a generational chain of abuse and neglect is said to be seen in approximately 30% of abused and neglected children who mistreat their own children when they themselves become parents[2)], which is a grave pathological phenomenon of family and society passed down through generations[3-4)]. Such persistent abuse and neglect from parents to children who are rapidly growing is a serious problem in society as well as children and must be solved as quickly as possible.

Meanwhile, Japan has an excellent maternal and child health system which is incomparable in the world and public health nurses are assigned to municipalities throughout the country[5)]. Public health nurses are able to have opportunities to meet most parents with infants through the health services such as home visits, health checkups, and immunization programs, and they provide parents with consultations and make home visits under normal circumstances. Therefore, expectations on public health nurses who are close to residents and active at the front lines in local health services for the prevention and support of child abuse and neglect has been increasingly raised.

Child abuse and neglect is a pathological phenomenon in family relationships which involves various family factors such as parents' early developmental history, experience of abuse and neglect, mental disorder of parents, personality traits, lack of attachment to children, and husband and wife relationships[3)4)6)]. In addition, intricately entangled life conditions such as financial or housing situations, living environment, or social isolation are attributable to occurrences of child abuse and neglect, which requires a long-term and broad range of support. Therefore, workers who provide support see no direction and effects of help and often end up suffering from a sense of powerlessness or a feeling of insufficiency[7)]. When public health nurses who provide support are overwhelmed by a sense of powerlessness, it is obviously difficult to solve most of abuse and neglect problems, so their sense of powerlessness needs to be improved. Also, workers who deal with families exhibiting domestic violence and sexual abuse may suffer from deep stress and traumatic experience. It is, therefore, considered important for such workers to receive burnout prevention and supervision[8)9)]. Nonetheless, few sufficient stress management measures for workers to support abuse and neglect cases have been taken and very few studies on this subject have been conducted.

We can see from the above that measures should be taken to encourage public health nurses with difficulties and a sense of powerlessness to notice their potential strength and proactively help families where child abuse and neglect take place.

II. Purpose of the Study

This study aims to change awareness and care practice of the participants, realize positive support of abusing families, and describe such changes through the establishment of a child abuse and neglect case study group with local health centers and municipal public health nurses using the action research method.

III. Study Methods

This study adopted action research methods. Action

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research is said to be a research method which links practice, studies and theories[10]. According to Hart & Bond[11], action research is the most fundamental research strategy for residents; according to Meyer[12], the strength of action research aims at solving actual problems and enables empowerment of people who are engaged in tasks on the spot through participation in studies or later development.

Specifically, referring to studies by Hart & Bond[11] and Morton-Cooper[13] which show action research procedures for health care, the procedures below were followed. The procedures are: 1) clarification of problems and proposal for the establishment of a child abuse and neglect case study group; 2) pre-establishment publicity and implementation of the child abuse and neglect case study group;

and 3) evaluation and data feedback of the child abuse and neglect case study group. Furthermore, based on the principle of action research where study participants share studies and agree to proceed, we flexibly moved forward by providing the participants with feedback of the study data at each stage of the study process, reviewing the data together with the participants, and obtaining their consensus.

1. Study period

The study period lasted for two years and nine months, from July 2004 to March 2007.

The period for preliminary field work and negotiation was from July 2004 to April 2005; the implementation period was from May 2005 to November 2006; and the period for result feedback and follow-up was from December 2006 to March 2007.

2. Study participants

A total of 11 public health nurses participated in the study: One from 'A' health care center and 10 from B City and C Town which were under the control of 'A' health care center. The background of the participants was shown in Table 1.

3. Procedures of case study group and role of facilitator

As the researcher, I facilitated the child abuse and neglect case study group; the case study proceeded as shown in Table 2. I encouraged each participant to express his/her feelings and thoughts and promoted their proactive participation; I also encouraged the group members to identify each other's strengths to activate mutual interaction and support. Furthermore, I gave consultations to the participants before and after the case study group meetings and provided information which helped them access necessary resources such as literature and relevant organizations.

4. Analysis methods

Data resources included the description of participant observation, case progress reports, minutes of meetings, and records of individual and group interviews. Speech and behavior of the observed participants and thoughts and interpretation of the researcher were recorded in the field notebooks; case study meetings and interviews recorded on an IC recorder after obtaining the consent from the participants were transcribed into a word for word description. The acquired data on the case study group, the study participants, researcher, and workplaces of the participants were put in chronological order; the contexts were studied based on the collected data; and the contents in 1) the participants, 2) groups, 3) workplaces and relevant organizations, and 4) the changes of case studies were interpreted in connection with researcher' actions. Then, a theme which was drawn focusing on the changes in public health nurses' awareness and care practices was described.

5. Ethical consideration

The participants and their supervisors were told about the concept of the study and informed that the participants may withdraw from the study at any time; personal information and privacy protection were secured verbally and in writing; and written consent was obtained from those concerned. Since it was difficult to obtain consent from families of case study subjects due to the nature of abuse and neglect, data such as name, date of birth and address of the subjects remained anonymous and only information necessary for study was obtained to the extent of permission given by

Table 1. Background of the Participants

Public Health Nurses (fictitious name)	Age	Organization	No. of Attendances	
Fujita	30's	A' Health Care Center	14	
Takiyama	40's	B City, Welfare Dept.	14	
Tanaka	30's	B City, Health Dept.	8	(participated in the 1st year only)
Maruyama	40's	B City, Health Dept.	13	
Yamamoto	30's	B City, D branch	11	
Sato	20's	B City, E branch	8	(participated in the 1st year only)
Aoki	20's	C Town, Health Dept.	14	
Konno	30's	B City, Welfare Dept.	6	(participated from the 2nd year)
Nakamura	20's	B City, Health Dept.	6	(participated from the 2nd year)
Ozawa	20's	B City, Health Dept.	6	(participated from the 2nd year)
Takahara	40's	C Town, Health Dept.	6	(participated from the 2nd year)

*All names of the pubic health nurses are fictitious.

