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Setting New Directions and Meeting Old Challenges

Since 1969, each year's new volume of the *Canadian Journal of Nursing Research* begins with the Spring issue. I am unaware why Dr. Moyra Allen, the Journal's first editor, made the decision to launch *Nursing Papers* (now called the *Canadian Journal of Nursing Research*) in the Spring. Being a woman of great foresight and wisdom, one can only assume that this was a deliberate decision. Spring is a time of renewal, of new beginnings. It is a time filled with anticipation, hope, energy, and excitement of things to come. These are the feelings that we, at the *Canadian Journal of Nursing Research*, are experiencing as we plan for the future.

In my first editorial, (vol. 24, no 3, Fall 1992), I wrote that in assuming the editorship it was time to take stock, to evaluate where the Journal has been and to set its future course. My first priority was to examine all aspects of the Journal's present operations, including its mission statement, the quality of the manuscripts, the review-process, the Journal's format, marketing and financing.

To assist me in setting the Journal's future course, I established an advisory committee, comprising Professors Helene Ezer, Francine Ducharme, and Doctoral candidate Sandy Lefort. I appointed Dr. Mary Grossman as assistant editor to work with me on all aspects of the Journal. I also solicited readers opinion through a questionnaire included in the mailing of the Fall issue of the Journal. Readers were asked about the Journal's future direction and the factors that determined why they would select the *Canadian Journal of Nursing Research* to publish their manuscript.

I would like to share with you some of the findings from the questionnaire. I would also like to inform you about the changes that have taken place and those that are being planned for. Finally, I would like to share with you the challenges that we face and the ways in which you can help.

Sixty-seven readers responded to the questionnaire. It was clear that the readers wanted the *Canadian Journal of Nursing Research* to be broad in its focus. They felt that the Journal should continue to publish research articles on a wide variety of topics. Having said this, there was consensus that high premium should be given to the publication of clinical research studies and lesser priority to research articles dealing with education, administration, and history.

In deciding to submit their manuscripts to the *Canadian Journal of Nursing Research*, respondents stated that the length of the review process and the quality of the reviewer's comments were of utmost importance in their decision. Moreover,

the type of exposure that their article would receive, as reflected by the number of subscribers and where the Journal was indexed, factored into their decision.

These findings confirmed our own assessment and directed immediate actions. For example, we reexamined the review process and have put in place measures to expedite the process. Authors can expect a response within three months of submission. We are in the process of rebuilding review panels, panels that will include many of the very talented researchers in this country. We now indicate in our mast head where the Journal is indexed and are investigating other indices.

Other actions require more long-term planning. We face major challenges: first, we need to attract quality manuscripts that reflect the calibre of research within this country and second, we need to improve the financial situation of the Journal. The two challenges are interrelated; improvement in the quality of the Journal will attract more subscribers, which in turn will generate more revenue.

We have identified a number of strategies to deal with two challenges. We will need time to plan for and implement changes. To assist me in doing this, we have decided to change the editorial structure. In the past, the editorial structure was comprised of three associate editors and a very dedicated review board. During the past five years, Drs. Joan Anderson, Leslie Degner, Fabienne Fortin, Annette O'Connor, have served with graciousness as associate editors. In keeping with my goal to increase involvement and ownership of the Journal, the associate editors and the review board will be replaced by section editors. Section editors will be responsible for planning future issues with a given focus topic, soliciting manuscripts, promoting the Journal, grooming potential reviewers and so forth. We will be working closely together in the months to come to plan for the Journal's future and will keep you informed of these developments.

The most serious and immediate threat that the Journal faces relates to its financial status. At the moment the Journal has a deficit that seriously threatens its viability. First, I ask you to make sure that your institution is subscribing to the Journal. Second, I urge you to renew your subscription as soon as it comes due. Third, I ask you to recruit at least one new subscriber. Finally, I ask you to serve as an ambassador and promote the Journal as a vehicle for advertising upcoming events. I ask you to take on this responsibility to ensure that the new beginnings that are being planned for the *Canadian Journal of Nursing Research* will be able to take root. I thank you for your past support and count on your continued support.

Laurie Gottlieb
Editor

Définir de nouvelles voies et relever les anciens défis

Chaque année depuis 1969, le nouveau volume de la *Revue canadienne de recherche en sciences infirmières* débute avec le numéro du printemps. Je ne sais pas pourquoi la D^{re} Moyra Allen, première rédactrice en chef, prit la décision de lancer les *Nursing Papers* (qu'on appelle maintenant la *Revue canadienne de recherche en sciences infirmières*) au printemps. Comme elle était une femme très prévoyante et sage, c'était sûrement une décision délibérée. Le printemps, c'est l'époque du renouveau, de nouveaux commencements. C'est une période pleine d'expectative, d'espoir, d'énergie et de fièvre à l'idée de ce qui va venir. Ce sont les sentiments que nous, à la *Revue canadienne de recherche en sciences infirmières*, avons pendant que nous planifions l'avenir.

Dans mon premier éditorial (automne, volume 24.3, 1992), j'écrivais qu'en prenant la rédaction, je considérais qu'il était temps de faire le point, de faire une évaluation du passé de la revue et de s'attacher au futur. La priorité pour moi était d'examiner tous les aspects du fonctionnement de la revue, y compris sa vocation, la qualité des articles, le processus de révision, la taille de la revue, les besoins de la commercialisation et du financement.

Pour m'assister dans l'élaboration du cours à venir de la revue, j'établis un comité de concertation comprenant les professeures Helene Ezer, Francene Ducharme et la candidate au doctorat, Sandy Lefort. Je nommai la D^{re} Mary Grossman, rédactrice adjointe, afin qu'elle travaille avec moi sur tous les aspects de la revue. Je sollicitai également l'opinion des lecteurs par un questionnaire inclus dans le numéro de l'automne. Je demandai aux lecteurs ce qu'ils pensaient de la direction de la revue à l'avenir et les facteurs déterminants qui les amèneraient à choisir la *Revue canadienne de recherche en sciences infirmières* pour la publication de leurs articles.

J'aimerais vous faire savoir ce que le questionnaire nous a permis de découvrir. J'aimerais également vous informer des changements qui ont eu lieu et ceux que nous prévoyons. Enfin, j'aimerais partager avec vous les défis que nous essayons de relever et les différentes façons dont vous pouvez nous aider.

Soixante-sept lecteurs ont répondu au questionnaire. Il est évident que les lecteurs veulent que la *Revue canadienne de recherche en sciences infirmières* ait une base large. Ils pensent que la revue doit continuer à publier des articles de recherche dans un grand nombre de domaines. Ceci dit, un consensus s'est fait sur le fait que la primauté doit être donnée à la publication de recherches cliniques et une priorité moindre à des articles de recherche sur l'éducation, l'administration et l'histoire.

En décidant de soumettre leurs manuscrits à la *Revue canadienne de recherche en sciences infirmières*, les répondants firent savoir que la durée du processus de révision et la qualité des commentaires du réviseur étaient de la plus haute importance dans leur décision. De plus, le type d'exposition que leurs articles recevraient, comme cela peut s'apprécier par le nombre d'abonnés et où la revue est répertoriée, était un autre facteur dans leur prise de décision.

Cela confirma notre propre évaluation et dirigea nos actions immédiates. Par exemple, nous avons réexaminé le processus de révision et nous avons mis en place des mesures pour l'accélérer. Les auteurs peuvent s'attendre à recevoir une réponse dans les trois mois qui suivent leur soumission. Nous sommes également en train de revoir les comités de révision, comités qui comprendront nombre de nos meilleurs chercheurs au pays. Nous indiquons maintenant dans notre encadré administratif où la revue est répertoriée et nous cherchons d'autres index.

D'autres actions exigent une planification à plus long terme. Nous devons relever deux défis importants : premièrement, nous devons attirer des articles de qualité reflétant l'envergure de la recherche dans ce pays et deuxièmement, nous devons améliorer la situation financière de la revue. Les deux défis sont intimement liés : l'amélioration de la qualité de la revue attirera plus d'abonnés, ce qui en retour, générera plus de revenus.

Nous avons établi un certain nombre de stratégies pour relever ces deux défis. Il nous faut du temps pour planifier et mettre en place les changements. Pour cela, nous avons décidé de modifier la structure de la rédaction. Par le passé, la rédaction comprenait trois co-rédacteurs et un comité de révision très dévoué. Durant les cinq dernières années, les docteurs Joan Anderson, Leslie Degner, Fabienne Fortin et Annette O'Connor furent de fort bienveillantes co-rédactrices. Gardant à l'esprit mon objectif d'améliorer l'engagement et la propriété de la revue, les co-rédacteurs et le comité de révision seront remplacés par des rédacteurs de section. Les rédacteurs de section devront planifier les numéros à venir sur un sujet précis, solliciter des manuscrits, promouvoir la revue, sélectionner des réviseurs potentiels etc. Dans les mois qui viennent, nous travaillerons de concert pour planifier l'avenir de la revue et vous serez informés de ces progrès.

La menace la plus grave et immédiate que connaît la revue est l'état de ses finances. En ce moment, la revue est déficitaire et cela menace sérieusement ses chances de succès. Chacun de vous peut apporter sa contribution. Premièrement, je vous demande de vous assurer que votre établissement est abonné à la revue. Deuxièmement, je vous invite à renouveler votre abonnement aussitôt qu'il arrive à échéance. Troisièmement, je vous demande de trouver au moins un nouvel abonné. Enfin, je vous prie de vous faire ambassadeur et de promouvoir la revue comme support pour faire la publicité des événements à venir. Je vous convie à prendre cette

responsabilité pour faire en sorte que les nouveaux commencements planifiés pour la *Revue canadienne de recherche en sciences infirmières* prennent racine. Je vous remercie pour votre soutien passé et je compte sur sa continuation.

Laurie Gottlieb
Rédactrice en chef

La souffrance: clarification conceptuelle

Éliane Béfékadu

This article is an attempt to clarify the concept of suffering and its relationships with other concepts such as pain, distress, loss and grief. Several definitions are discussed. Sources of suffering as well as reactions to suffering are then presented.

L'article s'attache à préciser le concept de souffrance et ses relations avec des concepts voisins comme la douleur, la détresse, la perte et le chagrin. On y discute plusieurs définitions et on y présente les sources de souffrance ainsi que les réactions possibles à la souffrance.

La souffrance est décrite comme une expérience inévitable de la condition humaine (Rawlinson, 1986; Travelbee, 1971; Vasse, 1983; Watson, 1985). Elle survient à l'occasion d'une maladie, d'une incapacité physique, d'une modification de l'image corporelle ou d'une perte significative.

La souffrance est un sentiment très intime et, de ce fait, elle est difficile à mesurer. Bien que le terme "souffrance" soit fréquemment utilisé dans la conversation courante, dans les médias, ou dans les écrits spécialisés, peu d'auteurs s'arrêtent à en préciser le contenu conceptuel. Si plusieurs définitions ont été proposées, aucune ne résiste à la critique et n'apparaît totalement satisfaisante. Vouloir préciser ce qu'est la souffrance pose en effet le problème de ses rapports avec de nombreux sentiments qui lui sont apparentés, dont la douleur, la détresse, l'anxiété, la perte, le chagrin et la dépression.

La souffrance est un concept complexe, global, qui fait appel à la dimension subjective et individuelle de l'expérience vécue. Étonnement, on l'utilise peu dans la littérature infirmière (Kahn et Steeves, 1986) alors que les membres de cette profession en sont quotidiennement témoins. Bien qu'un certain intérêt commence à se manifester dans quelques écrits concernant la santé (Bertman, 1983; Downey, 1983; Miles et Crandall, 1983), c'est surtout en relation avec la douleur que la souffrance est mentionnée (Crue, 1970; Davitz et Davitz, 1980; Petrie, 1972; Saunders et Baines, 1983; Spross, 1985) malgré la différence entre les deux concepts, que nous examinerons plus loin.

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L'infirmière partage avec d'autres professionnels de la santé (Downey, 1983; Oréopoulos, 1985) la responsabilité d'assister les personnes malades ou traumatisées, mais c'est sa responsabilité première d'alléger leur souffrance, étant la personne la plus présente auprès de ces personnes (Paterson et Zderad, 1976; Travelbee, 1971).

Le rôle de l'infirmière ne se limite pas à prodiguer de bons soins physiques, à enseigner les pratiques de santé et à apporter des encouragements. Il consiste aussi à aider les personnes soignées à trouver un sens à l'expérience de la maladie, de la souffrance, de la douleur et de l'existence (Travelbee, 1971; Watson, 1985). Lorsque l'infirmière peut analyser les comportements exprimant la souffrance et trouver les interventions qui la soulagent, elle devient capable de dominer le sentiment d'impuissance fréquemment ressenti face à la souffrance. C'est ce sentiment d'impuissance qui conduit plusieurs personnes à adopter une attitude distante, impersonnelle et non thérapeutique (Davitz et Davitz, 1980; Flaskerud *et al.*, 1979; Riemen, 1986).

L'infirmière doit donc se familiariser avec le concept de souffrance. C'est en précisant et en discutant les diverses définitions, intensités et sources de souffrance identifiées dans les écrits que se dessinent les relations conceptuelles évoquées précédemment.

Définition de la souffrance

Selon le dictionnaire Webster, la souffrance est l'état de celui qui souffre; le verbe intransitif souffrir signifie : endurer la mort, la douleur ou la détresse ainsi qu'éprouver une perte ou un dommage; le synonyme de la souffrance est donc la détresse. Le dictionnaire Robert explique le terme de souffrance par la douleur physique et morale, l'antonyme étant le bonheur, la joie ou le plaisir. Beaucoup d'auteurs ne vont pas au-delà de ces définitions. C'est le cas de Petrie (1972), de Copp (1974) et de Davitz et Davitz (1980).

Une première distinction est à faire ici entre la souffrance et la douleur. Travelbee (1971), Davitz et Davitz (1980), Cassell (1982) ainsi que Kahn et Steeves (1986) distinguent très nettement ces concepts alors que la conversation quotidienne les confond souvent.

Selon Travelbee (1971), la douleur physique n'est qu'un aspect de la souffrance; la douleur mentale, qu'elle nomme aussi détresse mentale ou douleur morale, en est l'autre aspect : la douleur physique et la détresse mentale s'éveillent l'une l'autre pour ensemble former la souffrance. Ainsi la douleur mentale peut être somatisée en une douleur physique que Walters (1952) nomme la douleur symbolique. A

l'inverse, la douleur physique peut conduire à la détresse lorsqu'elle est interprétée comme une menace à l'intégrité de la personne (Kahn et Steeves (1986).

Pour éviter l'ambiguïté du terme douleur, Bartley (1982) propose qu'on le réserve à la douleur physique, ayant une composante sensorielle, et qu'on assigne le terme angoisse à la douleur mentale. Cette dernière suggestion apparaît critiquable, pourtant, car l'angoisse correspond à un degré extrême d'insécurité à l'origine de la souffrance mais ne définit pas la souffrance elle-même, comme il sera discuté plus loin.

Certains auteurs (Knox *et al.*, 1974; Petrie, 1972; Urban, 1982) n'envisagent la souffrance que dans le sens restreint de l'émotion associée à la douleur. D'autres, comme Wilson *et al.* (1976) développent une dimension plus globale de ce concept et en proposent la définition suivante :

la souffrance peut résulter 1. d'épisodes paroxystiques de douleur sévère et de la réaction émotionnelle à cette sensation, 2. du développement d'un état affectif sévère ou 3. d'une combinaison des deux facteurs. (p. 76, traduction libre)

Cette définition a le mérite d'inclure les deux pôles, physique et émotionnel, par lesquels on peut aborder la souffrance. Cependant, la terminologie utilisée dans cette définition fait plus référence à l'origine de la souffrance qu'à son identité; elle ne précise pas ce qu'est la souffrance en tant que perception.

