CURRICULAR CONTENT OF CANADIAN UNIVERSITY SCHOOLS OF NURSING ON LAY SUPPORT GROUPS

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Self-help, mutual aid, strengthened social networks and public participation are widely thought of as mechanisms with which to effect health promotion and primary health care (see, for example, Canadian Nurses Association, 1988; Epp, 1986; World Health Organization, 1984). Nevertheless, not all professionals who might aid this process do so. From the professional viewpoint, lay help groups can seem to be a social movement that challenges professional beliefs, methods and prerogatives (Todres, 1982). Self-help groups hope to demystify professional expertise by shifting power to consumers and altering traditional roles of lay people and professionals (Gartner & Riessman, 1984; Katz & Levin, 1980).

Clearly, social support networks should be of particular interest to health professionals because of their impact on health, on health behaviour and on health services utilization (Berkman, 1985; Cohen & Wills, 1985; Gourash, 1978). As Katz (1985) predicts, "The self-help phenomenon is here to stay and professionals must pay attention to how mutual aid ideas and organizations can be more fully used in serving clients" (p.129). Effective public participation requires that professionals be knowledgeable about community groups and willing to participate in a collaborative, facilitative, consultative, partnership relationship with lay helpers (Government of Canada, 1983; Reid, 1986; Stott, 1983).

Some consider the greatest obstacle to collaboration with lay persons or groups to be a deficiency in professionals' knowledge and skill base (e.g. Gartner & Riessman, 1984). Tensions between different types of knowledge and values, including ideological assumptions about the helping process (Kurtz, 1984) and about respective roles, make partnership difficult. In this context, health professionals are traditionally socialized and educated in the "expert" provider role (Rappaport, 1985; Schon, 1987). This education is incompatible with the consultative, partner role recommended for primary health care work with lay helpers.

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Interviews and surveys of professionals working with mutual-aid self-help groups and of self-help group members reveal a prevalent perception of a professional knowledge gap with the vast majority of professionals reporting little or no coverage in their educational programs, rating their current knowledge as either fair or poor and desiring further information about such groups (Black & Drachman, 1985; Farquharson, 1981; Gottlieb, 1982; Levy, 1978; Miller, 1983; Todres, 1982; Toseland & Hacker, 1985).

The foregoing suggests the need for professional education in appropriate knowledge, roles, skills and attitudes. Indeed, the World Health Organization (1984, 1985) recommended changes in professional training, internationally and nationally, to enable health professionals to develop knowledge and understanding of self-help groups. Hence, pertinent content should be included in health professional curricula. If one function of curriculum content is to teach students about professional practice and thereby to improve the quality of professional praxis, there is a need to assess curriculum content to determine whether or not appropriate didactic and experiential elements are incorporated.

A few successful examples of curricula that achieve this W.H.O. goal, to a greater or lesser extent, are emerging. However, none of these curricula and programs have been empirically evaluated according to short- or long-term modification of roles, knowledge, attitudes and skills. For example, consultation skills do not appear to be stressed in curricula, so consultant roles may be infrequently assumed in practice. Further, the self-help literature reflects a predominant emphasis on social worker education and on physician preparation (Bremer-Schulte, 1983; Goetzel, Shelow & Croen, 1983; Gottlieb & Farquharson, 1985; Traunstein, 1984). The single largest health professional group that might interact with and contribute to self-help groups--nurses--has been overlooked.

Initial basic education of nurses at the undergraduate level about the role and impact of lay helping and support networks and about appropriate professional roles and relationships with these networks thus appears advisable; however, only one nursing program that encompassed some social-support relevant content has been briefly outlined by Tilden (1985). Accordingly, the purpose of this descriptive study was to identify curricular content in Canadian university schools of nursing germane to lay support groups.