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Table 2. Procedures of Case Study Group

(1) How to provide cases
The participants provide cases for which they have continuously given proactive support.
(2) Procedures of case study group meetings
a. The participant who provides the case explains the outline of the case, the goal of assistance, processes of assistance, contents to be discussed, struggles and difficulties when giving assistance.
b. Through Qs and As the participants form the overall picture of the case to share.
c. The participants examine the case as if it is their own case.
d. The participants examine the following points:
- The needs of the case recognized by the participant who provided the case;
- The goal of assistance or assisting plan made by the participant who provided the case;
- Processes of assistance (grounds of approach, appropriateness of timing, observation of reaction/change of the subject); and
- Assisting policy in the future (the techniques and resources currently or hereafter used by the participants who provided the case are discussed)
(3) Important points of the case study group meetings
a. In the form of voluntary group learning, the participants can express their opinions from all angles in a free atmosphere as much as we can.
b. If discussions get stuck, we clarify the focus of discussions, straighten out our thinking, and then reverse the way of thinking.
c. We try to point to conceivable ideas from all standpoints and angles with a broad perspective, considering what the subjects of the case, people around the subjects, the participants, and people concerned think (or decide on); this process will lead us to solutions.
d. All participants learn the good and effective assistance which the participant who provided the case has given.
(4) Record and report
a. A participant takes the minutes of the meetings, but the participants who provided the case organize the record and hands out to the participants the summary of the discussion results of the case study group meetings, learning, and things to be put in practice.
b. The participants apply the ideas discussed at the meetings, implement them, and report the results of the implementation at the subsequent case study group meeting.
The report written in an A4 page includes the discussion results of the previous meeting, things to be put in practice, the results and issues of such implementation.
(5) Protection of personal information and ethical considerations
Information shall be given anonymously and specific contents shall be collected on the spot.
Information shall be published to the extent permitted by the supervisors.
The participants shall carefully keep the materials taken home.

the supervisors. The analysis results were provided to the participants to make sure that there were no mistakes in the description of facts and interpretation and obtained approval with regard to the limit of publicity and contents of the data; the study results were provided to those who were interested. The protocol of this study was submitted to the Ethical Review Board of Studies of the Japanese Red Cross College of Nursing and approved by the Board. (October 30, 2006, approval no. of the *Rinkeni:* 2006-50)

6. Ensuring of credibility

As for interpretation of study data, the primary data and researcher's interpretation were contrasted and supervision was given by a professor of nursing experienced in qualitative study. Also, the primary data and researcher's interpretation were presented to the researchers experienced in child abuse and neglect study or working as public health nurses to have the opportunity of discussion and to get comments on the interpretation. In addition, credibility was ensured by presenting the primary data and interpretation to the study participants to make sure that there were no mistakes in the description and interpretation.

IV. Results

1. Actual practice procedures

After the preliminary field work and negotiation for 10 months, 14 case study meetings were held in one year seven months; for four months after the completion of the meetings, follow-up and feedback on the study results were provided. All the names below are fictitious.

1) Clarification of problems and proposal for the establishment of a child abuse and neglect case study group

A health care center asked me to take charge of case study examinations at the 'training for infant abuse and neglect cases'. The participating public health nurses had no opportunity to discuss problems with each other due to their busy work schedule even when they came across cases suspected of abuse and neglect; they wanted to take advice together. The participants who attended the case study meetings said: "case study discussion clarified the issue, so I felt much better"; "I often feel depressed after examining child abuse and neglect cases, but today I rather felt energized because I got the idea what to do next"; and "it was a spectacular meeting which I could attend for the first time in a long time, I like the process where the participants gradually recognize their problems through discussion without strong leadership of the instructor."

I, therefore, strongly felt the necessity of a child abuse and neglect case study group and proceeded to prepare with support from the participants and their workplaces.

2) Pre-establishment publicity and implementation of the child abuse and neglect case study group

The child abuse and neglect case study group aimed at "encouraging the participants to make efforts to solve child abuse and neglect cases and increasing their motivation of

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Table 3. Implementation Outline of Child Abuse and Neglect Case Study Group Meetings

*All names of the pubic health nurses are fictitious.