Bien qu'elle limite apparemment les sources de la souffrance à la seule douleur physique et que, pour cette raison, elle nous semble insuffisante, la définition utilisée par Imbault-Huart (1981) caractérise mieux la qualité de perception globale et intérieure de la souffrance:

Sous le terme de souffrance, nous désignons la perception de la douleur dans l'ensemble du moi psychosomatique. C'est donc un phénomène fondamentalement psychique qui est d'autant plus aigu que la conscience est plus évoluée. (p.16)

Travelbee (1971) donne de la souffrance une définition qui tient mieux compte de son contenu perceptuel :

La souffrance est une expérience qui varie en intensité, en durée et en profondeur. Elle est un sentiment de déplaisir qui va du simple inconfort transitoire mental, physique ou spirituel à l'angoisse extrême et, au-delà de l'angoisse, peut atteindre la phase maligne de désespoir (*despairful not-caring*) et la phase terminale de l'abandon de vie (*apathetic indifference*) (p. 62, traduction libre).

La définition de Travelbee (1971) a le mérite de préciser divers degrés d'intensité de la souffrance ainsi que son caractère global. Le premier degré de souffrance décrit par Travelbee (1971), celui de l'inconfort transitoire, est à rapprocher du sentiment d'«avoir mal» (*hurt*), mentionné par Gaylin (1979). C'est une émotion légère avec peu de sens de dommage profond et permanent. Watson (1979) décrit, dans le huitième facteur de soin infirmier, plusieurs aspects de l'inconfort et en montre le caractère global, mais elle n'en précise pas expressément les degrés plus intenses.

Travelbee (1971) souligne que, au deuxième degré de souffrance, celui de l'angoisse, souffrir est vivre l'impact d'un stress si intense que l'on ne ressent plus rien. C'est éprouver l'engourdissement du corps, de l'esprit et de l'âme et supporter l'impact d'une fatigue que le repos ne soulage pas. C'est vivre la peur et l'anxiété. Selon Vasse (1983), «la souffrance fait vaciller nos repères... nous ouvre à la dimension de la mort» (p. 29); dans la souffrance se fait l'expérience «d'une altération de nous-même; nos projets sont contrariés; notre moi, la projection de nous-même, altéré» (p. 13). Rawlinson (1986) affirme que la souffrance surgit comme une rupture à l'intérieur du sujet lui-même, une rupture entre sa situation et les buts qu'il se définit. Domine alors le sentiment du temps rétréci, de la concentration dans l'épreuve et l'oblitération de tout ce qui n'est pas la souffrance elle-même, expérience émotionnelle qui émerge de la totalité de l'être présent et passé et de son héritage social (Bond, 1980). Gaylin (1979) emploie l'expression : se sentir blessé, traumatisé, écrasé, qui signifie que de la détresse est ressentie et que la cause est une blessure psychique. Ceci se rapproche du sentiment de blessure, que Watson (1979) associe à la perte, et du sentiment de menace à l'intégrité personnelle, qui provoque la souffrance selon Cassell (1982) et Kahn et Steeves (1986).

Travelbee (1971) décrit le troisième degré de souffrance comme étant celui du désespoir. La souffrance est alors si intense ou si prolongée, ou le soutien est si insuffisant, qu'elle devient insoutenable. Les réactions à cette souffrance sont la colère, le désespoir et la dépression, analogues à celles qui surgissent à la suite d'une perte, telles que décrites par Bowlby (1968). Elles sont un appel à l'aide désespéré et indiquent l'urgence d'une intervention. Ces réactions, qui se situent sur le versant moteur de l'émotion (Walters, 1952), signalent l'intensité de la souffrance. Mais elles ne sont pas la souffrance elle-même, puisque celle-ci se situe sur le versant réceptif, perceptuel de l'émotion.

Travelbee (1971) qualifie le plus haut niveau de souffrance d'indifférence apathique et elle en souligne le caractère souvent irréversible. La souffrance est alors extrême et la personne abandonne la lutte, perd la volonté de vivre et se laisse mourir. Cette phase est décrite particulièrement par Frankl (1962) lorsqu'il fait état de la souffrance de certains dans les camps de concentration nazis.

La définition de Travelbee (1971) permet ainsi de mieux préciser le concept de souffrance à divers niveaux d'intensité. Cependant, les termes angoisse, désespoir et abandon de la vie, utilisés pour caractériser les degrés sévères de cette souffrance, nous apparaissent inadéquats car ils font appel à des concepts appartenant à une autre dimension. Ils correspondent en effet soit à la source de la souffrance soit à la conséquence de celle-ci. Le concept d'angoisse désigne une source de souffrance et non la souffrance elle-même (Béfékadu, 1991). L'angoisse et le désespoir sont les degrés extrêmes de l'insécurité lorsque le besoin d'actualisation de la personne est menacé ou affecté, lorsque l'intégrité de la personne est menacée ou perdue. L'angoisse et le désespoir sont des perceptions inconfortables comme l'est une blessure mais elles ne sont pas l'inconfort (la souffrance), de la même façon que la blessure n'est pas la douleur. L'insécurité est la source de la souffrance comme la blessure est celle de la douleur, mais l'insécurité n'est pas la souffrance. De même, le terme abandon de la vie réfère plutôt, dans l'expression de Travelbee, aux conséquences d'une souffrance extrême, c'est à dire la perte de l'énergie vitale. Cette dernière est la traduction de la souffrance par les réactions qui la révèlent. Elle n'est cependant pas la souffrance elle-même, qui est la perception intérieure de la détresse ou de la douleur.

Plus récemment, Cassel (1982) propose une définition plus simple de la souffrance, qu'il qualifie ainsi :

un état de détresse sévère associée à des événements qui menacent l'intégrité de la personne (p. 640, traduction libre).

Le seul élément qui caractérise ici la souffrance se trouve contenu dans le terme détresse sévère, ce qui donne peu de profondeur à cette définition où en outre le caractère global de la souffrance n'est pas souligné. Par ailleurs, lorsque Kahn et Steeves (1986) ajoutent que : «La souffrance est ressentie quand un aspect crucial du soi, de l'être ou de l'existence est menacé» (p. 626, traduction libre), cela précise mieux les sources possibles de souffrance, mais toujours pas son identité.

Rawlinson (1986), qui a rédigé une topologie de la souffrance ne propose pas, pour sa part, de définition explicite du concept. Elle considère que, dans la souffrance, non seulement la personne éprouve une menace à son intégrité comme le suggèrent Kahn et Steeves (1986), mais elle ressent déjà une rupture de son existence et de son intégrité.

Compte tenu des imperfections des précédentes définitions de la souffrance, il semble intéressant maintenant d'en envisager une dernière, même si son auteure ne nomme pas expressément le concept de souffrance. En effet, Watson (1985) considère deux dimensions de l'altération de la santé *illness*, l'une objective et l'autre subjective. La dimension objective est la maladie ou *disease*, au sens médical

du terme. La dimension subjective, qu'elle désigne par le terme *dis-ease*, fait l'objet des soins prodigués par l'infirmière. Sa définition nous paraît s'appliquer très exactement à la souffrance. L'intérêt de la retenir se précisera avec l'examen des sources de souffrance.

Cette définition est la suivante :

le tourment subjectif, la dysharmonie du soi intérieur... ressentis dans l'esprit, le corps et l'âme de manière consciente ou inconsciente... lorsque le «je» est séparé du «moi» (Watson, 1985, p. 48, traduction libre).

Sources de souffrance

Une personne ressent de la souffrance lorsqu'elle vit des expériences pouvant l'affecter elle-même ou affliger une personne aimée (Travelbee, 1971). Selon Vasse (1983), les occasions de souffrance sont les rencontres avec la maladie, l'accident, l'injustice ou la mort.

Rawlinson (1986) affirme aussi que toute situation humaine présente un potentiel de souffrance. Elle a rédigé une topologie de la souffrance qui sera utilisée pour préciser les sources de celle-ci. En même temps, il sera possible d'apprécier les différences conceptuelles annoncées en introduction.

Rawlinson (1986), qui est philosophe, définit quatre domaines de souffrance de la personne qui sont : a) dans son corps; b) dans ses relations interpersonnelles; c) dans la volonté et dans le sentiment d'unité du moi et de cohérence. Il est facile de reconnaître que ces quatre domaines de souffrance recouvrent l'ensemble des composantes bio-psycho-socioculturelle et spirituelle de la personne avec lesquelles toute infirmière est familière.

Souffrance dans le corps (de source physique). Rawlinson (1986) utilise la vision du corps développée par Merleau-Ponty (1945), pour qui le corps est ce qui donne accès au monde et le pouvoir de le façonner. Fisher (1978) décrit aussi le corps comme une source vitale pour définir le moi et l'unité du moi. La consistance du corps joue donc un rôle primordial dans cette intégrité du moi (Buck, 1984).

Ainsi, la maladie, la privation, la douleur ou l'incapacité peuvent empêcher une personne d'accéder au monde et ainsi fermer ses horizons ordinaires; quand cela survient, il y a souffrance (Rawlinson, 1986). Selon cette auteure, le sentiment général qui caractérise cette souffrance est l'aliénation. Il en résulte une perception de dépendance accrue envers les autres, de rétrécissement humiliant de l'autonomie

et de conflit entre ce que la personne voudrait être et sa faiblesse, sa non-fiabilité et sa douleur.

La relation entre la souffrance et la douleur a déjà été partiellement évoquée. Pour Kahn et Steeves (1986), la douleur ne provoque la souffrance que dans la mesure où la personne interprète cette douleur comme une menace à son intégrité. Les écrits de source biomédicale et infirmière évoquant cette association, sont unanimes pour dire qu'à la douleur aiguë est rattachée une réaction émotionnelle de type anxiété, tandis qu'à la douleur chronique est habituellement associée la dépression, que beaucoup assimilent à la souffrance (Coyle et Foley, 1985; Myers, 1985; Sternbach, 1976; Wilson *et al.*, 1976). C'est à la douleur chronique, d'ailleurs, que ces écrits rattachent la souffrance (Benoliel *et al.*, 1980; Chapman, 1984; Copp, 1974; Le Shan, 1964; Spross, 1985; Wolff *et al.*, 1980). Rowat (1983) a montré que le sentiment qui domine en association avec la douleur chronique est l'incertitude quant à la nature de la douleur elle-même, à la vie familiale future et au contrôle possible de la douleur. Cette incertitude concourt à la détresse engendrée par la persistance de la douleur. La relation entre douleur et souffrance n'est pas univoque; elles peuvent s'entretenir l'une l'autre (Chapman, 1984), car la souffrance est globale (Travelbee, 1971). Beaucoup parlent de «douleur totale», signifiant que la douleur a des composantes reliées au processus lésionnel, à l'anxiété, à la dépression et à une réaction complexe aux pressions psychologiques et sociales (Black, 1980; Melzack et Wall, 1982 ; Schattner, 1988).

La perte d'intégrité physique aussi donne lieu à la souffrance. Watson (1979) distingue la perte d'une fonction biologique et la perte d'une structure du corps. La perte d'une fonction biologique peut causer de la faiblesse, de l'inactivité, de la douleur et de la fatigue, et s'accompagne du sentiment de perte de santé, d'une menace à la survie. La perte d'une structure donne lieu à une perte de l'apparence physique et de l'attrait de la personne. Le sentiment est alors celui d'une perte psychologique de soi par la perte du rôle de participant actif dans l'environnement psycho-social, dans la capacité d'accomplissement et d'actualisation de soi. Lindemann (1981), comme Watson (1979), reconnaît les mêmes phases de deuil que celles décrites pour toute perte à la suite d'une incapacité. Cependant, Werner-Beland (1980) réclame une attention plus particulière à ces réactions. En effet, lorsque l'incapacité physique s'installe, la constatation de la perte sera rappelée en permanence à la victime par ses limites. Au contraire, la mémoire d'un être ou d'un objet disparu s'estompe d'habitude avec son absence.

Werner-Beland (1980) considère le chagrin comme le concept pivot qui devrait guider l'analyse et les interventions des infirmières confrontées aux réactions des personnes qu'elles soignent à l'occasion d'une incapacité physique mais aussi des maladies, du vieillissement ou des diverses pertes que comporte le fait de vivre.

Il semble pourtant que le concept de souffrance soit encore plus central, étant plus global que le concept de chagrin. En effet, la souffrance incorpore le concept de douleur qui est exclu du concept du chagrin.

Souffrance dans les relations interpersonnelles (de source socioculturelle). Dans le deuxième domaine de souffrance, la relation entre la souffrance et le chagrin, relation attachée à une perte, est encore présente. La perte est la situation objective, alors que la souffrance et le chagrin sont des éléments subjectifs de la situation.

En effet, l'identité de la personne est, dans une large mesure, acquise et maintenue ou perturbée à travers les rôles qu'elle joue, non seulement par l'assimilation et l'incorporation, mais aussi par la différenciation et la séparation (Rawlinson, 1986). Travelbee (1971) tient compte, non seulement de la perte de personnes aimées, par la mort, le divorce, la séparation, à laquelle se limite Rawlinson (1986), mais aussi de celle d'un objet aimé, d'une possession matérielle, d'un emploi, ou d'un rôle de prestige. Watson (1979), pour sa part, rattache l'ensemble de ces pertes à la catégorie de perte physique, car la perte d'une personne-soutien, en particulier, signifie aussi, selon cette auteure, la perte de certains aspects du soi physique. En outre, elle introduit la notion de perte socioculturelle lorsque la personne est transplantée dans un milieu étranger alors qu'elle perd ses relations, son environnement familial et son travail.

Travelbee (1971) et Bowlby (1968) relient la vulnérabilité à la souffrance, au degré d'attachement à la personne, à l'objet ou à la situation perdue. Plus la personne qui perd éprouve de l'attachement, plus elle est vulnérable à la souffrance. Le chagrin est décrit par Bowlby (1968) comme un amalgame d'anxiété, de colère et de désespoir. Travelbee (1971) n'utilise pas ce terme et concentre son propos sur la souffrance. Ces deux concepts évoquent l'impact d'une perte irréparable. Ils sont très voisins car ils se rattachent au même versant perceptuel de l'émotion reliée à la situation objective de la perte. Ils apparaissent pourtant différents : au moins dans la langue française et peut-être aussi dans la langue anglaise, la distinction semble tenir à la différence d'intensité de l'émotion contenue dans les deux termes. Comme Gaylin (1979) le souligne, la différence quantitative, dans beaucoup d'émotions, amène une différence qualitative.

Souffrance dans la volonté (de source spirituelle). Dans ce troisième domaine de souffrance, Rawlinson (1986), héritière de la pensée nietzschéenne, précise que la souffrance est en rapport avec le pouvoir qu'a la personne de donner un sens à la vie, de forger l'unité de son histoire, de produire et de maîtriser des tâches, ainsi que de se définir des règles morales. Dans ce contexte, la souffrance consiste en des sentiments de regret et de fragmentation lorsque la personne ressent qu'aujourd'hui réfute hier (Rawlinson, 1986), qu'elle n'est pas en accord avec elle-même et qu'elle ne peut compter sur elle-même. C'est le sentiment d'inefficacité, d'échec et de perte

d'estime de soi lorsqu'elle souffre à cause de la contradiction entre un idéal de maîtrise et d'accomplissement et ses actions primaires (Rawlinson, 1986). Enfin, la personne ressent un déchirement et de la culpabilité lorsqu'elle transgresse les principes moraux qu'elle s'est imposés (Rawlinson, 1986) ou des principes religieux importants pour elle (Travelbee, 1971).

Il s'agit ici du sens philosophique que la personne donne à l'expérience vécue, à son existence et à la souffrance. C'est le besoin d'actualisation de soi, par lequel elle tend à démontrer un sentiment de liberté intérieure et de contrôle de sa vie, qui est touché (Watson, 1979).