Method

To determine the extent to which the curricula of Canadian university schools of nursing include theoretical and clinical content specifically oriented towards and relevant to those dealing with lay helping networks,

questionnaires were distributed to all 26 deans or directors at a recent annual meeting of the Canadian Association of University Schools of Nursing. This was accompanied by the expressed support of the Association's executive director and by a request that the deans or directors or a knowledgeable member of their faculty respond to the questions on curriculum content relevant to social support and self-help groups. A follow-up reminder letter, with an enclosed stamped and addressed envelope, was mailed one month later to increase the return rate. Twenty-four completed questionnaires and one program description were returned, constituting a response rate of 96%.

Most questions were closed-ended to facilitate computer coding and data analysis. However, an "other" category was consistently included to permit flexibility and freedom of response. In addition, one question solicited opinions regarding desirable curriculum content and an "other comments" question also promoted unrestricted answers. The "nonempirical" papers that proposed curricula for social workers (e.g., Gottlieb & Farquharson, 1985) served as a guide for some questions, but most were specifically designed for this study. Information regarding relevant didactic and experiential learning experiences, clinical or field assignments and desired curricular change was elicited.

Results

Seventy-one percent of the schools integrated some curriculum content concerning self-help groups in their undergraduate programs; only six (26%) reported having a separate course on this subject. Forty-two percent of those schools that had graduate programs integrated relevant content. Only two schools (8.7%) had continuing-education programs that made reference to self-help groups.

Relevant classroom content

Most curricula (62.5%) included definitions of self-help groups. Such groups are commonly defined as "voluntary, small group structures for mutual aid and the accomplishment of a specific purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem and bringing about desired social and personal change. The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing social institutions." (Katz & Bender, 1976, 9)

The socioeconomic and political forces that led to the historical evolution of such groups were addressed by less than half (41%) of the nursing programs. Common stages in the development of self-help groups -- origin

(25%), informal organization (29%), emergence of leadership (33%) and beginnings of formal organization (25%) -- were identified in less than one-third of the curricula.

Nurse educators stressed the following characteristics of self-help groups in the curricula: membership limited to those with similar problems (66.6%) and informal help (54.1%) (reflecting common definitions of self-help groups) rather than reciprocal help (41.6%), experiential knowledge (41.6%), role models (29.1%) and the helper principle (29.1%). There was comparable emphasis on the following benefits of self-help groups: opportunity to share experiences (66%), informational support and emotional support (62.5% each), reference group and vehicle to aid coping (54.1% each). Fewer cited appraisal (feedback) support (29%) and instrumental (material) support (42%) as benefits. House and Kahn (1985) conceptualize social support as encompassing emotional, informational, instrumental and appraisal support.

Germane theoretical foci frequently identified in curricula were coping theory (100%), self-care theory (91.3%), community organization (87%), social-support theories (87%), change theory (87%), primary health care (82.6%) and group process theories (79.2%). Social-learning theory (58.3%), loneliness theory (50%), the lay helper principle (33.3%), attribution theory (29.2%) and social-distance theory (20.8%) were included in some curricula. Social-movement theory (12.5%), social-comparison theory (4.3%) and equity theory (4.3%) were generally overlooked. One respondent identified deviance theory under the "other" category, which implies premises congruent with self-help groups constituted for the socially isolated and with loneliness theory. Table 1 gives definitions and shows the relevance of several of these theories.

Classroom content on the linkage or connection between professionals and self-help groups emphasized the manner in which self-help groups influence professional services (54.2%) more than professional impact on lay helping groups (37.5%). Natural tensions between professionals and non-professionals (stemming from differences between ideologies, control and knowledge) were examined in less than half (45.8%) of the nursing curricula. Self-help groups were sometimes (41%) portrayed as "an extension of professional services".

Of 19 professional roles that nurses might have in dealing with self-help groups, only three — consultant, information resource and facilitator — were reported as being identified in didactic form in the curricula of more than half of the reporting schools (Table 2). Initiator and leader roles were rarely identified.