No.	Date	Discussed Cases	Monitored Cases	Meetings by Participants	Participants
1	May 20, 2005	Aoki: 'Elementary school boys/sisters physically abused by their father in the name of discipline' (A)		Problems and challenges to handle child abuse and neglect cases	7 public health nurses
2	July 4, 2005	Sato: 'Infant who has head-injured aftereffects of a fall due to parents' incaution' (B)	A		7 public health nurses
3	Aug. 22, 2005	Yamamoto: 'Despite (suspected) abuse and neglect reported by a day-care center, no support has been provided' (C)	A, B		7 public health nurses
4	Oct. 7, 2005	Takiyama: 'Family with a foreign mother whose child is truant, which may be due to DV and abuse and neglect' (D)	A, B, C		7 public health nurses
5	Nov. 10, 2005	Maruyama: 'Elementary school child whose parents have psychiatric disorders may have become truant due to neglect' (E)	A, B, C, D		7 public health nurses
6	Dec. 9, 2005	Tanaka: 'Maltreatment was suspected at physical check-up for infants; reconstruction of the scene they do not know how to deal with this case' (F)	A, C, D, E	Degree of the challenges achieved by case study discussion	7 public health nurses
7	Jan. 20, 2006		A, D, E	Necessary support system worked out by case study discussion	7 public health nurses
8	Feb. 17, 2006		A, D	Necessary support system worked out by case study discussion	6 public health nurses
9	May 12, 2006	Maruyama: 'Elementary school child whose parents have psychiatric disorders may have become truant due to neglect (continuation)' (E)		Problems and challenges to handle child abuse and neglect cases	9 public health nurses
10	July 12, 2006	Ozawa: 'Infant with a developmental problem; abuse and neglect by his/her father is suspected' (G) Fujita: 'Neglected child with delayed development in a poor living environment' (H)	A, E		9 public health nurses
11	Aug. 21, 2006	Nakamura: 'Mother's history of abuse was reported from the maternity hospital, but no support has been provided due to their move' (I)	A, E	Management and procedures of the case study group	8 public health nurses
12	Sep. 19, 2006	Takahara: 'Nursery school infant from a single parent family; psychological abuse and neglect by his/her mother is suspected' (J) Takiyama: 'Elementary school child whose parents have psychiatric disorders may have become truant due to neglect (taken over from Maruyama)' (E)	A, G, H, I		8 public health nurses
13	Oct. 23, 2006	Konno: 'Handicapped high school student who became stay-at-home due to psychological abuse by his/her mother' (K) Aoki: 'Elementary school boys/sisters physically abused by their father in the name of discipline (continuation)' (A)	E, G, I, J		8 public health nurses
14	Nov. 17, 2006	Maruyama: 'Unmarried mother with a baby seeking help with childcare from alcohol-dependent grandmother' (L)	A, E, H, J, K	Learning and achievement through the case study group activities, and issues	9 public health nurses

support and confidence"; the health care center recruited participants and started the case study group composed of seven public health nurses applying for the project.

The first case study meeting was held in the form of a participant meeting, where, in the brainstorming session, the participants freely expressed their own thoughts which they were not particularly aware of and shared their problems and the direction of the case study group among the members. The participants first confirmed their "problems for supporting child abuse and neglect cases" written on sticky notes; then, to clarify the problem structure, an association chart was made by categorizing them in similar categories. The problems sorted out in the association chart included "feelings that I'm not good at it, anxiousness, and hesitation", "lack of awareness of abuse and neglect/ knowledge/ techniques", "difficulty in dealing with changing cases", "no adequate system to take advice for supporting abuse and neglect", "do not know how to cooperate with relevant organizations", and "need supervisors". Next, the direction of approaches to solve "the problems when supporting child abuse and neglect cases" shown in the association chart was discussed with the participants and was sorted out in the following way: at "the child abuse and neglect case study group", the members 'share anxiousness and hesitation when dealing with child abuse and neglect cases', 'receive advice without trying to solve cases alone', 'learn problems specific to child abuse and neglect and how to deal with them', and 'learn actual procedures to collaborate with relevant organizations'. As stated above, the direction of the case study group and its participants was shown.

The case study group started in May 2005 and usually had meetings once every month or two; a total of 14 meetings were held up to November 2006; all the participants provided cases to be discussed (Table 3). The actual number

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of people participating in the case study group during the 2-year period was 11. A public health nurse providing a case summarized 'discussion results' and 'practice and results after case discussion' based on the discussed contents and gave a report at a subsequent meeting. This was called 'monitoring' where practice was reviewed and the contents of support were evaluated at the case study group meeting; by repeating this process at every meeting, we were aiming at improving support through discussion on difficult situations for persons who provided support.

3) Evaluation and data feedback of the child abuse and neglect case study group

At every case study group, we listened to the thoughts from participants and modified them; participants' meetings were held once every three to six months to discuss how the issues of the participants had been changed through the activities of the case study group. Also, we reported to the participants and the leaders of public health nurses of the participants at work about current practice and evaluation conducted by the case study group and asked for comments from them. At the case study group continuous evaluation and modification were given in this way and the results were fed back to the participants.

2. Changes in awareness and care practices of public health nurses through the practice processes of the case study group

The analysis of the word-for-word records of the 14 case study group meetings held between May 2005 and November 2006 and field notebooks showed the following changes in the participants.

1) 'I used to stop there', but now 'I can take the first step'

Public health nurse Yamamoto who was just transferred to the branch due to municipality merger presented the case at the 3rd case study meeting; Yamamoto was confused about the first response to the case. She was contacted two months ago, but she had trouble in providing support because the family was always away from home when she visited. Brothers/Sisters of two and four years of age had noticeable cuts and bruises on their bodies and the doctor who conducted a health checkup at the nursery school 'suspected abuse and neglect'. A few days ago, both had black eyes. When a nursery teacher asked about the black eyes, their mother said "they fell down the stairs; it is not the abuse and neglect which often happens recently."

Yamamoto thought that she should visit the family as soon as possible considering this as an abuse and neglect case, but when she discussed how to deal with the case with other two public health nurses at work, they disagreed. Yamamoto doubted her co-workers' idea, but had no confidence in her own decision, either; she explained her wavering mind.

Yamamoto: *I thought that I should visit their home soon; but two public health nurses said "the mother could (hit her kids)"; since they knew (her personality and behavioral trait), they did not recognize (the urgency) and said "we do not have to act so quickly; (we can confirm later at a health checkup)." At that point, I felt "I do not need to (visit their home), then."*

The participants who listened to the story nodded and public health nurse Sato started to talk about a similar situation at her work.