Ce n'est pas la gravité objective d'une maladie, d'une perte ou d'un événement qui occasionne de la souffrance (Cassell, 1982; Travelbee, 1971; Watson, 1979), mais la signification que la personne attribue à l'expérience. C'est l'appréciation cognitive d'une situation qui fait souffrir lorsque celle-ci est perçue comme une menace (Lazarus et Folkman, 1984). Ce sont les croyances irrationnelles et, plus encore, le dialogue interne, le langage subvocal des croyances inarticulées (Smith, 1982) qui impriment une signification à la situation et à la souffrance.

La civilisation occidentale moderne est partagée entre plusieurs tendances qui influencent l'individu. D'une part, la poursuite du plaisir et du bonheur est valorisée et la souffrance doit être évitée à tout prix (Gaylin, 1979). A l'inverse, la tradition judéo-chrétienne attribue une signification et un but à la souffrance, qui est méritée, rédemptrice ou récompensée (Rawlinson, 1986). Pour Frankl (1962), la souffrance cesse lorsqu'elle prend un sens, qui peut être celui du sacrifice. Rawlinson (1986), pour sa part, considère la souffrance comme la voie qui permet à l'être humain d'affirmer son autonomie; elle est essentielle à la croissance et au développement.

En général, la personne, héritière de croyances, de valeurs et d'expériences, aura tendance à considérer soit que la souffrance lui est imposée de l'extérieur, comme une injustice ou une punition, soit qu'elle peut exercer un contrôle sur la souffrance et même l'accepter en la transcendant (Travelbee, 1971).

Souffrance dans le sentiment d'unité du moi et de cohérence (de source psychologique). Quel que soit le domaine initial d'où émerge la souffrance, celle-ci n'y demeure jamais enfermée mais tend à se diffuser aux autres domaines (Rawlinson, 1986). Toute souffrance aboutit à cette souffrance intérieure, à cette rupture à l'intérieur du sujet lui-même, rupture entre sa situation et les buts qu'il prend pour siens.

En effet, le soi psychologique est une conscience de soi qui inclut des perceptions sensorielles autant que des états cognitifs, affectifs et spirituels, vécus de manière globale dans une unité de l'esprit avec le corps et l'âme (Watson, 1985). Toute perte

est alors ressentie comme une perte du moi (Buck, 1984). Le centre ne tient pas, le sentiment d'unité est perdu (Rawlinson, 1986). La personne a la tâche de passer à travers la souffrance, c'est-à-dire de rebâtir son monde intérieur (Bowlby, 1968).

Lorsque l'unité du moi est perdu, c'est l'écho de la lutte entre Éros et l'instinct de mort (Bakan, 1968), de la lutte éternelle de l'ego (Rawlinson, 1986). A la limite, c'est la détresse fondamentale. Bowlby (1968) rattache l'anxiété de séparation à la période où l'enfant éprouve la détresse reliée à l'absence de la mère, alors que Kessen et Mandler (1961) font remonter la source de l'anxiété, qu'ils assimilent à la détresse fondamentale, à la période néonatale, celle des premières privations. Vasse (1983), pour sa part, rattache même la souffrance à l'écho qu'évoque en nous la première séparation, celle vécue à la naissance.

La souffrance et l'anxiété sont ainsi des concepts très voisins. Dans l'anxiété, il y a perception d'une menace à l'intégrité de la personne (May, 1977 : voir Beck *et al.*, 1984). Dans la souffrance, l'intégrité de la personne est déjà atteinte, la perte n'est pas pressentie mais vécue, et le moi est changé (Rawlinson, 1986). C'est une des raisons qui fait rejeter les définitions de la souffrance proposées par Cassell (1982) ainsi que Kahn et Steeves (1986).

Par ailleurs, lorsque Rawlinson (1986) soutient que la souffrance est vécue comme une rupture intérieure, une concordance très claire s'établit avec la manière dont Watson définit la perte de la santé, la dimension subjective de *illness*. Celle-ci est le tourment subjectif, la dysharmonie intérieure consciente ou inconsciente lorsque le «je» est séparé du «moi» et qu'il existe une non-conformité entre le soi tel que perçu et le soi tel que vécu (Watson, 1985). Ceci est donc bien la définition de la souffrance.

Réactions à la souffrance

Travelbee (1971) décrit deux grands modes de réaction, l'une étant «Pourquoi moi?», lorsque la personne n'accepte pas la souffrance, l'autre étant l'acceptation de la souffrance. Selon Travelbee (1971), les comportements émotionnels les plus fréquents qui expriment la non-acceptation sont l'incompréhension, la pitié pour soi, le sentiment d'attente, le blâme et la dépression. Ils sont très voisins des réactions signalées dans le processus de deuil. Travelbee ne fixe pas de chronologie dans l'apparition de tous ces comportements, qui peuvent coexister. Elle insiste particulièrement sur l'apitoiement sur soi, qui démontre une souffrance très intense, le sentiment de vide, de peur et d'horreur du non-sens que la personne ressent. La personne s'apitoie sur elle-même parce qu'elle se sent injustement affligée ou parce qu'elle se sent punie en raison de ses fautes. Dans le premier cas, elle réagit

principalement par la colère. Dans le deuxième cas, le sentiment de culpabilité la conduit à se blâmer.

Lorsque la personne est incapable d'extérioriser sa colère, et que cette colère se dirige vers l'intérieur, Travelbee (1971) parle de dépression et décrit cette souffrance excessive dans la phase de désespoir. Des prédispositions antérieures conduisent à ce faisceau de sentiments masochistes associant perte de l'estime de soi, auto-accusation excessive et besoin intense d'autopunition (Gaylin, 1976). Cependant, l'intensité de la souffrance elle-même ou sa prolongation excessive et l'absence de soutien peuvent aussi conduire à la phase extrême et maligne de la souffrance (Travelbee, 1971).

Une autre réaction, le sentiment d'attente, est une tentative d'effacer la source de souffrance en niant le dommage subi. Le terme de négation est aussi utilisé pour désigner cette réaction (Kubler-Ross, 1969; Lindemann, 1981; Parkes, 1973; Watson, 1979).

Les réactions précédentes, ainsi que les autres mécanismes de défense, sont instinctives et irrationnelles. Elles appartiennent à ce mode de *coping* centré sur l'émotion (Lazarus et Folkman, 1984) qui apparaît efficace, mais seulement temporairement, pour diminuer la souffrance. Ces mécanismes de défense ne protègent pas mais blessent davantage encore, tout en paraissant protéger de la blessure (Bakan, 1968). Ils accentuent la souffrance s'ils sont utilisés trop ou exclusivement, et augmentent le schisme entre la réalité et la perception qu'en retient la personne (Coleman *et al.*, 1980).

Par contre, la réaction d'acceptation est la plus rare, selon Travelbee (1971). Elle est possible lorsque la personne perçoit la souffrance comme une voie dont un bien peut résulter.

La diminution de la souffrance et son acceptation sont favorisées par la capacité des personnes à clarifier leur situation et à lui trouver un sens positif, de même que par la force du soutien expressif qu'elles reçoivent (Béfékadu, 1991). Vash (1981) illustre de plusieurs exemples la capacité de la personne de trouver un sens positif à l'expérience d'incapacités physiques sévères.

L'acceptation de la souffrance ne signifie pas l'absence de souffrance (Béfékadu, 1991). La personne reçoit la souffrance sans protestation, parce qu'elle sait que l'être humain est vulnérable et que la souffrance est un aspect intrinsèque de la condition humaine.

C'est la philosophie existentielle que retient aussi Watson (1979) et qu'elle explicite dans le dixième facteur de soins infirmiers de sa théorie du *caring*, à savoir

que la personne doit accepter que : 1. la vie est parfois injuste; 2. au bout du compte, on ne peut échapper à la douleur et à la mort; 3. si proche que l'on soit des autres, on affronte sa propre vie en solitaire; 4. on a toujours l'option de faire face aux problèmes fondamentaux de la vie et de la mort et de ne pas se laisser enfermer dans les trivialités; et 5. on est, en définitive, responsable de sa façon de vivre, quels que soient l'aide et le soutien donnés par les autres.

Les mécanismes d'adaptation efficaces pour atteindre cette acceptation sont l'expression des sentiments, l'analyse et se définir un nouvelle unité cognitive de la situation, et les mécanismes d'adaptation centrés sur le problème (Béfékadu, 1991). Alors, la personne devient capable de faire face à la souffrance et de se redéfinir une nouvelle unité intérieure (Lazarus et Folkman, 1984).

Conclusion

La souffrance est un concept global, complexe et encore insuffisamment exploré. Cet article a tenté d'apporter quelques clarifications à partir d'une recension des écrits sur la souffrance et sur quelques concepts qui lui sont reliés.

Des recherches sont encore nécessaires pour préciser ce concept. La méthode phénoménologique, qui facilite la mise à jour du monde intérieur et subjectif des significations personnelles, est évidemment la méthode de choix pour conduire de telles recherches (Watson, 1985).

L'approfondissement des connaissances sur ce concept est en effet justifié par le besoin qu'ont les infirmières de comprendre la complexité du vécu intime des personnes qu'elles soignent, puisqu'elles ont pour mission de les aider à trouver un sens à l'expérience de la maladie, de la souffrance, de la douleur et de l'existence. Cet aspect du soin qui, n'a pas été abordé ici, faute d'espace, fait appel à la science et l'art du *caring*. Tous les facteurs de soins infirmiers de la théorie de Watson (1979, 1985) ont été jugés indispensables pour aider les personnes à accepter et à atténuer la souffrance (Béfékadu, 1991).

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Staff Nurse Perceptions of Stressors and Support Needs in their Workplace

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Cette étude qualitative explore les tensions et le besoin de soutien que connaît le personnel infirmier travaillant dans les services de soins de courte durée. Vingt-huit infirmières se sont portées volontaires pour consigner ces deux variables au cours d'une journée de travail. Elles ont été interviewées le lendemain pour clarifier leurs impressions. L'analyse de contenu des entrevues a révélé que les infirmières ressentent des tensions liées à des facteurs d'organisation et d'environnement, au travail proprement dit et/ou aux relations interpersonnelles. Ces causes de tension, le moment de la journée et le tempérament de la personne peuvent avoir une incidence sur le besoin de soutien. Onze besoins de soutien ont été répertoriés. Ces résultats indiquent que les recherches ultérieures sur ce sujet devront utiliser une méthodologie permettant que l'on étudie le soutien en tant que processus dynamique.

This qualitative study explored the stresses and support needs of individual acute care staff nurses. Twenty-eight nurses volunteered to keep a log of these two variables during one specific work day and were interviewed on the following day to elicit their perceptions. Content analysis of the interviews revealed that at any given time staff nurses experienced stress related to organizational/environmental, job component, and/or intrapersonal factors. Stress factors, time of day, and character of the individual can all influence the need for support. Eleven support needs were described. These results indicate that future research on this subject should employ a methodology which allows support to be studied as a dynamic process.

The purpose of this article is to describe the unique and variant nature of stressors and support needs for individual nurses. The occupation of nursing has traditionally been one of nurturing the sick, providing for their physical, as well as emotional needs. In addition to this, nurses today are expected to fulfil a more contemporary role which includes everything from preventative interventions to high-tech intensive care of the critically ill patient. Recently researchers have begun to ask at what personal cost to nurses these services are provided and what, in turn, are nurses' needs. (Marshall, 1980).

There is an increasing level of burnout in the nursing profession, resulting in a high rate of staff turnover and poor job performance (Lobb & Reid, 1987). More nurses are leaving the profession, enrolments in nursing schools have declined, and

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hospital beds are closing due to current nursing shortages. Although hospital employers may be able to alter some of the existing demands and stresses that are present for nurses, many cannot be removed from the health care milieu. Because of this, researchers have begun to look at available resources that can be employed to enhance nurses' ability to deal with stress. One such resource is social support in the workplace (Mowiniski-Jennings, 1987).

Literature Review

Stress is defined as a relationship between an individual and his/her environment that is appraised by the person as taxing or exceeding his or her resources, and endangering well-being (Lazarus & Folkman, 1984). For the nurse, the stress process begins with potential stressors including intrapersonal, organizational/environmental, and job component stressors, which all interact in a reciprocal manner (Hartrick, 1989). These interactions can result in stress appraisal and in time lead to emotional exhaustion and burnout. There are three important characteristics of the stress-support process in this model: it is individual-specific, multifactorial, and dynamic, changing over time. Within this process, support may occur at any time and enhance the nurse's ability to deal with stressors.

Conceptual and operational definitions of support vary widely among researchers making it difficult to compare the various studies (LaRocco, House & French, 1980; Starker, 1986). Cobb (1976) defines support in terms of information leading the subjects to believe that they are cared for and loved, esteemed and valued, and belong to a network of communication and mutual obligation. In contrast, Kahn and Antonucci define support as "interpersonal transactions that include one or more of the following key elements: affect, affirmation, and aid" (as cited in House, 1981, p. 16). Gottlieb (1978) asked individuals to describe supportive relationships in which they were involved. Four major categories of support were revealed: emotionally sustaining behaviours, problem-solving behaviours, indirect personal influence, and environmental action.

One area of debate within the literature on this subject is the importance of the perception of support versus the behavioral manifestation of support. Many researchers believe that the former is more important than the latter. Gottlieb (1985) points out, however, that both the support needed and the support provided impact on the outcome.

Little existing research has explored the nurses' perception of their own support needs. Smith (1986) conducted one such study, but looked at nurses' support needs from a static perspective. The stress-support model, on the other hand, emphasizes the specific and dynamic nature of support. The support needs of individual staff

nurses are in fact both unique and constantly changing as a result of existing intrapersonal, organizational/environmental, and job component stressors. Needs must therefore be assessed on an ongoing basis. The current study is part of a larger one which was undertaken to address staff nurses' perceptions of their stresses and support needs in the workplace.

Method

This study was primarily qualitative in nature. Since the literature concerning the dynamic nature of staff nurses' support needs is virtually nonexistent, this type of study would allow these unknown data to be revealed. "In other, less well understood areas of stress and coping...the more open-minded, qualitative grounded theory participatory approach offers the more useful research approach because obscure or complex relationships can be described" (Bargagliotti & Trygstad, 1987). Since the model from which this study stems views the stress-support process as unique to each individual, systematic (with multiple contributing factors), and dynamic, semi-structured interviews were conducted to gain insight into the experiences of the participating nurses.

Subjects

A written request for volunteers was distributed to the head nurses and staff nurses at two urban hospitals. Twenty-eight acute care staff nurses, (two nurses from each of the 14 nursing units) participated in the study including 27 females and 1 male. Their ages ranged from 24 to 50 years, with a mean of 34.3 years. Total years of nursing experience ranged from 2 to 29 years, with a mean of 7.6 years. Four participants had a Baccalaureate degree in Nursing, nine had a three-year diploma, and 15 had a two-year diploma.

Procedure

All volunteers were asked to keep a log of their experiences during the work day preceding their interview. The purpose of the log was to help them recall instances of workplace stressors and support needs during the subsequent semi-structured interview with the researcher (Cormier & Cormier, 1985). In order to ensure that the individual nurse's perspectives were obtained, subjects were not given specific instructions regarding the kind of experiences they should record. Rather, they were instructed to think of the log as a patient chart (of themselves) reflecting what happened to them during their work day with entries recorded as for a patient flow sheet, but in a form that was meaningful to them. Since nurses are trained to keep

accurate and complete records in patients' charts and flow charts, it was thought that this approach would be effective in obtaining the desired information, without requiring a lot of time for log completion. The researchers formulated interview questions which were judged independently by three psychologists, to establish content validity. They agreed that the questions were congruent with the objectives of the study.

The interview guide provided topics within which the interviewer was free to explore (Patton, 1980). It also helped to ensure the best use of limited time by keeping interaction focused, while allowing individual perspectives and experiences to emerge (Patton, 1980).