Table 1

Theories Relevant to Teaching Regarding Self-help Mutual Aid Groups

Theory	Reference	Definition	Relevance to Self-help/ Mutual Aid
Attribution	Heider (1958) Kelley (1967) Brickman (1982)	Attribution is the assignment or appraisal of responsibility, for causing and solving a person's problems, to the person or the environment.	Can enable explanation of motives of donors, the phenomenon of helpseeking and helping, and the possible negative effects of support efforts.
Coping	Lazarus & Folkman (1984 a, b)	"Constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person."	Demonstrates how social support and coping interface in the stress process by acknowledging individual and environmental perspectives, adds a cognitive dimension to support, and considers costs of support efforts.
Equity/Social Exchange	Adams (1963) Blau (1964) Homans (1961)	Desire to maintain balance and reciprocity of exchanges in relationships.	Explains reactions to support from donor and recipient viewpoints, the reciprocal nature of social support, its impact on help seeking, and its beneficial and detrimental features.
Loneliness	Peplau & Perlman (1982) Peplau (1985) Rook (1984) Rook (1985) Weiss (1973)	A subjective, unpleasant experience resulting from a perceived deficit in social relationships or relational provisions.	Attests to the significance of social relationships, takes into account the individual's contributions to the network and vice versa and emphasizes the affective dimensions of support.
Social Comparison	Festinger (1954) Suls (1977)	Process by which individuals evaluate themselves through comparison with others to validate and define reality.	Helpful in interpreting and evaluating positive and debilitating effects of support when the donor is a peer.
Social Learning	Bandura (1977, 1986)	Postulates that personal and situational influences alter coping behaviour and that transactions with environment and perception of capabilities affect behaviour and thinking in stressful situations.	Concepts relevant to self help mutual aid groups include: role modeling, reciprocal determinism, vicarious experience, social persuasion, collective comparison, collective efficacy, experiential knowledge (specialized information of a phenomenon based on first hand experience).
Social Movement	Melucci (1985) Touraine (1985) Smith & Pillemer (1983)	Structures directed toward social change, collective action, and conflict expression for control of resources	The self help movement satisfies some social movement criteria: networks of groups, ideology, opposition from society (real or perceived), sense of common purpose, need for both individual and social change, empowerment.
Social Support	House & Kahn (1985) Pearlin (1985) Tardy (1985) Wills (1985)	Emotional, appraisal, instrumental and informational assistance provided by kin, friends, neighbours, co-workers, community leaders, indigenous lay helpers, volunteers and self help mutual aid groups.	Self-help mutual aid groups are one prevalent type of social support network. Health effects of social support are interpreted by two hypotheses: indirect/ buffering and direct/main effect models.

Relevant learning experiences

All school curricula included a mixture of didactic and experiential learning experiences. The three most frequently cited learning experiences relevant to self-help groups were visits to agencies that have mounted support groups of clients who share similar problems (66.7%), invitations of group members to attend lectures or tutorial sessions (66.7%) and attendance with permission at open meetings of self-help groups (54.2%).

Role playing and creation of self-help groups for students themselves (33.3% each) were employed as strategies in fewer instances. Only 16.7% used videotaped role playing or films on self-help groups. One respondent indicated that professionals who worked with self-help groups were invited to speak to students.

Clinical assignments

The reported skill emphasis in field assignments for professional role development was on group work (62.5%) and leadership skills (58.3%), rather than on community organization (33.3%) and consultation (25%) skills. The types of groups with which students had contact were, in most cases, the elderly (75%), the chronically physically ill (66.7%), childbearing individuals or couples (62.5%), those with chronic mental llnesses (62.5%), new parents (58.3%) and caregivers (54.1%). Some curricula offered students opportunities for contact with groups of the bereaved (45.8%), children (45.8%) and the victims of abuse (41.6%).