Sato: *In my branch, if they know the background, they tend to say "it will be all right"; in that respect it is really good for someone who had no idea about the background, like Yamamoto, to see the case through different eyes.*

When public health nurses know the background and history of cases, they may find it difficult to recognize abuse and neglect cases because they cannot see the cases objectively, relying too much on their knowledge. I thought that the purpose of the visit seemed unclear, so I asked Yamamoto some questions.

Author: *(You were contacted and) you wanted to confirm something. What was it?*
Yamamoto: *Those bruises. What happened at home....(could not think of words to say).*
Author: *If you visit their home, I believe that you should definitely have clear objectives; what you should get from the visit....*
(Yamamoto could not answer, there was a pause.)
Yamamoto: *I have to think about (what a public health nurse should do, when I visit their home.)*
Author: *You have to make a concrete plan before you go; you cannot 'just visit their home'.... If it is an abuse and neglect case, what do you think you have to confirm? Is it abuse and neglect, as Takiyama said? If you want to provide support by confirming the background of abuse and neglect, (you should probably confirm) what bothers/sisters the mother most...*

The Yamamoto case shows that when public health nurses are informed of abuse and neglect, they tend to visit the home immediately without making a future plan. Public health nurse Maruyama participating in the meeting said "I have learnt the importance of having concrete supporting measures from the beginning when we visit home." Public health nurse Aoki said "at our initial interaction it is important to have an idea to which direction the case is going when asking questions or listening to their stories." After the discussion, Yamamoto expressed her feelings as follows:

Yamamoto: *After the discussion of the case, I feel better... Now I can see how to start approaching the case. We three public health nurses did not clearly recognize what abuse and neglect cases were; so we could not proceed with our policies from there... I have noticed that the initial response is very important. I am still worried whether I will be able to properly use what I learnt when I provide support in the future.*

I was concerned about Yamamoto who said in an uncertain manner "I am still worried whether I will be able to properly use what I learnt when I provide support in the future" although she made a positive remark. I thought that she may start an action if she had the grounds for her judgment, and I sent her a letter and materials. I suggested she review the first response for child abuse and neglect cases by following 'the procedures from receiving request for consultation to providing support' in the guide.

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Yamamoto said "I was so encouraged by your concern (about me) that I felt I had to act"; she reported at the 4th case study meeting what she had done at work based on the discussion results of the case study group meeting.

Yamamoto: *After the previous case study group discussion, three public health nurses at work reviewed all of our past involvement according to this guideline. We did not quickly respond to the request for consultation and could not meet the family when we visited their home.... and we gave up at that point. We discussed at work that we lacked awareness of issues. The public health nurses who are working in the community strongly believe that we know the cases well; therefore, we tend to think that 'it will be all right.' The nurse in charge of this case could finally make a home visit and confirmed the current situation; she plans to continue regular visits. Also, we have been talking with the nursery school teachers about extended day care to help the mother vent her frustrations.*

Yamamoto who reported, with a little more self-confidence, the results of putting the awareness of the case study group into action gave a push to other public health nurses who had hesitated to move forward. At the subsequent 5th meeting public health nurses Aoki and Sato who seemed not to have changed their attitudes even after discussion reported the results of their changes like starting delayed home visits or communication with doctors to put the awareness of the case study group into action. Furthermore, I started to hear from the leaders of public health nurses that 'after participating in the case study group meeting, they have proactively made home visits and asked advice from the leaders for how to provide supports.'

2) Turning attention to 'strengths'

(1) Turning our attention to the strengths of abusing families

The participants who provided cases often said "these cases have a pile of family problems and we have no idea where to start."

However, in this study, when we discussed the cases, we tried to turn our attention to the families' 'strengths' (abilities and resources) such as 'their abilities to feed and clean their children' without just looking at family problems. We focused on the families' 'strengths' because according to the literature by Kirino[14] and Zerwekh[15], nursing personnel who make home visits to provide support to the families first try to find the families' existing abilities ('strengths') to be able to support them focusing on the good aspects the parents have and to foster trust with the families and to develop their abilities, and helps the parents establish self-confidence and self-esteem. I also thought that, from my experiences as a public health nurse, if we turn our attention to their good and successful features rather than their problems and communicate such strengths to them, we would be able to foster trust with the families and provide support more smoothly.

Next, the changes of the participants which arose out of the discussion focusing on the families' 'strengths' are shown in the case of public health nurse Fujita (the 10th case study group meeting).

The case provided by Fujita was a neglect case about a prematurely-born underdeveloped infant. When she visited the family, she saw poor diet and unsanitary living environment; she said "looking at the bad child care environment, I could not help but blame the parents and give up." At the case study group meeting, we sorted out on a blackboard 'what they do'' and 'what they fail to do' for child-rearing in order to find the family's strengths.

Author: *Shall we assess the family's rearing abilities? Let's pick up 'what they do'' and 'what they fail to do' for child-rearing (we made a table on a blackboard to sort out the participants' opinions.)*
Fujita: *As for their rearing abilities, I would say they have 'none at all'.*

Fujita simply said that they had no 'strength'; first we accepted her opinion and started to sort it out.