After completion of the log, volunteers related their experiences during the semi-structured interview. Volunteers had their logs to refer to, which ensured accurate recall of the previous day. For purposes of the interview, Greenley's (1981) definition of need as something one wants, requires or desires was used. All interviews were conducted by one researcher and tape recorded for later analysis. They were held at the hospital at times mutually agreed upon by the subjects, hospital administration, and the researcher.

Data Analysis

The data were analyzed using the technique of content analysis as outlined by Woolsey (1986). First, the raw data were categorized or classified by relevant content characteristics (Guba & Lincoln, 1982). Categories were formulated inductively by sorting the responses into clusters that were judged to group together (Woolsey, 1986). In this study previously established classifications of types of support were not used; instead, the thoughts and feelings of the participants were used to generate the categories.

The interview tapes were reviewed and the subject responses to the questions transferred to index cards. These cards were then sorted into piles to form the initial categorizations (Woolsey, 1986). In most instances one of the volunteer's phrases was selected to represent the category.

The data categorization was validated by three independent judges. The average percentage of agreement between the researcher and the three judges was 87.5%, consistent with Andersson and Nilsson (1964) who suggest that a level of agreement above 75% is acceptable. It is unlikely that two people reviewing qualitative data would develop exactly the same categories (Guba & Lincoln, 1982). Having the categorization of the data validated by the judges, however, is in keeping with the expectations of replication (Miles & Huberman, 1984).

After categorization of the data, frequency counts were obtained for each theme by counting the number of nurses who mentioned the theme. These figures were expressed as a percentage of the maximum value of nurses that participated, 28.

Data categories were then ranked according to the highest frequency. If two categories occurred within the same percentage of the group, the two rank numbers were divided and each assigned the same ranking.

Results

Staff nurses experienced numerous organizational/environmental, job component, and intrapersonal stressors at any given time during their workday (Table 1).

Table I. Frequency Distribution of Staff Nurses' Perceptions of Stressors

Staff Nurse Stressor	Staff Nurses % of Group	Rank
I Organizational/Environmental Stressors		
Workload		
Too many demands	71.4	1.5
Extra duties	39.3	8.0
Nurse covers for everyone	42.9	6.5
No time for emotional/teaching	32.1	10.0
Unexpected factors	28.6	11.5
Relating to other Members of Health Team		
Interpersonal relations	71.4	1.5
Poor communication/conflicts	42.9	6.5
Doctor's lack of understanding	46.4	5.0
Lack of positive recognition	25.0	14.5
Lack of input	25.0	14.5
Physical/environment/supplies/equipment	21.4	17.5
II Job Component Stressors		
Time Pressures/Deadlines	35.7	9.0
Patients and Patients' Families		
Patient expectations	28.6	11.5
Demanding/difficult patients	53.6	4.0
Patients' families needs	25.0	14.5
III Intrapersonal Stressors		
Personal Expectations	67.9	3.0
Personal Threat Vulnerability	21.4	17.5
Lack Knowledge/Skill	25.0	14.5

In the organizational/environmental category, *workload* was identified as a major cause of stress. *Too many demands at once* was cited by 71.4% of the nurses. As an example of this, one subject volunteered "I was on second supper so I have six patients, have to give out meds and feed patients. I come back at 7:00, I give out the rest of my meds, look after my tube feeds and IVs and wash six people and do all of my charting." *Assuming extra duties* and *nurse covers for everyone* were reported by 39% and 43% of the nurses, respectively. One nurse stated, "The housekeepers can't mop up bodily fluids so the nurses have to." *No time for meeting patients, emotional, or teaching needs* was another workload stressor: "We have a lot of dying patients and sometimes you don't even have a chance to say 'are you scared?'" The last workload stressor, which was cited by 28.6% of the staff nurses was *unexpected factors*. As described by one nurse, "...so my schedule got all messed up and I had to interrupt my patient's lunch to give insulin."

Relating to other members of the health care team included another major group of organizational stressors. *Interpersonal relations* and *team co-operation* was reported by 71.4% of the nurses. "It was my first day back and it was really stressful 'cause if we're really busy, you pick it up like osmosis, if everybody is uptight, you get uptight." *Physician's lack of understanding* and *acknowledgement* was cited by 46.4% of the nurses: "Doctors expecting me to stop what I'm doing and come now to make rounds, just drop everything." *Lack of positive recognition* and *lack of input* were reported by 25% of the nurses: "We're the ones that are here 24 hours a day and there's no acknowledgement that we're important, that we're needed, you know, that the place would fall apart if we weren't here, don't feel very valued." *Physical environment* was seen as a stressor by 21.4% of the nurses: "When I don't have any linen, sometimes I have to go and steal some from another floor, it's crazy when you have to sneak around to get some towels."

The second major category was job component stressors. *Time pressures and deadlines* were reported by 35.7% of the nurses. *Patients and patient families* and *patient expectations the nurse is unable to fulfil* were additional job component stressors for nurses. As one nurse stated, "Patients wanting to know why aren't you here for me, that was a long coffee break—and I've been busy with other patients." In other cases they noted the *demanding/difficult patient problems or conditions* and *patient families demands and needs* as stressful.

Intrapersonal stressors were the third major category that impacted on the nurses. Many nurses (67.9%) cited *personal expectations* as a stressor: "Biggest frustration is that I can't give the kind of care I want to give..." Others reported *personal threat and vulnerability*: "You get to know your patients and they die, all you want is life around you, you begin to think you're going to get cancer." Lastly, 25% of the nurses stated they found *lack of knowledge/skill/procedures* to be stressful: "'Should I do this?' or 'Is this right?' and 'Don't really know'."

The support needs reported by the staff nurses are grouped into eleven categories (Table 2).

The most frequently reported support need was *help with physical tasks*. Other nurses cited *listening and understanding* as a support need: "People listening to me rant and rave and agreeing that, yea, it should have been done differently."

Consultation/problem solving was mentioned by 42.9% of the nurses: "A chance for consultation, you know, like, what should I do and two or three people give input." *Positive recognition/acknowledgement* such as "...someone to take me seriously, common courtesy, respect, being acknowledged..." was also expressed as a support need. A need for *extra support services* was reported by 42.9% of the nurses: "More support staff like porter, kitchen help so I have more time with my patients." Thirty-six percent of nurses cited a need for a *clinical coordinator*: "someone like a clinical leader to fall back on so if I've got somebody whose bleeding they can come and give you a hand and take care of your other patients so they aren't just sort of left." *Clear roles, procedures and policies* and *input into changes* (i.e., "listening to our concerns" and "following through with them") were other support needs that were identified. Finally, *support group for staff nurses* (14.3%) and *physical changes* (7.1%) were also seen as support needs by some of the nurse participants.

Table 2. Frequency of Distribution of Staff Nurses Perceptions of Support Needs (N = 28)

Staff Nurse Need	Staff Nurses % of Group	Rank
Help with Physical Tasks	71.4	1
Listening/Understanding	57.1	2
Consult/Problem Solve	42.9	4
Positive Recognition/Acknowledgement	42.9	4
Support Services	42.9	4
Clinical Coordinator	35.7	6
Communication	32.1	7
Input into Changes	25.0	8
Clear Roles/Policies	21.4	9
Support Group	14.3	10
Physical Changes	7.1	11

Discussion

In this study, nurses identified different sources of stress and needs for support during their workday. This indicates that stressors and support needs may be unique for each staff nurse. These findings are consistent with results from studies on job satisfaction. Landeweerd and Boumans (1988) found that there was a higher level of satisfaction among psychiatric nurses who worked on a unit where frequent contact between nurses provided ample opportunity to exchange opinions and feelings. In contrast, poor work satisfaction occurred when nurses were not able to meet their expectations for patient care. Factors that seemed to decrease work satisfaction included uncertainty and ambiguity about the treatment of patients, lack of an open and democratic structure to enhance problem-solving and communication, and lack of attention paid to the changing situation (Landeweerd & Boumans, 1988). Studies also have looked at job satisfaction in an attempt to find ways of attracting and retaining nurses. Positive influences included adequate nurse-patient ratios to assure quality care, a strong supportive nursing administration, open communication in all directions, and good nurse-physician professional relationships (Helmer & McKnight, 1989).

The purpose of this descriptive study was to illuminate an idiographic body of knowledge that describes support in relation to the needs of individual staff nurses (Guba & Lincoln, 1982). In idiographic interpretation, realities are multiple and different, with the findings to some extent dependent upon the particular interaction between the researcher and the participants (Guba & Lincoln, 1982). Caution, therefore, should be exercised in applying these findings to other settings. This study does, however, enhance the existing knowledge about staff nurse support needs and could act as a guide for future research. The fact that staff nurses have different needs for support means that nurse administrators should plan carefully when making support available. Future research on the subject should employ a methodology which allows support to be viewed or measured from a unique and dynamic perspective.

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Homeless Persons Communicate their Meaning of Health

Dianne McCormack and Sister Barbara Anne Gooding

Une étude qualitative utilisant un échantillon de commodité de 29 personnes a été faite pour évaluer ce que les sans-abri entendent par le concept de santé. L'analyse a révélé que les sans-abri ont deux conceptions différentes de la santé : les caractéristiques décrivant la santé et une vue d'ensemble de la santé exprimée dans diverses combinaisons des dimensions de la santé. Un total de 10 caractéristiques décrivant l'essence de la santé ont été établies : satisfaire les besoins élémentaires de la personne, ne pas avoir de raisons de se plaindre liées à une maladie, faire l'effort de se maintenir en bonne santé, remplir un rôle fonctionnel, avoir une image de soi et une apparence positives, être en forme, avoir un réseau de soutien, s'abstenir de prendre des drogues, avoir une bonne hygiène et structurer sa journée. Quatre perceptions distinctes de la santé se sont révélées : les dimensions exclusivement physiques de la santé, les dimensions physiques et mentales/émotionnelles de la santé considérées séparément, les dimensions physiques et mentales/émotionnelles de la santé coexistantes, et la santé en tant que processus multidimensionnel de bien-être. Les répondants ont également indiqué que des événements graves associés à des sentiments de perte ont précédé leur état de sans-abri. En général, les répondants de cette étude se considéraient comme étant en bonne santé.

A qualitative study that utilized a convenience sample of 29 individuals was conducted to uncover the meaning of health as it is experienced by homeless persons. Analysis revealed that homeless persons have two distinct conceptions of health: the characteristics that describe health, and a comprehensive view of the totality of health expressed in different combinations of health dimensions. A total of 10 characteristics that described the essence of health were identified: satisfying basic human needs, having no illness-related complaints, doing the work of health, fulfilling a functional role, having a positive self-image and outlook, being fit, having a support network, eschewing the use of addictive drugs, having good hygiene, and structuring the day. Four distinct perceptions of health were revealed: physical dimensions of health exclusively, physical and mental/emotional dimensions of health considered separately, physical and mental/emotional dimensions of health coexistent, and health as a multidimensional process of well-being. Respondents also indicated that acute life events associated with feelings of loss preceded their state of homelessness. Generally, the respondents in this study considered themselves to be healthy.

Since the beginning of towns and cities people have been displaced from their homes for a variety of reasons, such as health and economic problems. It was believed that these homeless persons were mostly middle aged and elderly men who had demonstrated insufficient efforts on their own behalf and chosen this way of life.

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Homeless people tended to congregate for mutual acceptance of appearance and conduct that were otherwise not tolerated (Brickner, 1985). Mainstream society ignored the plight of these individuals even though their poor socioeconomic status adversely influenced health.

The recent dramatic increase in the number of homeless people, the heterogeneity of this population, and the inclusion of children has made homelessness more difficult for mainstream society to ignore. Nevertheless, the gap between these people and other societal groups has not diminished. Even health care providers who are trying to assist homeless individuals to promote their health have limited empirical evidence to describe this population and the meaning of health to them.

Literature Review

In the United States, studies have estimated the annual rate of increase in homelessness to be 20-25% (Axelson & Dail, 1988; Francis, 1987). A survey conducted in Canada in 1987 estimated that more than 100,000 Canadians were homeless, and this number was expected to increase (McLaughlin, 1987). Further, it confirmed that homelessness in Canada was not limited to unemployed, middle aged, and elderly men, but included women, children, runaway youths, young adults and families. The heterogeneity of this population could no longer be ignored or disputed.

Health is related to socioeconomic status and is influenced by poverty, inadequate housing, and unemployment (Colantonio, 1988; Drennan & Stearn, 1986; Epp, 1987; Siler-Wells, 1988; Vladeck, 1991). The adverse effects of homelessness on health in relation to illness and disease have been well documented in the literature (Bowdler & Barrell, 1987; Boyer, 1986; Brickner, 1987; Damrosch & Strasser, 1988; Fischer, Shapiro, Breakey, Anthony & Kramer, 1986; Friedman, 1983; Kelly, 1985; Lenehan, McInnis, O'Donnell & Hennessey, 1985; Lindsey, 1989; Lovell, 1986; Pearson, 1988; Robertson & Cousineau, 1986; Ryder, 1982; Selby, 1985; Woolley, 1985; Young, 1985). Phillips (1985) stated that the perinatal mortality rate among unskilled workers was twice as high as that among professional couples. It would be expected that the perinatal mortality rate of babies born to homeless persons would be even higher.

Health problems of the homeless have been identified and categorized (Bassuk, Rubin & Lauriat, 1986; Drennan & Stearn, 1986; Maurin, Russell & Memmott, 1989; Mealey, 1981; Sebastien, 1985; Thompson, 1986; Wadsworth, 1984). The self-reported health status of homeless people has also been documented (Bowdler & Barrell, 1987; Fischer *et al.*, 1986; Robertson & Cousineau, 1986); as has their limited access to health care (Burke-Masters, 1986; Lenehan *et al.*, 1985; Lewis,

1986; Lovell, 1986; Young, 1985); and the difficulties they encounter when attempting to adhere to medical regimens (Maurin *et al.*, 1989; Slavinsky & Cousins, 1982; Strasser, 1978). It has also been reported that their vulnerability to disease is magnified by their lack of protection from the elements, their inadequate sleeping accommodations, and the alienation of life on the streets (Brickner, 1985; Lindsey, 1989; Sebastian, 1985).

Various nursing interventions have been attempted to promote the health of homeless clients, including assisting them to access available resources, and developing health education programs to promote their self-care (Atkinson, 1987; Lenehan *et al.*, 1985; Malloy, Christ & Hohloch, 1990; Marquis, 1986; Pearson, 1988; Young, 1985). Since the individual's conception of health influences the adopting of health-promoting behaviours (Baumann, 1961; Colantonio, 1988; Laffrey, 1985a; Way, 1990), it is important to understand what that conception is.

The authors found only one study that addressed this subject. In 1978, Strasser studied 34 homeless women to learn how they viewed their health. It was discovered that health was attributed to independence and related to the individual's resources and knowledge. These women expressed their beliefs about health through discussing illness, "...what caused illness, what prevented it, and how to take care of it" (p. 2079). Causes of illness were linked to dependence and events that they could not control.

Method

Purpose

The purpose of the current study was to investigate the meaning of health as it is experienced by homeless persons. Three factors prompted the decision to conduct this study: (a) Canadian policy makers have stated that the health inequities between people of different economic status must be reduced and self-care and individual responsibility for health maintenance promoted (Epp, 1986). (b) The increasing homeless population in Canada is highly susceptible to health deficits (Siler-Wells, 1988). (c) The concept of health is central to nursing, yet nurses have limited empirical knowledge of the meaning of health to homeless persons.

Research Questions

The following research questions were explored:

- 1) How do homeless persons perceive the meaning of health?
- 2) How do homeless persons perceive their own health status?

Design

This qualitative study followed a phenomenological approach which examines the underlying structure of a particular phenomenon (in this case, health) as it is experienced by respondents in the context of their environment. In this way the implicit experience of health can be made explicit. Respondents communicated their lived experiences concerning the phenomenon of health.

Procedure

The researcher gained entry into three facilities that offered homeless individuals overnight accommodations and a meal service, and a fourth facility that offered a meal service only. The director of each facility provided a private area for interviewing, and asked the program coordinator to select potential participants and introduce the researcher to them.