The only written clinical assignments incorporated in most of these curricula were community-needs assessment (58.3%) and observation and assessment of self-help group work and group dynamics (54.2%). Identification of specific self-help groups in the community (33.3%) and of tensions and prospects for partnership between professionals and lay group members (33.3%) were less frequently assigned as learning experiences (see Table 3).

Desired changes

When nurse educators were asked if there were specific classroom or clinical content foci that should be included in their curricula in the future, one each identified skill development, student contact with all types of self-help groups, assessment of current self-help groups and models and invitation of self-help group members to lectures or to tutorial groups. Two respondents indicated that their programs would include more content relevant to self-help groups as a result of planned curricular changes.

Table 2

Professionals' Roles/Functions in Self-Help Groups that are Identified in Didactic Form in Nursing School Curricula

Role/Function	Curricula identifying		Category
	No.	%	
Consultant	16	66.6	Partner[1]
Facilitator	12	50.0	Partner
Information Resource	12	50.0	Partner
Advisor	11	45.8	Partner
Linker	9	37.5	Partner
Catalyst	7	29.2	Partner
Sponsor	7	29.2	Partner
Validator	7	29.2	Partner
Advisory Board Member	5	20.8	Provider[2]
Evaluator	5	20.8	Provider
Researcher	5	20.8	Provider
Referral Agent	4	16.7	Partner/Provider
Skills Developer	4	16.7	Provider
Normalizer	4	16.7	Provider
Initiator	3	12.5	Provider
Organizer	3	12.5	Provider
Group Leader	3	12.5	Provider
Trainer of Group Leader	2	8.3	Provider
Provider of Aid	1	4.2	Provider

Sample = 24
1Partner (non-directive roles)
2Provider (directive roles)

Discussion

This is the first national study of the lay-help group content of university curricula for students in a human-service profession. Furthermore, only Black & Drachman (1985) have investigated the specific educational preparation of professional practitioners for working with self-help groups. This study, therefore, attempted to establish baseline data, given the state of virtual ignorance that exists with respect to professional education to prepare for working with lay groups. This Canadian study was designed to determine available educational resources for preparing nurses for such work.

Table 3

Field/Clinical Assignments for Professional Role Development in Relation to Self-Help Groups (SHG)

Clinical Assignments	Curricula identifying	
	No.	%
1. Conduct community needs assessment to determine available services and service gaps around which SHG might be developed.	14	58.3
2. Observe group meetings and describe group dynamics and group members' roles	13	54.2
3. Case studies of existing groups	11	45.8
4. Make oral presentation on activities associated with SHG	11	45.8
5. Distinguish professional intervention from lay helping patterns	11	45.8
6. Use community organization concepts and skills to identify natural resources and to develop/ maintain SHG	10	41.7
7. Assess current SHG and models	8	33.3
8. Identify and develop list of SHG in community	8	33.3
9. Identify tensions between professional and informal (lay) health services and prospects for professional-lay partnership	8	33.3
10.Describe roles played by professionals at various stages of development of SHG	7	29.2
11.Assess organizational settings for possible introduction of SHG	7	29.2
12.Spot and encourage leadership in SHG	4	16.7
13.Conduct public opinion surveys regarding necessity for SHG	3	12.5
14.Germinate SHG with agency/clinic and transplant them in community	3	12.5
15.Videotape actual SHG interactions using guidelines to examine group dynamics	3	12.5

Researchers in the self-help field have typically not used theoretical frameworks and none have specifically asked which theories are relevant to the teaching of this concept and of the professional or self-help group interface. Only balance, attribution and exchange theories have been used as frameworks for more general studies of professional and self-help group relations. This study attempts to overcome this omission. For example, although there is some evidence that social-learning theory could have a considerable affect on attempts to develop theoretical formulations of self-help and mutual aid (Katz, 1985), this has been overlooked in empirical studies to date. Therefore, the survey instrument included references to this theory and others.