Author: *What do they do to take care of their infant?*
Fujita: *They do not do the laundry; they leave his/her clothes unwashed.*
Author: *(Writing on the board), are the clothes very dirty?*
Fujita: *A little dirty.*
Author: *A little dirty? They don't do the laundry at all or they occasionally do?*
Fujita: *They occasionally do (the laundry). The infant goes to the nursery school in dirty clothes. He/she goes there without taking a bath or washing his/her face.*
Author: *(Writing on the board), doesn't he/she take a bath for a long time? How frequently does he/she take a bath?*
Fujita: *Once in every 2-3 days, not every day. He/she doesn't wash his/her face; many other things he/she fails to do from a sanitary viewpoint.*

We started to sort out the information so that we could objectively see the family; the focus, however, was on problems only and no 'strength' of the family was found.

Author: *What do 'they do'? I have been asking 'what they do', but you mentioned what they fail to do (laughs).*
Fujita: *I don't think there is anything the family can do.*
Author: *But they survive, don't they (laughs)?*
Takiyama: *Yes, they survive.*
Author: *Certainly there are a plenty of things the family fail to do. But 'they do things.' In other words, they do things even once in two times.*
Fujita: *Also..... They do read comments from the nursery school teacher written in the notebook.*
Author: *It is important.*
Fujita: *The mother wrote back as well; for example, "I'm sorry, I didn't bring a bath towel."*

Fujita began to recognize what this family did to raise their infant through my statement to encourage her to change her view on the family and the response from Takiyama. She looked at the board and gave impressions like "they somehow manage to survive." Some other participants also mentioned "it looks like they do things which are essential to survive."

At first Fujita was bothered by the problem of neglect and had no idea how to initiate support; she, however, gradually became able to grasp the situation in an objective way and focus on the abusing family's 'strengths' through the process of sorting out the information with the participants and she seemed to recognize the importance of approach which

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encourages the family to further develop their strengths. After the meeting, Fujita made a home visit and reported what was confirmed on their rearing activities which had been sorted out at the case study group meeting. She said "I confirmed that surprisingly the family made efforts to do things which I first considered as neglect such as feeding and cleaning; I leant that we need to seek cooperation from the nursery school on the matters which are difficult for the family to accomplish without help like face washing or toilet training."

In this way, the participants who only looked at the abusing families' problems and struggled to provide support, after the discussion which eyed the families' 'strengths', changed their view on the families and recognized what the families did and altered their support so that the families' strengths were developed further.

(2) Finding the participants' 'strengths'

At the case study group meetings, we also focused on finding the 'strengths' (advantages) of support provided by the participants and increased willingness to support through mutual learning.

At the final case study group meeting (the 14th meeting), each participant expressed their own or other participants' 'strengths'. They accepted the 'strengths' of each other such as: 'immediately doing what she comes up with (Yamamoto)'; 'facing difficulties without avoiding them (Aoki)'; and 'good at asking for advice (Ozawa)'. Fujita said "finding the 'strengths' of other people means observing them closely and respectfully". I think that through the activity to focus on the 'strengths' the participants tried to respect for and understand each other.

3) Linkage to infant health checkups from the perspective of abuse and neglect prevention

At the case study group meetings, we reviewed how we responded at infant health checkups where we had a chance to meet the subjects of all cases. Dealing with difficult cases, the participants questioned to themselves: "couldn't we notice any problems at infant health checkups before the case becomes so serious?" or "what if we listened to what the parents talked about their child-rearing a little more carefully at consultation".

At the beginning of the case study group Aoki expressed her thought that 'she could not support parents and infants when she suspected problems at infant health checkups; and Yamamoto said "even when one of the public health nurses suspected a high risk of abuse and neglect, other people involved in infant health checkups do not always share her thought, which frustrates her". I thought that we should make use of case study group meetings to review how infant health checkups should function; and at the 6th case study group meeting, the participants discussed the topic using the records of consultation at infant health checkups.

Tanaka: *The interview sheet has a question "I am often irritated by child-rearing"; we tend to think that 'it is not surprising'. We only ask mothers/fathers "What makes you irritated? What do you usually do when you are irritated?" I am worried that such responses are appropriate and what we should actually do.*

After Tanaka explained her feelings, at my suggestion, one of the participants read the mother's part in the record at consultation.

Tanaka: *What makes you irritated while you are taking care of your children? And what do you usually do when you are irritated?*
Mother: *When the younger one is there together, he/she won't listen to me. If it happens, the only thing I can do is to try to hold my temper.*
Tanaka: *It must be hard, right? If you have any trouble, please let us know.*

After reading the conversation, Tanaka said "I often say to mothers "if you have any trouble, please let us know", but I don't actually expect many of them to come back; I am worried about how I should communicate with them". Tanaka would like to provide some kind of child care support, but since she has no idea what she should do, she could not act, which worried her. I encouraged the participants to put themselves in the position of a mother.

Author: *Everybody, what do you think would make you feel relieved in such a situation?*
Yamamoto: *I wish (the public health nurse) to come close to me. I think that mothers want to have a feeling that the nurse has understood her irritation which nobody else has ever understood.*
Author: *Yes, I agree. For example, "I can tell you are in trouble."*
Yamamoto: *Even such words could make the mother feel relieved when she goes home (after the infant health checkup).*
Author: *The mother becomes happy if somebody understands her feelings and may think "maybe I can talk to this nurse who has understood my feelings". I do not think that patterned interviews and guidance can communicate your real worries to mothers. It is important to show your approval to mothers like "you are raising your baby very well."*
Tanaka: *Sure.*
Fujita: *They feel complimented.*

Each participant who was concerned about what could be done for parents and infants when problems were suspected at infant health checkups tried to imagine parents' feelings and what they sought from public health nurses at the checkups through the review of conversations held at usual checkups. Tanaka adopted the idea and began to offer positive words to parents like "you are raising your baby very well" at checkups. Also, she reported at the following case study group meeting that whenever she recognized something 'unusual' at checkups, she confirmed with other staff without leaving such situation untouched and reported at a conference.