The inclusion criteria specified that all participants would: (a) speak functional English; (b) be at least 16 years of age, the age at which children do not require parental consent for medical treatment in the province of Ontario; (c) be able to articulate their experiences; and (d) agree to a tape recorded interview. Program coordinators were guided by these criteria. Thus a sample of convenience evolved. Participants readily agreed to be interviewed, and some were anxious to volunteer.

The guided interview technique employing open-ended questions was used to focus on the interview so that the information collected was relevant to the research questions or useful in describing the sample. The effectiveness of the interview guide in eliciting appropriate information was verified in a pilot study comprised of eight respondents. Immediately following each interview, the researcher tape recorded all personal observations and inferences. All recordings were subsequently transcribed verbatim. These transcripts constituted the data base.

Categories were inductively derived from the data to describe the essence of health as it was reported by the respondents. Each respondent was identified as a unit of analysis and could only be coded into a given category once even if they repeatedly described the same category. Therefore, the total possible score for any one category was 29, the total number of respondents. This initial examination led to the unfolding of the characteristics of the phenomenon. To ascertain whether the

categories were mutually exclusive, random portions of the data were coded by two independent coders. Where difference occurred between coders, the categories were more precisely defined.

When the boundaries of the characteristics of health were examined, general perceptions of health were revealed. This, in turn, led to a more thorough examination of the characteristics of health, the internal relationships, and the specific features of each. Only features that further developed the meaning of a characteristic were included.

Subsequent examination of the data more precisely defined the characteristics of the phenomenon and confirmed that respondents had also revealed their perceptions of the totality of health. Distinct perceptions of health emerged from the data. The meaning of health as experienced by these respondents could now be understood and articulated. Random portions of the data were coded by two independent coders to determine the extent of agreement; the inter-rater reliability was 0.90.

Sample

The target population included all homeless persons living in a non-industrial city in the province of Ontario with a population of 600,000. The accessible population was comprised of those homeless persons who utilized shelters and hostels as a place to rest or to obtain food. All participating facilities were located within the central core of the city.

Twenty male and 10 female respondents were interviewed, a ratio in keeping with the gender composition of the homeless population reported in other studies (Robertson & Cousineau, 1986; Sergi, Murray & Cotanch, 1989). One interview with a female respondent was excluded from analysis because of inconsistencies in her response. During data collection four interviews were terminated by the researcher: one respondent refused to be tape recorded, two did not speak functional English, and one was agitated and unable to concentrate.

Results

Sample Characteristics

The age range of respondents was 18 to 62 years and the education profiles disclosed that two people had no high school education, 11 had some, and 15 had graduated from high school. Of these 15, nine had some post secondary education

and four were graduates of a post secondary course of study. One respondent did not relate level of education. These figures for age distribution and education are in agreement with results from other studies of the homeless (Axelson & Dial, 1988; Kelly, 1985; Malloy *et al.*, 1990; Maurin *et al.*, 1989).

Results indicate that the length of time respondents spent in shelters or without permanent accommodations was related to gender. For female respondents the amount of time spent in shelters ranged from 1 week to 3 years, and for male respondents, 3 weeks to 35 years. One other study also reported that women had been homeless for a shorter period of time than had men (Maurin *et al.*, 1989).

As in other studies of the homeless population (Cohen, Teresi, Holmes & Roth, 1988; Maurin *et al.*, 1989), this study also demonstrated that most homeless persons had worked. All respondents except one woman had work experience. The number of years worked ranged from zero to 29 years for females, and 3.5 months to 45 years for males.

According to Canadian voting regulations, individuals who live in the same geographic location for one year or longer are considered residents. Since society assumes that homeless people are transient, the geographic mobility of respondents is of interest. Twenty of the respondents (69%) had been living in the same geographic location for one year or longer and could not be considered transients. This finding is also in keeping with that of other studies (Action Consulting, 1987; Bassuk *et al.* 1986; Francis, 1987; Fischer *et al.* 1986; McGrath, 1986; Slavinsky & Cousins, 1982).

The Meaning of Health

In response to the first research question, regarding how homeless persons perceive the meaning of health, two distinct conceptions of health evolved from the respondents' descriptions: (a) the characteristics that describe the phenomenon, and (b) a comprehensive totality of the phenomenon expressed through various combinations of health dimensions.

Characteristics of health

Ten core characteristics of health were inductively derived from the data. Each contained related features that put forth the same notion of health. Three other features that were unrelated but strongly emphasized were included in the analysis as "other." The characteristics are presented in order of most to least commonly described.

Satisfying basic human needs. In their descriptions, 23 respondents related that “satisfying basic human needs” is essential to health. These needs include sufficient food, a place to rest, and a permanent shelter.

Being healthy is...to have, basically what you feel as a comfortable home or a place to rest. Sufficient, not an abundant amount of food. (R10, male)

Being healthy....for you to *get all* your vitamins, get your proper sleep, and all your nutrients. (P1, male)

Having no illness-related complaints. This characteristic, referred to by 23 respondents, included freedom from illness and medical treatment. Illness encompassed symptomatic or asymptomatic chronic and acute ailments. Treatment was described as either the continued use of medication or hospitalization.

Being healthy....not being ill. (R21, male)

A lot of people my age are, are not [healthy] you know. They're on medication every day of the week. (R14, male)

Doing the work of health. Twenty respondents referred to the work of health as promoting health and preventing health deficits. They spoke of taking care of themselves and assuming responsibility for, and participating in, the development of their own health.

Health means...you have to be careful about yourself, and you have to be considerate about yourself, and you have to know what is good for you and what is bad for you. And avoid the bad things and,...try to achieve the good things. (R15, female)

No, I'm not healthy....I'm not looking after myself and I'm not taking my medication. (R1, male)

Fulfilling a functional role. Nineteen respondents linked productive working and doing with health. They described the ability to work and/or the capacity to function in society as influencing health.

Well, being healthy, you are able to get up and go to work and do whatever you want to do and get out. (P6, male)

Being healthy?...Being a functioning part of society. (R3, male)

Having a positive self-image and outlook. Nineteen respondents indicated that feeling good about oneself, having control over one's activities, and receiving recognition from others contribute to health. Features of this characteristic included having self-esteem, a sense of control over stressful events that could create worry and tension, a positive outlook on life, self-confidence, and pride in accomplishments.

But to be healthy...I feel that you have to feel very good about yourself. Number one, be happy. You cannot be down on yourself. (R11, female)

Being healthy means...if you need something, you have the means and the ways to get it, without going through a big hassle....you have the means to change something that is doing you harm....there's something that starting to affect you, you can't change it because you have no means of changing it. (R9, male)

But it means a lot to me...To have my health back, ...and do the things that I can do....I can do it....and I'm proud of myself. (R5, male)

Being fit. Seventeen respondents connected health with being physiologically stable and physically fit without speaking of the work required to attain and maintain fitness. Physical fitness, physiological stability, the importance of regulated body weight, and quick recovery from infection were described.

'Cause my heart is strong and I got [sic] a good pulse and I breathe OK....I can work all day and I can work hard....my heart rate doesn't increase that much. And I don't get dizzy or light headed when I do a lot of heavy lifting or stuff like that. That's how I see myself, as pretty healthy. (R3, male)

I must be fairly healthy because I was sick with the flu last night and I'm up and around again today. So I must be in good shape. (P5, male)

...lost over ten pounds in one week. That's not healthy. (R17, female)

Having a support network. Eleven respondents indicated that "having a support network" contributes to health, or not having a support network adversely affects health. Respondents' feelings of self-worth and belonging were fostered by nurturing relationships with friends and family.

If you were married, a close family, immediate, that's healthy. If you're single, having good friends is healthy. (R9, male)

...I had to rely on myself too much and I wasn't ready to be independent. I wanted to be dependent on somebody but that somebody was me...emotionally, it screwed me up. (R3, male)

Eschewing the use of addictive drugs. Abstinence from addictive substances was considered a requirement for health by 10 of the respondents. They denounced the use of chemically addictive substances that lead to adverse effects on health, including the smoking of tobacco products, and the use of non-prescription drugs and alcohol.

...being free of this nicotine, would be healthy for me. (R2, male)

...made me more susceptible to disease. Alcohol and drugs do weaken you very much....malnutrition, I wouldn't eat when I was drinkin'. (R7, male)

Having good hygiene. Nine respondents referred to this characteristic of health, identifying the features of personal cleanliness and sanitary conditions in the environment.

Well, have a clean home to come in [*sic*], have clean clothes and everything like that....You gotta [*sic*] be clean. No dirt. (R1, male)

Structuring the day. Nine respondents described the observing of routines and the planning of daily activities as being important to health. Having structure in the day gave respondents a sense of direction and control in their lives.

You have to live every day....You got to have a plan and...it works out....You got to have direction of what you're going to do. (R4, male)

They know a basic routine...gives them their diet....When they leave the shelter at seven-thirty in the morning, they'll go...to the churches and things....They have their walk routine. (R10, male)

"Other" characteristic. Additional features of health that were reported and emphasized by up to three respondents included compliance with prescribed treatment, negotiating access to health services, and being motivated.

And that's why a lot of times these people that are in the hostels here are always down-and-out on their luck. They're unhealthy

because they...can't afford the proper medicine or the proper diets. (R12, male)

First I start getting diarrhea, then I start throwing up, and its my nerves. And I know its my nerves. And if you go to a doctor, a GP, anywhere; they're gonna tell you it's your nerves and that's all they're gonna do for you. See your shrink; and your shrink says go to a GP. (R17, female)

You got to get motivated....If anyone around here takes sick...you got to get motivated....Do things...even if its little things. (R5, male)

Perceptions of Health: A Synthesis of Health Dimensions

The second conception of health to evolve described respondents' perceptions of the totality of health. These were derived from four different combinations of the following health dimensions: physical, mental, emotional, spiritual, social, and environmental (Figure 1).

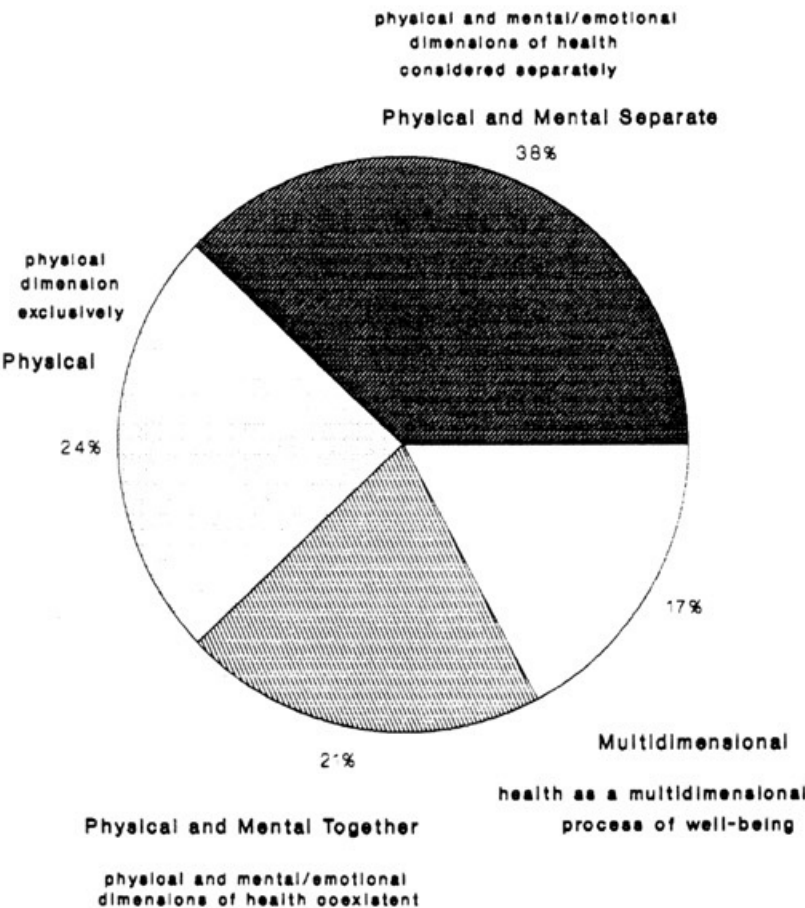


Figure 1: Respondents' perceptions of health.

Physical dimension of health exclusively. Seven respondents directly related health to the physical body. Health was linked to ability to engage in activities that require either strength or endurance to do physical work, fight and/or participate in sporting events. Respondents identified the physical perception of health by referring to images of famous personalities.

...gettin' strong and being strong. The first man that came into my mind was Arnold Schwarzenegger. Muscle man, see. I think that's healthy. (R2, male)

A healthy person like an athlete. Very healthful, eating the proper diet of food....maintaining their body, keepin' good, exercising all the time. (R12, male)

Separate physical and mental/emotional dimensions of health. Reported by 11 respondents, this is the perception most often disclosed. Consistent with the traditional reductionist view that health has two separate realities, respondents described physical and mental/emotional health as two independent dimensions of health. Health was assessed by examining each dimension separately. One could be either healthy or unhealthy, in one or both dimensions, at any given time.

...physical health is the most important health for most people, that's my opinion. And your mental health has to be in shape too. I've got the mental health, I think. The physical part, I haven't got too much going for me that way. (P3, male)

Not physically...not emotionally. But I tend to think the emotional thing is a time factor. You know, with time I'll be OK. My physical health, I worry about that a lot. (R22, female)

Coexistent physical and mental dimensions of health. Six respondents communicated that the physical and mental/emotional dimensions of health are interdependent and together comprise the health phenomenon. When either the physical or the mental/emotional dimension is challenged or further developed, health is influenced.

...there's your physical health and your mental health. That's what comes in my mind...one goes hand in hand with the other. If you're not physically well, sometimes it plays on your mental health....They both go together, cause if you allow yourself to go down physically, your mental health is not going to be good. (R11, female)

I think you can't be physically healthy if you're not mentally healthy. Just as you can't be mentally healthy if you are not physically healthy....They're just tangled in there together. (R17, female)

Multidimensional process of health and well-being. Five respondents related this perception of health. Health included many coexisting dimensions that contribute to the phenomenon in its entirety. This perception encompassed the notion of general well-being that emerges from the totality of life processes.

There's a lot of different healths. Health is not just physical. It's emotional, spiritual, it's, you know, it's what's around you. (R3, male)

Additional Findings

Other findings that relate to health emerged when respondents related why it was necessary for them to leave permanent living arrangements. They indicated that the homeless state had been created by having no place to go, being unemployed, experiencing family difficulties, participating in substance abuse, being evicted from affordable housing, having health deficits, and/or dealing with wanderlust. These responses are consistent with what has been reported in other studies (Bassuk, 1984; Boyer, 1986; Damrosch & Strasser, 1988; Damrosch, Sullivan, Scholler & Gaines, 1988; Fischer *et al.*, 1986; Francis, 1987; Friedman, 1983; Hodnicki, 1990; Malloy *et al.*, 1990; McDonald, 1986; Reuler, Bax & Sampson, 1986; Rosenthal, 1989; Roth, Bean & Hyde 1986).

Further examination of the data revealed that in 79% of all interviews, homelessness was preceded by the occurrence of an acute life event such as marriage breakdown, death of a parent or spouse, unemployment, business collapse, the necessity of placing a child for adoption, impaired body function, relocation or abuse. Many respondents had several acute life events occur simultaneously, and several related that ineffective coping strategies had prevented them from effectively dealing with these events.

...emotionally I'm not equipped with very good coping skills for dealing with a rough situation. (R19, female)

What upsets me is that I'm handling that, and I'm handling everything else that is happening in my life. But when upcoming pressures come, I've got no room to handle it. (R13, female)

Personal Assessments of Health

In response to the second research question, regarding how homeless persons rate their own health status, 76% of the respondents considered themselves to be healthy; 14% unhealthy; and 7% both healthy and unhealthy; and 3% did not answer. Results were similar when the data were separated by gender (Figure 2). The two respondents claiming to be both healthy and unhealthy viewed physical and mental/emotional dimensions of health as being separate, perceiving themselves to be physically healthy but mentally unhealthy.