Most curricula included some of the theories pertinent to lay-support groups but overlooked the relevance of others. The virtual absence of social-comparison theories (4%) seems incongruent with the fact that in most curricula self-help groups are identified as points of reference or comparison with peers. The premises of reciprocity or equity theories, so relevant to mutual aid groups, are addressed only by a minority of the schools, according to these respondents. It seems surprising that the most commonly identified benefit is experience sharing, while experiential knowledge and social-learning theories are less often identified in curricula (56%) and likewise, that only half identify the self-help group as a coping aid, when all curricula include stress and coping theories. Lastly, the minimal recognition of these groups' appraisal-support function (29.1%) reflects the infrequent inclusion of attribution theories (29.1%) that interpret appraisal. Thus, instruction regarding practice may sometimes be inadequately grounded in theory. On the other hand, there may not be uniformity in understanding the conceptualization and characteristics of self-help groups.

The most frequently cited benefits of self-help groups that were relayed in curricula were emotional support, opportunity to share experiences and informational support. Although other disciplines recognize the primary benefit of emotional support, they also emphasize normalization and decreased stigmatization (e.g., Miller, 1983; Toseland & Hacker, 1985). In contrast, self-help group members, while recognizing the benefits of shared experience and informational support, perceive reciprocal or bidirectional help as the greatest benefit of membership (e.g. Kurtz, 1984; Romeder, 1982).

There could be increased experiential emphasis on the natural tensions between professionals and nonprofessionals and on professional partnership relationships with self-help groups. Regrettably, less than one-third of the curricula included the partnership relationship and determination of appropriate professional roles as clinical assignments. In contrast, many of the roles frequently identified in the classroom could be categorized as indirect partner roles rather than direct or directive provider roles (Table 2).

The CNA (1988) recommends "equal emphasis in professional educational institutions...on partner, consultant, referral, advocate and educator roles along with traditional caregiver (provider) roles" (p.20). However, nursing curricula rarely conveyed the referral agent role (16.7%), which is unfortunate given the frequent identification of this facilitative role in self-help group studies. The most commonly conveyed professional role, the consultant role, is also emphasized by other disciplines and self-help group members (e.g. Cherniss & Cherniss, 1987; Gottlieb, 1982; Toseland & Hacker, 1985).

The traditional focus on developing group-work and leadership skills, rather than on community-organization and consultant skills, is perhaps misplaced in light of the skills reinforced in the self-help mutual aid literature. For example, Zarem (1982) found that social workers required educational preparation in group-work and community-organization skills for work with self-help groups. Group stability, growth and innovation were associated with consultation between self-help group members and professionals in the study by Cherniss and Cherniss (1987).

The predominant mixture of didactic and experiential learning experiences reflected educational recommendations in the self-help group literature (Bremer-Schulte, 1983; Gottlieb & Farquharson, 1985). However, observational and assessment learning experiences were more frequently used than role playing, videotaping and direct role implementation. "Passive" observation of self-help group meetings was also the most prevalent form of professional nurses' contact with self-help groups (Stewart, 1989). One-sixth of the schools employed videotaped role-playing sessions as a teaching technique, which have also been incorporated in the one documented curriculum for social workers (Gottlieb & Farquharson, 1985). Nevertheless, given the paucity of information on social-work and medical curricula about self-help groups, and given the fact that what has been reported has not been evaluated, these comparisons may not be useful.

Finally, the fact that 71% of the responding schools reportedly include some content relevant to self-help groups in their undergraduate curricula is encouraging in light of the World Health Organization (1985) recommendation referred to earlier. Yet relevant continuing education courses offered by a logical vehicle, university schools of nursing, are virtually nonexistent in the country, in spite of the probable need. Most nurse educators (e.g. Bevis, 1982) advocate integrated curricula; as such, it is not surprising that the undergraduate content relevant to self-help groups is usually integrated rather than presented in a separate course. However, such curricula may inadvertently ignore certain content areas; this would be less readily discernible than in curricula that have separated subjects.