At the final case study group meeting, the participants reported how they changed their responses at checkups, etc.

Ozawa reported that the awareness of abuse and neglect prevention has grown among people concerned and said "when I suspected problems at interviews, I introduced social resources to parents to prevent abuse and neglect and told them not to worry on their own; and I believe that more suspected cases come up at the general conference; I have a feeling that the staff members move in that direction all

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together".

The participants wished to prevent serious situations presented at case study group meetings from occurring; they discussed not only support for abuse and neglect cases, but also regular health checkups and daily operations emphasizing prevention.

Takiyama: *When I look at survey slips of the nursery school with family structure or other information, I sometimes think that 'this person may look for help for child-rearing'; I used to check the development of babies and children only and determined that 'there is no problem'.*

It is considered that Takiyama seems to have acquired the ability to convert the information on survey slips which used to have little meaning for providing support into meaningful information which implies needs for care after she participated in the case study group meetings and gained firsthand knowledge about the background of various risky cases.

4) Expansion of supporting networks and their influence on workplaces and regions

As for Takiyama's case discussed at the 4th meeting, sexual abuse on children of a foreign mother came to light; we initially planned to give guidance to the father at a child consultation center with the assistant principal of the elementary school. When the case was reported at the case study group meeting, I determined that we had to seek cooperation from an NPO with broad experiences in DV and abuse and neglect on foreign women; and suggested the idea to Takiyama. This led Takiyama to work on the NPO to send a consultant to the conference held by the parties concerned; and we made a leap forward to protect the mother and children. Takiyama talked about the process as follows:

Takiyama: *At the conference held by the parties concerned (in January 2006) we came to a conclusion that it was imperative and urgent for us to protect the children and change the environment considering their healthy development. We knew that the mother definitely wanted to run away because the father had said "I will kill all (of my family) and myself". As a result, the NPO consultant successfully confirmed the mother's intention and also knew how to protect the children and the mother, so we protected them on the day.*

Author: *It is good that you could manage to put an end to the case there. If you couldn't.....*

Takiyama: *If we (the public health nurses) didn't know what to do and carried on in the same way for a few more years, the family might have died....*

Author: *A serious incident might have been caused.*
(All the participants gave a big nod with a grave look.)

The case provided by Takiyama was quickly solved by asking the NPO which offered advice to foreign women to join our supporting team. The NPO consultant who had had a little experience in collaborating with the public health nurses said "we could more smoothly cooperate with the police, schools, and child consultation centers by working together with public health nurses". Thus, the supporting team which collaborated with schools and child consultation centers has now started working with NPOs and the police as well.

In addition, case study groups themselves are increasing in number and gaining greater influence in this region.

Yamamoto from a branch of B City started an article study group and a case study group with nursery school teacher sand administration staff at work as from October 2005; in C town six public health nurses started their own case study group which included summary reporting of this case study group activities and the members did a role-play about the cases and the leader of public health nurses accompanied home visits. In B City the participants of the case study group, consulting with their leader, have been taking the initiative in establishing their own case study group since March 2007.

V. Consideration

1. Mind frame shift from 'solution of problems' to 'use of strengths'

It is said that in the field of family support 'the social service assessment has traditionally focused on the weaknesses of the family rather than the abilities of family'[9]. The participants of the case study group had a tendency to focus on family's problems more closely than their strengths when they provided support by screening children's development or grasping child-rearing problems at infant health checkups or home visits. Especially in child abuse and neglect cases the first priority is given to the security of children; the tendency it to try to quickly discover family problems which cause such abuse and neglect and solve those problems. More attention has therefore been paid to finding abusing families' problems rather than their strengths. The 'strengths' mean the individual's inner strengths (skills, knowledge, desire, abilities, and confidence) and external environment surrounding the individual (resources, social relationship, and opportunities) [16].

Most abusing families refuse to admit their abuse and neglect in the first place and are unwilling to cooperate with us on solving problems. Under the circumstances, if we take negative approaches such as pointing out family problems to seek improvement, the families become increasingly stressed and turn down the offer of support; as a result, even after problems are found, it is difficult to tackle them and to plan future support. To make matters worse, some workers who provide support end up suffering from a sense of powerlessness and losing their confidence.

Furthermore, since abuse and neglect cases are caused by multiple factors and most parents and children whom public health nurses are helping continuously in local communities live together, it is necessary for the nurses to provide support from long-term perspectives cooperating with childcare centers and schools[5]. Therefore, they are required to support the lives of parents and children by encouraging the families to make use of their own strengths.

As explained in Results above, once we turned attention to families' 'strengths', we stopped blaming abusing parents and began to understand parents' feelings more; then we gradually admitted parents' efforts and in turn they accepted our support. Abusing parents who used to be abused by their own parents when they were young or who believe they were not loved by their parents have low self-esteem[5]. Also, abusing families are often rejected by people around them or rarely evaluated positively.