The findings of this study do not concur with previous reports that 30 to 39% of homeless adults perceived their health status as being poor (Bowdler & Barrell, 1987; Fischer *et al.*, 1986; Robertson & Cousineau, 1986). In the current study several of the respondents with chronic illnesses and/or disabilities perceived themselves as healthy, indicating that their definition of health entailed more than the absence of disease. For them, the perceived assessment of health was a reflection of the individual's conception of health.

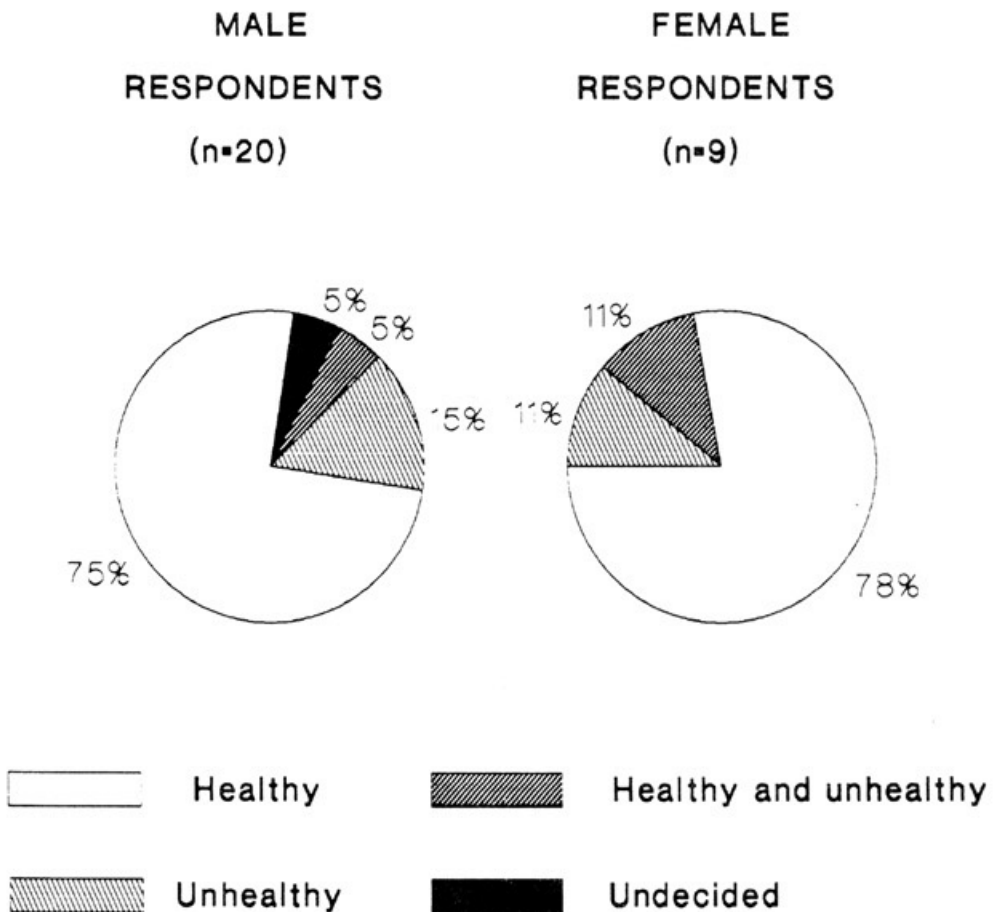


Figure 2: Self assessment of health by homeless people.

Discussion and Nursing Implications

One of the primary concerns or goals of nursing is to assist clients in attaining, maintaining or regaining health (Schlotfeldt, 1972). Nurses have a responsibility to identify the health challenges that a community, family or individual may be experiencing, and assist clients in developing effective coping strategies.

The literature indicates that nurses should address the challenge of making health care accessible to the homeless population (Abdellah, Chamberlain & Levine, 1986; Atkinson, 1987; Lenehan *et al.*, 1985; Marquis, 1986; Pearson, 1988; Sebastian, 1985; Young, 1985). Homeless people encounter difficulties when attempting to gain access to health care (Bowdler & Barrell, 1987; Burke-Master, 1986; Lenehan *et al.*, 1985; Lewis, 1986; Lovell, 1986; Young, 1985). In Canada, a country with a national health insurance plan, this difficulty is often related to lack of acceptance by health care providers.

Homelessness arises from complex precipitating factors that may be related to an inability to cope with acute life events. This is essential information for nurses who work with homeless individuals. Understanding the precipitating events that lead to homelessness and recognizing the barriers that prevent reentry into mainstream society will help nurses to develop innovative strategies for coping. This would subsequently increase the effectiveness of nursing interventions and help nurses and other health care providers to overcome their own reluctance to work with homeless persons.

Koegel (1992) had noted that homeless persons have negative attitudes towards traditional health care delivery services. The respondents in this study revealed that interventions that are not compatible with their lifestyle are difficult to observe. It is critical that health interventions be acceptable and appropriate. Furthermore, the characteristics of health identified by homeless people in this study indicate that they view health in much the same way as "housed" people do (Baumann, 1961; Colantonio, 1988). Since homelessness is usually a temporary state most homeless people have lived in homes and undergone a socialization process similar to that of mainstream society. Therefore, many of the nursing interventions developed to address the health needs of the homeless population will also be applicable to mainstream society and vice versa. As well, evidence from this and other studies indicates that homeless people are a part of the community in which they live, therefore, community programs must be developed to promote the health of this population.

The current analysis reveals that not all respondents cited the same characteristics of health, nor did they hold the same overall perception of health. This finding that perceptions of health are diverse is consistent with the literature (Baumann, 1961;

Colantonio, 1988; Keller, 1981; Laffrey, 1986; Morse, 1987; Payne, 1983; Smith, 1981; Tripp-Reimer, 1984; Woods, Laffrey, Duffy, Lentz, Mitchell, Taylor & Cowan, 1988).

In this analysis homeless persons combined the physical, mental-emotional, spiritual, social, and environmental health dimensions in unique ways to formulate four distinct perceptions of health. Conceptions of health are inherent in values and beliefs (Laffrey, 1985b; Parse, 1981), reinforce a specific world view, and influence many choices, including those concerning health.

Nurses who are aware that their clients' perceptions of health may differ from their own will focus on gaining an understanding of these differences. Only then can the nurse guide the client in the use of appropriate interventions to improve his/her health. Likewise, health programs that are designed to accommodate different perceptions of health may more effectively convey health information and meet the needs of diverse consumers. As Susser (1974) stated, the meaning of health depends on the person defining it. Therefore any definition of health should be concise, yet flexible enough that the whole and its integral parts can be understood.

Future Research Recommendations

Qualitative studies are needed to explore how health conceptions influence health behaviour. The results of these studies would impact upon the nurse-client relationship and influence how the business of nursing is conducted.

Secondly, the information from this study could be used to design an instrument for measuring health conceptions of homeless persons, which in turn could be used in a quantitative study of large sample size. This would help to establish a data base to describe current demographics and health related issues of the homeless population.

Lastly, this study indicates that acute life events may precipitate homelessness. Therefore, a qualitative study to investigate the underlying causes of homelessness is needed. The findings would guide nurses who are assisting people in learning to cope effectively with life experiences.

In conclusion, this study reflects the views of 29 homeless persons who accessed facilities for the homeless. All but one of the interviews were included in the analysis of these data. As Koegel (1992) pointed out, there is no reason to suspect that the information reported by homeless persons is any less accurate than that reported by "housed" people when responding to sensitive issues. The findings from this study are consistent with those found in the literature. However, observation and other

empirical evidence would further validate the meaning of health for homeless persons.

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Time and a Waning Moon: Seniors Describe the Meaning to Later Life

Gail J. Mitchell

Six cents Canadiens âgés ont écrit leur histoire sur ce que signifie pour eux être une personnes âgée. Les textes ont été analysés et on y a trouvé un style riche en comparaisons, en paradoxes et en humour. Deux genres de paradoxes ont été décrits : d'une part, la similitude et la différence ; d'autre part, la limitation et l'expansion. Les personnes âgées ont ainsi dévoilé le mystère de leurs expériences de vie. Elles ont employé trois aspects de l'humour pour éclairer les différentes façons de faire naître la force et la joie : l'humour personnel comme étant essentiel pour survivre et comme moyen d'éclairer les fragilités personnelles, et l'humour partagé comme catalyseur de la joie et de l'amusement.

Six hundred older Canadians wrote narratives about the meaning of being a senior. The narratives were analyzed and descriptions of simile, paradox, and humor were extracted. Two paradoxical experiences — sameness-yet-difference and restriction-yet-expansion — were described as seniors shared the mystery of later life. They specified three aspects of humor to shed light on human ways of creating strength and joy: personal humor as essential for survival and as a means of making light of personal frailties, and shared humor as a source of joy and entertainment.

The meanings that individuals assign to their personal experiences are uniquely structured and intimately linked with health and quality of life (Moch, 1989; Parse, 1981; Sarter, 1987). With such universal experiences as aging, there is also a horizon of shared meaning that when explicated can enhance the health care provider's understanding (Parse, 1992). Further, shared experience provides a background that gives sharper definition to the uniqueness of individual experience. In nursing, new understanding of the aging experience may enhance the nurse-person relationship and lead to innovative ways of promoting health with older persons.

There is mounting evidence in the literature that traditional research methods are limited when it comes to generating knowledge about the human process of aging and health in later life (Ainlay & Redfoot, 1982/83; Howard, 1987; Marshall, 1986; Nadelson, 1990). In addition, much of the research on aging has focused almost exclusively on deficits, problems, disabilities, and dysfunctions. Little is known about the meanings older persons give to their life situations, or how they create health and quality of life despite limitations or chronic ailments. Yet, this knowledge is essential for nurses who practice with older persons and their family members.

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The purpose of this article is to present findings from a secondary analysis of narratives, written by 600 older Canadians, about the meaning of being a senior. The original research project conducted by Mitchell (in press) followed the six operations of scientific explication as specified in van Kaam's (1966) phenomenological method: elicitation of descriptive expressions, identification of common elements, elimination of expressions not related to the phenomenon, formulation of a hypothetical definition of the phenomenon, application of the hypothetical definition to the original descriptions, and identification of the structural definition (Parse, Coyne, & Smith, 1985). Findings from the initial project revealed that seven common elements structured the aging experience for older Canadians (Mitchell, in press). These were discussed in relation to descriptive expressions from the narratives, Parse's theory of nursing, and the human-health interrelationship. The common elements shed light on aspects of shared meaning for seniors. The written narratives also contained other phenomena that helped enhance understanding of the meaning of being an older person. According to Polkinghorne (1988), narrative is a way of "meaning making and the drawing together of descriptions creates a higher order of meaning that discloses relationships" (p. 36). Three other meaning-laden phenomena were prevalent in the 600 narratives: simile, paradox, and humor. The meanings related to these phenomena were analyzed in the current paper.

The researcher was guided by Parse's (1981, 1987, 1992) nursing theory of human becoming. Parse specifies unique attributes of the human-health interrelationship that guide interpretation of findings from a nursing perspective. From Parse's perspective human beings are unitary, open, and in mutual process with the universe; they create unique patterns of relating and "freely choose ways of becoming as meaning is given to situations" (Parse, 1992, p. 37). Health is viewed as a process of becoming and as the way people live their daily lives. Interpretation of findings was guided by three themes contained in Parse's theoretical principles: "structuring meaning multidimensionally," "cocreating rhythmical patterns of relating," and "cotranscending with the possibles" (p. 37-38). The researcher believed that human beings assign meaning to life experiences, establish patterns of relating, and continuously move toward new possibles. The findings presented in the current paper specify what meanings, patterns, and possibles were described by older participants in simile, paradox, and humor.

Method

The quarterly newspaper, *Especially for Seniors*, published an invitation for the submission of original essays about the meaning of being a senior. Six hundred respondents, 65 years old or more, sent their 500-word (maximum) narratives to the Ontario Advisory Council on Senior Citizens. The invitation indicated that submissions would be viewed as consent, allowing the newspaper to "retain the rights to

future publications of submitted material” (Ontario Advisory Council on Aging, 1988, p. 1). Permission to analyze the essays was granted to the researcher by the Advisory Council. The essays were copied by the researcher with all names and addresses removed to protect confidentiality.

During the first analysis of the narratives, the researcher was struck by the prevalence of three phenomena: simile, paradox, and humor. This led to a second analysis of the 600 essays with the specific purpose of identifying and synthesizing descriptions of these phenomena. The method followed for the second analysis was to:

1. Identify descriptions - Each narrative was read to identify and extract passages that contained simile, paradox, and humor.
2. Identify themes - Similes, paradoxes, and descriptions of humor were grouped according to predominant theme.
3. Relate themes to experience - The themes were related to the unity of experience of being a senior as described in the 600 narratives.
4. Validate findings - The researcher consulted with an expert nurse researcher who validated theme construction based on participant descriptions.

The researcher focused on meeting the standards of qualitative inquiry outlined by Burns: “Standard I, descriptive vividness; Standard II, methodological congruence; Standard III, analytic preciseness; Standard IV, theoretical connectedness; and Standard V, heuristic relevance” (1988, p. 48). The findings were vividly described and themes linked to both the lived experience of later life and Parse’s nursing theory in order to advance the knowledge base of nursing. A second researcher verified themes and interpretation. Polkinghorne (1988) stated that when interpreting any qualitative data, “intersubjective consensus minimizes the likelihood of arbitrariness or...falsity of interpretation” (p. 116).

For the purpose of this study, simile, paradox, and humor were defined, as follows. Simile is a figure of speech comparing two unlike things that is often, but not necessarily, introduced by “like” or “as.” For example: Life is like a roller coaster of ups and downs. Similes link ideas that have a common element in such a way that the newly established commonality enhances understanding of meaning (Nimis, 1988). Simile prompts a pause and a reflection upon the meaning of a particular phenomenon.

Paradox is the coexistence of contradictory ideas, thoughts, or feelings. Defined by Parse as “apparent opposites” that actually comprise different aspects of the same rhythm (1992, p. 38), paradox conveys meaning about the complexity of life and

the process of shifting views in day to day living. For example, a person might express both feelings of joy and feelings of sadness related to a given situation. Paradox has been linked to health in later life (Gadow, 1983; Jonas, 1992; Mitchell, 1990; Wondolowski & Davis, 1988).

Humor is a disposition, temperament, quality, and state. It has been identified as an important aspect of health and healing (Buxman, 1991; Cousins, 1979; Nahemow, McClusky-Fawcett, & McGhee, 1986; Rose, 1990; Ruxton, 1988) that is personal and contextual, and often brings a change of perspective to a serious or difficult situation (Montagu, 1981; Parse, 1990; Rose, 1990; Wagnild & Young, 1990). The meaning of a humorous situation sheds light on a person's situation in ways that can change health experiences.

Findings

Of the 600 narratives analyzed, approximately 300 were submitted by women and 200 by men (not all persons indicated their gender). Findings reported here are based on a total of 100 similes, 73 uses of paradox, and 60 illustrations of humor. The similes were grouped according to six themes; two patterns of paradox and three aspects of humor were also uncovered.

Themes Expressed in Simile

Approximately 100 older persons used simile to describe the meaning of being a senior. Similes were grouped according to six predominant themes. The first theme compared life to travelling or journeying. Later life was described as both the last lap of the road and as a new pathway of discovery. Struggles and hardships were likened to potholes and detours.

We are like travellers in time, enjoying the wonder of three worlds.
We can choose to retreat into a safe, secure memory world of the past, or plunge boldly into the challenging world of the future. Or, within microseconds we can choose to touch the peaks of both worlds while living life to the fullest in each moment of time.