Potential limitations of method

In this needs-assessment (goal-free) approach to curriculum "evaluation", the researcher was independent from faculty, and outcomes were elicited by means of supplementary open-ended queries rather than prespecified intents only. Witkins' (1984) discussion of needs assessment in educational programs included surveys (questionnaires and interviews) as one of five methods of gathering data about needs. Hence, the strategy employed in this study appeared appropriate. However, a survey does not yield the same in-depth insights as an interview approach.

In this context, the quantity and quality of specific content is difficult to determine, partly because of the nature of the measuring instrument. Having the dean or director or the faculty member most familiar with the "self-help relevant content" serve as representative respondent or key informant could be seen as a limitation, but with the ready availability of standardized documentation regarding each school's curriculum as a validity check, this sampling technique seemed realistic, accurate and cost-effective.

Implications

In summary, most Canadian university schools of nursing legitimately include theoretical and clinical coverage regarding mutual-aid self-help groups in their undergraduate curricula. However, some didactic and experiential deficits identified in this preliminary assessment suggest implications for nursing curricula. This review of the relevant curriculum foci of Canadian schools of nursing in conjunction with another preliminary assessment of the learning needs of a sector of the Canadian nursing population (Stewart, 1989) supplemented the creation of a conceptual framework for undergraduate nursing education (Stewart, in press). The framework portrayed a philosophy of consumer input and collaboration with lay helpers. Implementation is presently under investigation.

While several relevant theories are taught, some theoretical premises germane to comprehending and conceptualizing social support (e.g. social-movement, social-comparison and social-exchange or equity) were overlooked in most nursing curricula. The range and influence of existing self-help and peer helping groups, referral and consultation skills, linking clients to self-help networks and establishing joint lay-professional linkages should be emphasized increasingly in educational programs. Thus, experiential learning experiences could be expanded to include more direct involvement or linkage with self-help groups and greater preparation for the roles of part-

ner and consultant. The potential conflict between distinctive knowledge bases, ideologies and roles of lay and professional helpers and the requisite collaborative, partner roles for nurses should be addressed to a greater extent in curricula, if nursing students are to prepare for the challenge of consumer-participation movements and appropriate primary health care roles.

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RÉSUMÉ

Contenu du curriculum se référabe aux groupes de soutien non-professionnels dans les écoles universitaires de nursing au Canada

Les soins de santé primaires, reflétant une philosophie de collaboration avec des non-professionnels, sont utilisés de plus en plus couramment par les professionnels de la santé. Pour déterminer jusqu'à quel point le contenu du curriculum des écoles universitaires de nursing au Canada contient un caractère théorique et clinique s'adressant spécifiquement aux réseaux d'aide non-professionnelle, des questionnaires ont été distribué aux 26 doyennes et directrices lors d'une récente réunion de l'Association canadienne des Ecoles universitaires de Nursing. Des 25 écoles qui ont répondu au questionnaire, 71% avaient dans leur curriculum une partie se rapportant aux groupes auto-soignants. Dans la plupart des cas, on y retrouvait des théories pertinentes aux groupes de soutien non-professionnels mais on y négligeait la pertinence des théories équitables et socio-comparatives. On pourrait souhaiter plus d'emphase sur les tensions qui se créent tout naturellement entre les professionnels et les non-professionnels ainsi que sur les relations entre partenaires. Le rôle professionnel identifié le plus souvent, celui du conseiller, était identique à celui approuvé par d'autres disciplines et groupes d'auto-soins décrit dans les études empiriques qu'on retrouve dans la littérature. L'enseignement par sessions d'observation et d'évaluation y figurait plus fréquemment que les psychodrames, les enregistrements par video et les réalisations par rôle direct. L'accent qu'on met traditionnellement sur le développement du travail d'équipe et des aptitudes de leadership, plutôt que sur l'organisation communautaire et l'exercice du conseiller, est peut-être déplacé en vue des aptitudes d'aide mutuelle renforcées par les publications de groupes d'auto-soignants.