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Providing support focusing on the 'strengths' of abusing families encourages parents to build confidence and self-esteem[14], to foster trust relationship with the families, and to develop families' abilities[15]. Kaplan & Girard[9] emphasized the strength-oriented support in the social work practice for high-risk families; and workers providing support believe changes of families and the necessity of support admitting the 'strengths' of family members. It means that we provide support so that people feel confident about their abilities; and to sustain and expand families' strengths and resources. Once the public health nurses who used to focus their attention on abusing families' problems takes a positive view on such families, relations focusing on problems and increasing families' stress change to those reducing families' stress, raising their self-esteem, and building their confidence. People are usually motivated to make more changes when their strengths are supported[9]. It is said that the changes in attitude made by being praised gradually make up a large part of one's usual attitude and eliminate an unfavorable attitude. I believe that when public health nurses take and express an interest in families' efforts, which is the use of a positive mirror to reflect 'strong aspects', the families become aware of the 'strong aspects' and make more efforts to develop those.

Furthermore, as mentioned above, I encouraged the participants to focus on the 'strengths' of families and at the same time to become aware of good and excellent points of support provided by the public health nurses. It is said that "dealing with high-risk families is very stressful; the prevention of burnout starts when the staff feel that their approaches are highly evaluated and approved"[9]. In child abuse and neglect cases, since workers who provide support can see little evidence of improvement, they are likely to lose their confidence and find it difficult to keep motivated to provide support. It is not easy to improve child abuse and neglect cases through support from public health nurses. Therefore, it is considered that the participants gradually recognized their own potential power through their discussion on each other's strengths in providing support, not successful results of support which improved the abuse cases provided at the case study group; for example, "I have positively worked on the cases without giving up", or "I often work together with the people concerned". As mentioned by Rapp "focusing on strengths will motivate people" [16], I think that by paying attention to their own excellent aspects ('strengths') of support, they recovered their confidence and became motivated to give support again.

2. Group power of the case study group

It seems that changes of awareness and support of the participants were brought about by the group power of the case study group which the facilitator helped to develop. Which power of the group actually moved the participants?

For a long time, public health nurses have not been involved in the support of child abuse and neglect cases; sufficient practice experiences have not been accumulated and effective supporting methods have not been studied yet. The public health nurses who participated in the child case study group were able to take a step forward from their usual self and to provide different support for the abuse cases with the help of the voice of other participants encouraging them when they were facing the cases in scenes where they hesitate, if they are alone, to give support, thinking "the parents may refuse me" or "I may fail to support them".

The participants strongly felt the necessity of support and were able to put it into practice when their thoughts gained acceptance at the case study group and the grounds and support methods which had been vague became clearer. As Yanagi et. al.[17] said 'the members can experience encouragement in a group like "although I cannot do it when I am alone, I can work on the problems with my peers", I think that each of the participants of the case study group was able to face problems being encouraged by the voice of other participants.

Moreover, I had an intention to maintain the child abuse and neglect case study group as a peer support group where public health nurses could discuss problems of support and give and receive advice or consultation. This is why I tried to seek solution to problems by utilizing interactions among the participants and drawing their strengths, as the manager of 'A' Health Care Center said "I felt comfortable with the process where the participants spontaneously recognized their problems not through the strong leadership of the teacher (the author) but through our discussion". According to Zander[18], in order to increase interactions among the group members, 'the group should have a small number of members' and 'the members should spend time discussing important matters and seeking opinions'. In this study I believe that we could increase interactions among the group members because we had a small group of fixed members each time and secured enough time to discuss problems. The participants who expressed their desire to 'have a place where I can speak of my thoughts and problems' or 'have a place where I can seek advice for support' enthusiastically discussed how to handle the cases as if they were their own cases, and after they discussed cases, they consulted or advised on supporting one another. It is said that when the individual's goals are consistent with those of the group, positive interactions develops within the group[18]; here, in this group, since the goals of each participant and those of the group mutually affected each other, the participants reached out to their supervisors or public health nurses at work and take the initiative in continuing case study groups at health care centers and municipalities.

3. Role of the facilitator

Now I describe my role as a facilitator when I encouraged the participants to change with the help of group power.

(1) Elevation of positive feelings and review of support

I tried to ensure that the participants could freely express their opinions. In order to encourage out-of-the-box thinking in the participants regardless of their workplace or position, I proceeded with the case study group meetings taking the approach that 'I would like to listen to the participants' thoughts and problems'. I believe that because of this approach the participants felt an atmosphere where they could freely express their opinions. The participating public health nurses gradually shared secure feelings and a sense of togetherness like 'I can tell them my troubles' or 'I am not the only person who has problems'; and tried to talk about and understand one another's serious 'thoughts' regardless of their positions or titles at work.

I sometimes made severe comments to the participants

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although I basically maintained the free and comfortable atmosphere. Yoshida[19] said that 'strict comments' and 'affirmative feelings' are both necessary to stimulate the mutual growth of the group members. Strict comments revealed the mistakes of the participants and we sometimes wrapped up the case study discussion without having an image for support. However, since I sought feedback from the participants including the one providing the case and I expressed my desire to help them whenever necessary at the end of each case study group meeting, they put the awareness into action saying "I was so encouraged by your concern (about me) that I felt I had to act". I thought that they might have also felt heavy pressure from the facilitator. Therefore, I carefully observed the reactions from the participants and I asked Fujita, who played a role like a coordinator between the participants and me, to give me feedback on their reactions. Moreover, when I thought that someone else should give assistance, I asked other participants to do so after obtaining consensus from both sides with the intention of building a mutually-helping relationship among the participants.

(2) System to put the awareness into action

I had a strong desire that the participants of the case study group put their learning into practice, not just attend an unpractical training session, so I considered the following system to implement our discussion.