Travelling across miles of life, there comes a time when some would say we have reached the finish line.

The second theme compared later life with a wearing down or diminishing. People wrote about feeling that life was shrinking, winding down, or coming to an end:

Being a senior means a diminishing. It is something like a waning moon, pinch-faced and pressed against the night sky. But now, the shadowed light pulls inward all the edges and every form seems hunched for a diminishing.

Your face and body start falling and looking like a prune.

The third group of similes related to color, rainbows, and light. Respondents described later life as vividly colorful and referred to themselves as beacons of light for others.

Being a senior is as colorful and glowing as the weathered maple standing stalwart and majestically attired in a rainbow of autumn colors.

Being a senior is like a coat of many colors, being coated with many characteristics and qualities like knowledge, experience, and wisdom gathered through the years.

Freedom, flight or sudden release was the theme of the fourth grouping of similes. Older persons used descriptions like spreading their wings, having shackles severed, and being freed from responsibilities and timetables.

Being a senior means to be free, like an eagle soaring high in the sky.

Time, that old ogre that bossed your life, is now a servant of yours to command.

The fifth group of similes compared later life with aspects of nature—harvest time, winter, or sunset—and respondents compared themselves to flowers, rivers, snowflakes, trees, and gardens.

The flower signifies our growth and maturity. By the time we have experienced the sun, wind, rain, and storms in the varied events of our lives. The seeds that ripen and spread are like an image of the way in which seniors can share knowledge.

Days seem to hasten like the autumn leaves driven in the fall breeze. Leaves like the seniors, once lush and green and full of vigor, now brown and wrinkled, are free to blow in the gutters or to be piled up in refuse heaps.

Some seniors compared themselves to works of art, with wrinkles as marks of a long and meaningful life. For example:

We are all different pictures in the gallery that life has painted. Painted as a creative, independent, and viable loner or collaborator.

A senior is a work of art, roughed in by all the past ages and specifically and intimately etched by the acids of the twentieth century.

The Use of Paradox

In this analysis, 73 narratives related paradoxical experiences. Of these, sameness-yet-difference was the most common theme. People reported no change or difference in themselves, yet at the same time, saw change and difference:

I am still the same person, with the same need to love, feel needed and useful. But, I've also changed. Memory plays embarrassing tricks, but this is outweighed by greater experience and mature judgement.

The odd aches and pains in the knees slightly confirm my age; the fear of falling substantiates it. Strangely, one doesn't feel different inside; one cares for the same things and people, and looks at the world much the same way. Perhaps one has gained a little wisdom. I think it is the mirror that finally gives credence to the fact that one is a senior.

Restriction-yet-expansion was a second paradoxical theme. People saw themselves as living with limitations while simultaneously seeing self or situations as expanding. The following excerpts capture the restricting-expanding paradox:

Being a senior has its drawbacks, its ups and downs, its limitations. But there are compensations that far outweigh the negative side. Every day is a renewal, a challenge. I came to the conclusion that, in a monetary sense, I have nothing. But in the love and consideration of my beautiful family, I would say, yes, I have everything.

Being a senior is bittersweet. The gradual leave-taking from the familiar details of one's professional life, all the while wondering. There is also anticipation and a sense of exhilaration that comes with looking forward to doing so many things that have been put on the back burner over the years.

The Use of Humor

Sixty essays contained specific references to the experience, quality or need of humor or laughter. Three different aspects of humor in life were identified. First, humor was described as important or essential for survival. For example, elders wrote:

My sense of humor is still there. I need it more these days I find, especially since I'm gray.

The aging process covers a lot of disagreeable problems, but a certain long term philosophy and a sense of humor help a great deal.

I enjoy my life and find that an open mind and a sense of humor help.

The second aspect of humor described laughing at self and personal frailties. For example:

And how uplifting when we laugh at our frailties and the stages we go through. Memory seems a problem, but we laugh it off and say join the club.

Seniors do not need to save face, they have learned to laugh at themselves.

Rocking with laughter at missing a street.

The third aspect of humor related to the joy of sharing humor and laughter with others. The following excerpts are typical:

The time I squeezed Nivea face cream to brush my teeth gave me a jolt. I rushed to the phone to share this one with my sister-in-law. It was worth the long-distance call to hear her hardy Har! Har!

I have raised four children and when we are together we are all young and age is no factor. We laugh a lot together and enjoy each other.

To be still good friends with my husband so we can talk and laugh together at bits of nonsense.

Discussion

Similes in the 600 narratives examined here, linked the meaning of later life to journeying, diminishing, color and light, release and freedom, seasons and trees, and the artful making of wrinkles. Taken as a whole they convey the depth of meaning given to old age.

The simile is a literary device that has been used for centuries by philosophers and poets to describe the aging experience. Aristotle claimed that metaphors and similes allow people to grasp fresh ideas and to communicate meanings that are difficult to put into words (Nimis, 1988). Socrates referred to older persons as having travelled a road that all must journey, and suggested asking elders to describe whether the road was easy and smooth or rough and difficult (Plato, 1968). Many other authors and poets have capitalized on simile to stretch thinking about the aging experience. Consider the following poem, *The Coming of Wisdom with Time*, by Yeats (1951):

Though leaves are many, the root is one;
Through all the lying days of my youth
I swayed my leaves and flowers in the sun;
Now I may wither into the truth.

Poets have compared older persons to sturdy oaks (Sarton, 1974), and aging knees to twisted old thorn trees (Yeats, 1962). Old age has often been compared to an uphill climb, sunsets, winter, and the harvest of life (see for example Rossetti, 1962; Shakespeare, 1932; Taylor, 1937). Sohngen and Smith (1978) noted that most poets who use similes perpetuate a negative view of later life. The similes contained in the 600 narratives analyzed here did not overwhelmingly illuminate life's thorns, warning signs, diminishings, uncertainties, fears, and finish lines. On the whole they were connected to strength, courage, discovery, wisdom, freedom, and reward. Few narratives presented only one side of the aging experience. Consider the following:

I am travelling down the last lap of the road of life with a smile and a song.... This intrepid traveller scans the territory, uncertain and fearful, yet eager too. The shoes are made for adventuring, as tough and comfortable as the character who wears them. The jacket is light but warm, made of tenderness and caring. The outfit is completed with a jaunty cap of courage. On one arm hangs the umbrella of hope to protect in stormy weather. A walking cane made of determination and perseverance gives strength There are some aches and pains. The legs are not as strong. The road seems to be winding uphill. More rests are required. Some of the companions have fallen by the wayside. Others have gone on ahead.

The journey becomes onerous as the traveller leans more and more heavily on the cane. A steady rain begins to fall. Up goes the umbrella, bringing fresh hope. The cap is tilted, to let more courage reach the walker.

The meaning that older persons give to their experiences in later life is often revealed in simile. Meaning shapes and is shaped by the individual's perspective and way of viewing self and the world (Parse, 1981). Parse suggests that people, "continually cocreate reality through assigning meaning to multidimensional experiences that occur all at once (1981, p. 42). For example, there are unique perspectives on the significance of facial wrinkles. For some, wrinkles signified a shrinking, and for others they represented the creation of art. Sarton (1984), who equated wrinkles and wisdom, wrote that, "A face without lines, that shows no marks of what has been lived through in a long life, suggests something unlived and empty" (p. 61). Campbell (1962) wrote, "As a white candle / in a holy place, / so is the beauty / of an aged face" (p. 1148).

The two paradoxical rhythms uncovered in the 600 narratives shed light on the complex nature of the older persons' relating with the world. The paradoxical pattern of feeling the same, yet different is especially critical for understanding lived experience in later years. Older persons are frequently judged and labelled by the way they look rather than according to their beliefs and perspectives about who they are. Cowley (1980) captured this prejudice when he stated, "We start by growing old in other peoples' eyes, and then slowly we come to share this judgement" (p. 5). The older persons in this study indicated a timeless sense of self, yet also described agreeable and disagreeable changes that contributed to a continuously changing process of growth.

The phenomenon of feeling the same while changing with age has been described elsewhere. Sarton (1984), in her journal at 70 years of age, made repeated references to not feeling like her age. She wrote, "One thing is certain and I have always known it - the joys of my life have nothing to do with age. They do not change...flowers, the morning and evening light, music, poetry, silence" (1984, p. 17). Kaufman (1986) an anthropologist, also reported on the "ageless self" from her research with 60 elders who were more than 70 years of age. Although Kaufman focused on the ageless self, the other side of the paradox was clearly present in participant descriptions. Kaufman stressed the importance of continuity and suggested that there is less "becoming" in later years.

It is suggested from the current study that the complex rhythm of feeling the same yet different does not mean less becoming. Indeed, the complex nature of the rhythm may indicate movement toward increasing diversity and people may simultaneously live at multiple realms of the universe (Parse 1981, 1992). Scott-Maxwell wrote,

"Life has changed me greatly, it has improved me greatly, but it has also left me practically the same" (1968, p. 17-18). In the current study older individuals felt timeless, ageless, and unchanging in one realm, yet they described disagreeable changes in appearance and despairing limitations. Still other realms revealed discoveries, comforts, surprises, and growth. As noted earlier, numerous nursing studies have addressed the limitations of later life, and ignored the paradoxical expansions and opportunities. In the current study, the restricting-expanding experiences referred to the many limitations and opportunities described by older persons. Amidst the aches, pains and memory lapses, and failing eyesight and hearing, respondents described many freedoms, challenges, discoveries, and wonders in later life. Mitchell (1990) and Jonas (1992) both described a paradoxical rhythm of lived experience in old age that was very similar to the restricting-expanding one uncovered here. Older persons in Mitchell's study described the meaning of taking life day by day; one of its core concepts was "glimpsing a diminishing now amidst expanding possibles" (Mitchell, 1990, p. 32). The elderly individuals experienced many restrictions and hardships in later life, but they also envisioned expanding horizons and opportunities for growth, learning, and change. Similarly, Jonas (1992) described restrictions that prevented 45 Nepalese elders from working in the fields, but with the restricted activities came new opportunities to help others and be respected for wisdom. Wondolowski and Davis (1988) explored the aging experience with 100 older persons and described a concept called creative transfiguring that related to a frailty-vitality paradox. Gadow (1983) also elaborated on the frailty-vitality paradox in later life, maintaining that to view only frailty distorts the perspective of aging.

In the current study humor was found to enhance life, change perspectives, and foster joy with others. These findings are consistent with several other authors' works (Montagu, 1981; Nahemow, 1986; Parse, 1990; Rose, 1990). Montagu (1981) claimed that humor broadens one's outlook, and that the ability to laugh at oneself is a more important and powerful capacity than the ability to laugh at others. Older persons in the current study wrote about laughing at one's self, and at the trials and tribulations of life, honoring the past with a laugh, chasing tears with humor, and having the freedom to develop a stronger sense of humor. Ruxton (1988) quoted a woman living with cancer as stating, "through humor I have found freedom. Freedom to be honest, to take risks, to live one day at a time" (p. 60).

Nahemow (1986) referred to humor as a defining human attribute. She elaborated on the humor that emerges from incongruities or discrepancy between what is expected and what is found. This aspect of humor, which happens when persons see two sides of a situation simultaneously, is said to be, "more complex but less intimidating" (Nahemow, 1986, p. 21). Further, this phenomenon of finding humor in incongruity has been linked to health (Parse, 1990; Rose, 1990; Wagnild & Young, 1990).

Parse (1990) described the spontaneous glimpsing of the paradoxical as an aspect of moving oneself toward desired change. The recognition of incongruence can lead to laughter, which changes one's outlook. Montagu (1981) and Rose (1990) also suggest that humor expands the person's view. Several nurse researchers have described this aspect of humor that involves the glimpsing of the paradoxical.

In a phenomenological study of psychologic health, Rose (1990) reported that women described an inner strength that was linked to humor. One woman related, "No matter how deep the pain is, I nearly always can find something humorous in it...that somehow I've got the resilience or that ability to see two sides at least...and then there's that bubble that comes up and makes me laugh" (Rose, 1990, p. 65). Similarly, Wagnild and Young (1990, p. 253) offered the following quote from a 70-year-old female study participant: "It just seems as if you have to take things in stride. And you have a sense of humor. You have to be able to laugh. You have to be able to laugh at things that seem terribly tragic - kind of see it in a different perspective....You have to laugh loud..." (Wagnild & Young, 1990, p. 253).

Interpreting Findings for Nursing Science

Simile as a vehicle of meaning relates to three concepts of Parse's first principle: languaging, valuing and imaging. Older persons cocreate reality by giving meaning to their experiences. And their perspectives are "incarnated through the personal languaging of imaging and valuing" (Parse, 1981, p. 42). Expressing oneself through simile is a way of languaging. Languaging expresses the images of one's chosen values and meanings. It gives a distinct form to one's structure of reality and illuminates the unique perspective of one's world view. The images shared in the similes reveal the reflective-prereflective shaping of personal knowledge. Parse (1981) states that the pictures or images of one's perspective reflect a searching for truth and knowing. One's images of life also reflect chosen beliefs and values that clarify concerns, fears, hopes, and dreams. Values reflect meaning and as one moves toward increasing diversity there is a continuous process of integrating and reprioritizing what is valued and important. According to Parse (1981), this process of prioritizing values and choosing meaning in daily life is health.

The paradoxical rhythms reported here, of feeling the same-yet-different and restriction-yet-expansion, are connected to Parse's second principle, "cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating" (1981, p. 50). The paradoxical patterns reported in the current study further confirm Parse's belief that human beings cocreate rhythmical patterns of relating with the universe. Further, the restriction-expansion paradox is linked to Parse's theoretical concept of enabling-limiting. This concept is evident in human life as people choose how to engage

the struggles of daily living, what projects to be involved with, and who to relate to. Choosing happens simultaneously at many different realms. Every choice leads to a range of possible consequences, opportunities, and limitations. The restriction-expansion paradox shows the unique nature of what constitutes opportunities and limitations in any given situation.

The enabling-limiting paradox is described by Parse as a unitary rhythm. The concept enabling-limiting refers to the many opportunities and limitations that unfold as persons make choices and live cherished values. As described by elders in the current study, life is never entirely restricting or expanding. Both sides of the rhythm coexist as daily life fluctuates in a mysterious way embracing both restrictions and expansions. The 600 narratives contained multiple references to the blessings, joys, and comforts that exist simultaneously with fears, sorrows, and concerns.

The paradox of feeling the same-yet-different is connected to Parse's description of the rhythmical process of transforming, in which there is "struggling to integrate the unfamiliar with the familiar" (1981, p. 63). Transforming is a concept in Parse's third principle, "cotranscending with the possibles is powering unique ways of originating in the process of transforming" (1981, p. 55). From this principle flows the notion that in the process of transforming there is a continuous integrating that confirms the person one is, was, and will become all at once. In the paradoxical rhythm of feeling the same-yet-different, there is both the connecting thread of sameness and the unfolding new that prompts a "leaping beyond in continuous movement toward greater complexity" (Parse, 1981, p. 63). In this process there is an openness to the discovery of self as new perspectives and meanings layer and transform human becoming.

Humor is also linked to the concept of transforming. Parse describes an aspect of transforming that involves a person's changing perspective amidst new insights and fresh ways of viewing familiar situations. These ideas are connected to the changing perspective that accompanies the often humorous experience of glimpsing the paradoxical. Additionally, humor is related to Parse's concept of powering in which there is a pushing-resisting movement toward increasing diversity. Older persons described a strength gained through humor that made it easier to go on living. Indeed, humor powers human becoming for some persons.

The three phenomena explored in this paper relate to health and quality of life. Health, in Parse's theory, is the unfolding process of human becoming. Values, beliefs, choices, meanings, hopes, fears, paradox, and dreams are all aspects of human becoming. But the specific ways in which these phenomena are experienced by individuals can only be defined by the persons themselves.