I asked the participant who provided the case to explain the concrete actions for subsequent support and her image of the result of such actions at the end of each case study group meeting. I thought that she would be able to take action by having concrete successful images where she took a step forward from current herself and began walking toward future positive herself by combining the two approaches such as looking at her current problems which she was suffering from and imagining an altered, positive self[20]. For instance, I asked the participants 'what do you think you can actually do?' to draw concrete action plans from them. Also, I narrowed down the points of discussion records and elaborated the records so that the participants could implement them more easily. That is, I prioritized and itemized the discussion results, highlighted important points, and added charts which would help them quickly visualize the ideas.

Also, I communicated my desire to give necessary assistance to the participants whom I worried about after the case study group meetings by calling, e-mailing, or sending letters. I tried to maintain the valuable awareness at the case study group meetings and encourage the participants to put the awareness into action.

On the other hand, I sent reference materials containing some clues for practice to the participants who had no idea how to put the awareness into action and asked them to implement the awareness and report the result at the following monitoring session. Also at the monitoring session I suggested to such participants that they make a report which combined the results of case discussion and implementation.

Thus, I built a multi-layered system which would put the awareness into practice.

At the same time, I intentionally proceeded with the establishment of the support system involving the participants' workplaces. I arranged a meeting where the participants who were dealing with difficult cases discussed how to provide support with the help of people from their workplaces including the leaders of public health nurses. In this way, I gradually involved the participants' workplaces. I believe that the participants' practice was accelerated further by figuring out difficulty of the cases and capacity of the participants and thinking together of the system to assist workers providing support.

VI. Limit of Study and Issues

As for the data sources in this study I made efforts to obtain information from diverse and multiple sources as much as possible with regard to the participants' statements and discussion materials at the case study group meetings or information offered by the supervisors of the participants; however, considering the particularity of child abuse and neglect cases and ethical aspects I did not observe home visits or conferences of concerned parties. Therefore, although I checked the credibility or added information by returning recorded data to the participants, there is a limit of the quality and amount of information obtained in this study.

Furthermore, it is necessary to verify the difference produced by the changes in support provided by the public health nurses participating in the case study group from a long-term perspective.

This study is my doctoral thesis for the Graduate School of The Japanese Red Cross College of Nursing on which I made minor additions or alterations.

References

1) Kempe, C.H. and Silverman, F.N. et al. "The battered-child syndrome." *Journal of the American Medical Association*. 181(1), 105-112, 1962.
2) Nishizawa, S. *Child abuse and neglect: the therapeutic approach to children and families*. Seishin shobo, Tokyo, 1994.
3) Whitfield, C.L./ transl. M. Suzuki and M. Saito. *Healing the Child Within: Discovery & Recovery for Adult Children of Dysfunctional Families*. Seishin shobo, Tokyo, 1997.
4) Nobuta, S: *DV and abuse: what can be done to support 'families' violence' cases*. Igaku-Syoin, Tokyo, 2002.
5) Satoh, T. *Manual on local health activities for child abuse prevention: all activities for children from the abuse prevention perspective*. Shakai Hoken Kenkyujo, Tokyo, 2002.
6) Yoshikawa, H. "Relationship in family: child abuse." *Journal of Home Economics of Japan* 51(6), 81-87, 2000.
7) Tsuzaki, T. "How to support child abuse families." *Social Work Kenkyu* 26(3), 11-16, 2000.
8) David, N.J./ A. Suzuki and M. Kobayashi et al. *Child abuse prevention handbook*. Igaku-Shoin, Tokyo, 1995.
9) Kaplan, L. & Girard, J.L./ transl. K. Okuda and T. Suzuki et al. *Family empowerment in social work practice: to restore high-risk families*. Chuoh Publishing, 2001.
10) Minegishi, H. and E. Endo. "Review paper on action research in nursing." *Kango Kenkyu* 34(6), 451-463, 2001.
11) Hart E. & Bond M. *Action research for health and science care a guide to practice*. Buckingham, Open University Press, 1995.
12) Meyer, J.E. "Using qualitative methods in health-related action research, In C.Pope & N. Mays(Eeds.), Qualitative research in health care", 59-74, London, BMJ, 1996.
13) Morton-Cooper, A./ tranl. R. Okamoto and Y. Sekito et al. *Action research in health care*. Igaku-Shoin, Tokyo, 2005.
14) Kirino, Y. and Home visit support project team, authors & eds. *Manual on child care support for family: local child care support and child abuse prevention*. Akashi shoten, Tokyo, 2003.

This paper was published at "the Japan Society of Nursing Research" Vol.34 No.2 in 2011.

15) Zerwekh, J.V./ transl. M. Kayama and Y. Takaoki. "Home-visit care for supporting families' self-help abilities: looking for families, establishing trust relationship, and nurturing strengths." *Kango Kenkyu* 32(1), 15-24, 1999.
16) Rapp, C.A./ K. Ebata (supervisor of translation). *Case management for the mentally- disabled*. Kongo Shuppan, Tokyo, 1998.
17) Yanagi, Y and K. Masuda et al. *Introduction to group activities: theories and practice of group activities: group development you can do*. Yadokari Shuppan, Saitama, 2002.
18) Zander, A./ transl. M. Kurokawa and C. Kanagawa et al. *Utilizing groups*. Kitaoji Shobo Publishing, Kyoto, 1996.
19) Yoshida, M. *Group dynamics of human relationship*. Nakanishiya Shuppan, Kyoto, 2001.
20) Prochaska, J.O. and Norcross, J.C. et al/ M. Nakamura (supervisor of translation). *Changing for good*. Houken, Tokyo, 2005.

This paper was published at "the Japan Society of Nursing Research" Vol.34 No.2 in 2011.