Implications for Practice and Research

Findings reported here about simile, paradox, and humor considered in light of Parse's nursing theory surface possible ways of being with older persons in practice. It seems redundant to emphasize the crucial role that personal meaning has in relation to health and quality of life. For nurses who view persons as unitary beings, who are open and continuously participate in the process of human becoming, meaning is viewed from the perspective of each person, and is honored by the nurse when it is expressed in the nurse-person relationship. Nurses whose practice is guided by Parse's theory ask persons what life is like for them. This question invites the individual and/or family the opportunity to describe what is happening and what their experiences mean to them. Descriptions are imbued with meaning and the nurse offers true presence to the individuals as they illuminate meaning with as much depth and clarity as they choose. For example, if an older man states that he feels like a bump on a log, this simile could be explored. The nurse might ask him to tell more about what it is like to feel like a bump on a log, and what that means.

The meaning revealed by persons in these situations, is not for the nurse's benefit although it is a privilege to bear witness to such expressions. The process is valued because as Parse suggests, when persons speak about the meaning of personal thoughts and feelings, the meanings change and they are propelled beyond the meaning moment. In addition to exploring the meanings language in simile, the nurse might ask the person to image the simile and describe its appearance. Alternatively, the person might want to write about the simile or make a drawing that captures the experience. Practice with groups of older persons could be enhanced by exploring the meaning of similes. Group members might choose to relate stories, read poetry with similes, or share various similes that capture the meaning of experiences throughout life. During these group discussions, the nurse explores what the stories, poems, and similes mean to individuals.

The paradoxical rhythms of feeling the same-yet-different, and restriction-yet-expansion might be explored in discussion with nurses. The nurse guided by Parse's theory believes that patterns of human becoming are paradoxical and that by going with the person's rhythm in whatever direction or realm that may be, other aspects and dimensions of the rhythmical pattern will surface. Thus, if an older person speaks of feeling the same, the nurse might ask him or her to speak more about the sameness. This process of going with the person's rhythm commonly surfaces other paradoxes. Persons often continue to mull over what they said in the presence of the nurse and in this way continue to change and transform long after a specific discussion has ended (Parse, 1992).

The current study describes three aspects of humor in later life. However, some persons may not value humor or want to create it in their lives: this choice is

respected in Parse's theory even though some individuals find it to be a source of great strength. Parse (1990, 1992) suggests that people know their own way, and that their becoming can be enhanced by nurses. It was evident from the current study that many persons do value humor and sharing laughter with others. In such cases, the nurse might explore things e.g, a comedic movie or a book of jokes or experiences that increase the presence of humor in day to day life. It is important that the nurse be open to others' desires for humor and facilitate their plans for creating it.

The final more complex aspect of humor to be discussed is glimpsing of the paradoxical. It surfaces in the individual's relationship with the universe, and is connected to an expanding, changing perspective. It is a consequence of shifting views and perspectives and may show itself in nurse-person discussions as individuals illuminate meaning, synchronize rhythms, and move beyond, all at once. One way the nurse might enhance this process is by exploring the different views of a situation that a person sees. For example, after a person describes how terrible a certain situation is, the nurse may ask if there is any other way of looking at the situation. New views may thereby surface and the person may glimpse the paradoxical.

Further research based on findings from this study might include more in-depth exploration of the identified paradoxical rhythms or the experience of humor. Research with groups of older persons could evaluate changes in quality of life when opportunities for sharing meaning or humor are incorporated into nursing practice.

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An Exploration of Nursing Disillusionment

Kathleen Oberle and Betty Davies

Le cadre d'analyse de certaines des difficultés courantes que rencontrent les professionnels des sciences infirmières est constitué d'un modèle de soutien positif élaboré dans une précédente recherche et d'une théorie de l'éthique. Les auteurs affirment que la cause principale de la désillusion du personnel en sciences infirmières est la discordance entre les valeurs personnelles qui sont enracinées dans la déontologie des soins et un système de soins de santé qui valorise la compétence technologique plutôt que les valeurs humaines.

A model of supportive care developed in prior research, combined with ethical theory, is used as a framework for analyzing some of the current problems facing the nursing profession. The authors argue that a central cause of nursing disillusion is dissonance between personal values rooted in an ethic of caring and a health care system that rewards technological competence above human values.

Among nurses, particularly those in acute care settings, disillusionment, frustration, and burnout have become common. Why are so many nurses unhappy with their profession? In this paper the authors examine results of their previous research in an attempt to find some answers. Based on a model of supportive care developed in the earlier study (Davies & Oberle, 1990; Oberle & Davies, 1992), the authors propose that a central cause of nursing disillusionment is a health care system that repeatedly forces nurses to betray their personal values in the context of their professional practice. The model's various components can be used with recent ethical theory to explore the possibility that the erosion of personal integrity places the individual nurse in jeopardy. According to recent literature, and the authors' own current research, nurses who maintain a personal ethic that is rooted in caring and nurturance often become frustrated and dissatisfied in a system that rewards technological competence above human values.

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The Model

The earlier-mentioned supportive care model was developed using grounded theory methods, through which the authors examined the expert care provided by one nurse to 10 palliative care patients and their families. Six interwoven but discrete dimensions of care were identified: *valuing*, *connecting*, *empowering*, *doing for*, *finding meaning*, and *preserving integrity* (Figure 1). Details of the study are described elsewhere (Davies & Oberle, 1990; Davies & Oberle, 1992; Oberle & Davies, 1992). Of these six dimensions, some are primarily attitudinal, while others are more task-oriented. *Valuing* is an attitude that affects all the nurse’s activities; *valuing* it means having respect for the inherent worth of others. Although it is possible to provide nursing care without *valuing*, it would be incomplete or inadequate to meet patient needs.

Whereas *valuing* is the encompassing dimension, *preserving integrity* is central to the model because it is integral to the nurse’s effective functioning. It involves the nurse’s maintenance of a sense of wholeness, self-worth, and self-esteem. At the same time, preserving integrity is patient-centred, for it is related to the wholeness of the patient, and in fact, is the goal of nursing care. It is in keeping with more usual definitions of the goal of nursing as the maintenance of the patient’s physical,

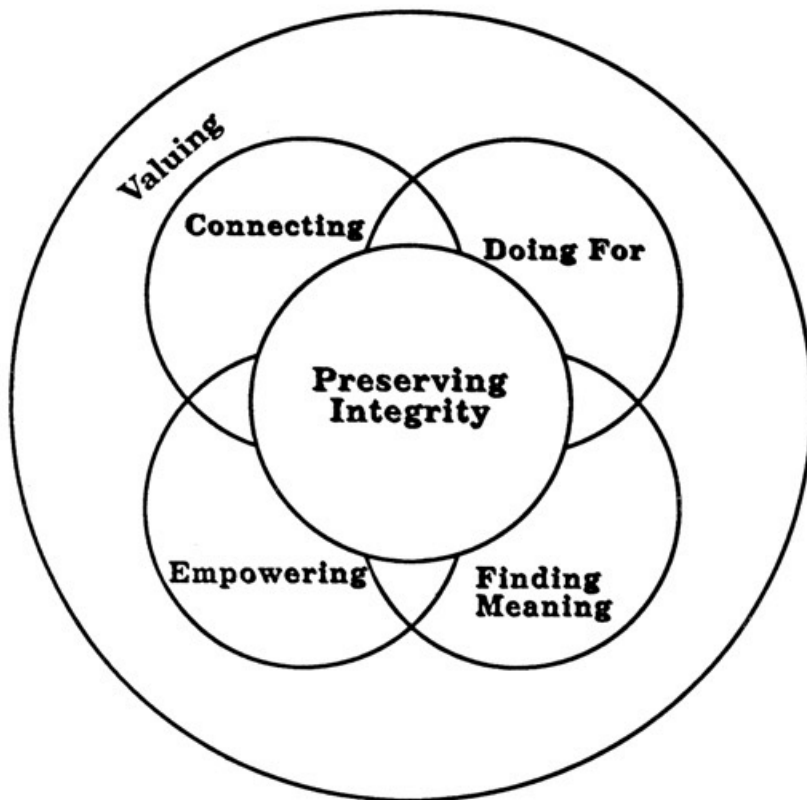


Figure 1: Dimensions of Nursing Care in the Supportive Care Model

emotional, and spiritual well-being (Quinn, 1989). *Valuing* and *preserving integrity* are enacted through the four action components of the model: *connecting*, *empowering*, *doing for* and *finding meaning*.

Connecting means getting in touch with, or establishing a bond or relationship with the patient and family. *Empowering*, or helping the patient and family to do whatever it is they need to do, is strength-giving or energizing, rather than tangible or task-oriented. The nurse has an armamentarium of skills and knowledge from which the patient/family take what they need. Exactly what the individual patient finds *empowering* depends on the person, and is not defined by the nurse. *Finding meaning* is closely related to *empowering*. It involves helping patients and their families to develop a perspective on the health problem and its role in their lives, and helping patients make sense of what is happening to them.

Doing for focuses on the physical care of the patient. This is the aspect of nursing that receives the most attention in the literature, in practice, and in educational settings. When *doing for*, the nurse uses resources that are extrinsic to the patient and family, whereas *empowering* draws on their intrinsic resources. In Figure 1 the overlap of the circles indicates that the dimensions are interwoven and difficult to separate. For example, when the nurse connects with the patient this implies that she or he values the patient as an individual, which could help the patient find meaning, and thus be empowering. Similarly, *doing for* can be empowering if the patient is in need, that is, if the patient is unable to do for self. However, too much *doing for* can become disempowering if the nurse does that which the patient has the ability and will to do. Therefore the nurse must be constantly alert to the interactions among the dimensions.

The supportive care model was developed to explicate the clinical role of a nurse. However, nurses in other practice settings reported that the model was useful as a basis for orientation programs and teaching undergraduate nursing students. One psychiatric hospital based its nursing mission statement and philosophy on the model, and many nurses have indicated that it renewed their enthusiasm for nursing. Thus, nurses in practice have validated the model, suggesting that it accurately reflects the essence of nursing practice.

Nursing Disillusionment

In the context of the disillusionment of nurses, the importance of *valuing* becomes increasingly clear. The holistic nursing care described by this model demands that the nurse believe in the intrinsic worth of the individual(s) being cared for. Thus, the model suggests that *valuing* is foundational to the concept of excellent nursing practice, and defines its ethos. Belief in the intrinsic worth of others is a very personal

experience. Excellence in nursing therefore depends on a congruence between the nurse's personal belief system, or ethic, and the values espoused by the profession.

The interconnection between personal and professional values can be better understood in light of ethical theory. Traditional views of ethics suggest that it focuses on "justice," that is, the application of abstract principles and rules. In the established justice perspective, relationships are essentially unimportant, and caring is a confounding factor (Kohlberg, 1981; Kohlberg & Candee, 1984; Rest, 1982, 1987). However, a number of scholars have recently described another view of moral development in which connectedness and caring are seen as cornerstones of a way of thinking about the world. They have proposed that either a justice or a caring orientation will predominate in any one individual (Baier, 1987; Gilligan, 1982, 1988a, 1988b, 1988c; Meyers & Kittay, 1987; Noddings, 1984). This thinking, which is relatively new in philosophical circles, suggests that caring can be at the centre of a personal belief system. If the arguments of these scholars are correct, and it is possible to have an ethic based on caring, and if caring is central to nursing, as has been suggested (Benner & Wrubel, 1988), then the foundational ethic of nursing must be one of care (Fry, 1989; Gadow, 1985). If nursing professional values are based on an ethic of caring and connecting, then the nurse holding an ethic based on care will find personal values congruent with professional values.

The supportive care model can be used to demonstrate the foundational relationship between an ethic of care and nursing practice. In the model, *connecting, empowering and finding meaning* are action components that appear to be "rooted in receptivity, relatedness, and responsiveness" (Noddings, 1984, p. 2). When *doing for* is linked with these dimensions, it becomes another manifestation of a caring ethic. The core of the supportive care model is *preserving integrity*, which is the nurses's ability to maintain a personal sense of coherence or oneness, while at the same time helping maintain the patient to wholeness. This overlap of the nurse's goals for self and patient care makes personal values central to nursing care. In this construction, the nurse's sense of professional worth must be tied closely to the type of care she/he provides, and the nurse must be true to personal values to maintain a sense of personal worth. In order to maintain an ethic based in connectedness and nurturance, the nurse must put values into practice by providing holistic care.

By this reasoning, the action components of the model and the *valuing* and *personal integrity* components are inextricably linked through the patient-nurse relationship. Nursing activities must be in concert with the values of both patient and nurse. If connectedness and caring are nursing values, then they must be actualized by nursing activities. Clearly, there must be a balance between actions and values; the nurse cannot focus only on the interpersonal aspects, nor exclusively on the physical tasks.

This argument may provide some insights into the discontent many nurses, particularly those in acute care settings, feel with their profession. For the nurse whose personal belief system is rooted in caring, ethical nursing, care could be defined in terms of the supportive care model. However, the nurse's work environment may not be conducive to providing the kind of care defined by the model. In hi-tech acute care settings, the nurse may experience little support for practicing the personal and professional values of caring and connectedness. The result is a lack of fit between what the nurse feels should be done and what she/he is able to do within the limits of the system. This can lead to what has been called cognitive dissonance, a discomfort experienced when situations are logically or psychologically incongruent with one another. Dissonance is so uncomfortable that the individual will take extreme measures to reduce it, e.g., by lessening the importance of one of the opposing forces or cognitions (Schneider, 1976).

In the supportive care model, the *doing for* component incorporates the tasks and technologies that are so much a part of a nurse's work life. When the institutional system confines the nurse's focus to *doing for*, as when reward and recognition are primarily for task-oriented activities, it becomes increasingly difficult to incorporate other dimensions into care. If the nurse as person believes that complete care is important, and that it consists in all four action components, then dissonance results.

One way the nurse can reduce dissonance is to change her or his view of what should be done. When faced with too many tasks and insufficient time, the nurse may find it necessary to downplay the importance of *connecting*, *empowering*, and *finding meaning*. The nurse focuses on *doing for*, either because it is encouraged and rewarded, or because time permits nothing more. In effect, *doing for* becomes disconnected from the other components and moves outside the *valuing* context (Figure 2). However, by distancing *doing for* from a caring ethic, the nurse betrays deeply held personal and professional beliefs, and the result is an erosion of personal integrity. Thus the nurse's unconscious effort to reduce dissonance by devaluing the caring and connecting aspects of care has a boomerang effect. Much attention has been given to the personal cost of caring (Forrest, 1989; Warren, 1988), but little notice has been paid to the obverse, the personal cost of not caring. When the system of values within the organizational culture is different from that held by the nurse, the cost to the nurse is high (Morrison, 1989).

Another point may help to explain the distress experienced by nurses in the work place. When the supportive care model was developed, the data indicated that through *connecting*, *empowering*, and *finding meaning* there was a mutual exchange of energies that was essential to the maintenance of the nurse's personal integrity. The enrichment and empowerment that the nurse got from the patient gave her or him the strength to continue despite the high cost of caring. In making a true connection with the patient, and sharing the patient's experience, the nurse was

likewise empowered. Thus, the model suggests that when the nurse is constrained to focus on the *doing for* aspect of care at the expense of the other components, she or he experiences a betrayal of personal values and is denied the primary source of satisfaction and energy that is experienced when complete care is provided. Lacking a sense of personal accomplishment, nurses become emotionally exhausted and, in the popular phrase, burned out (Williams, 1989).

Costs to the Caregiver

Is betrayal of personal integrity a cause of nursing disillusionment? Support for this contention is found in a recent study where nurses in an acute care institution were asked to describe ethical problems they had experienced in practice (Oberle, 1993). Interviews were tape recorded and transcribed. Preliminary analysis suggests that nurses are concerned about their inability to provide what they perceived to be quality care. One nurse talked about what happens when she has too little time to give complete care:

...When I ...do that which I know to be the best, ... I have a tremendous sense of accomplishment and of righteousness ...

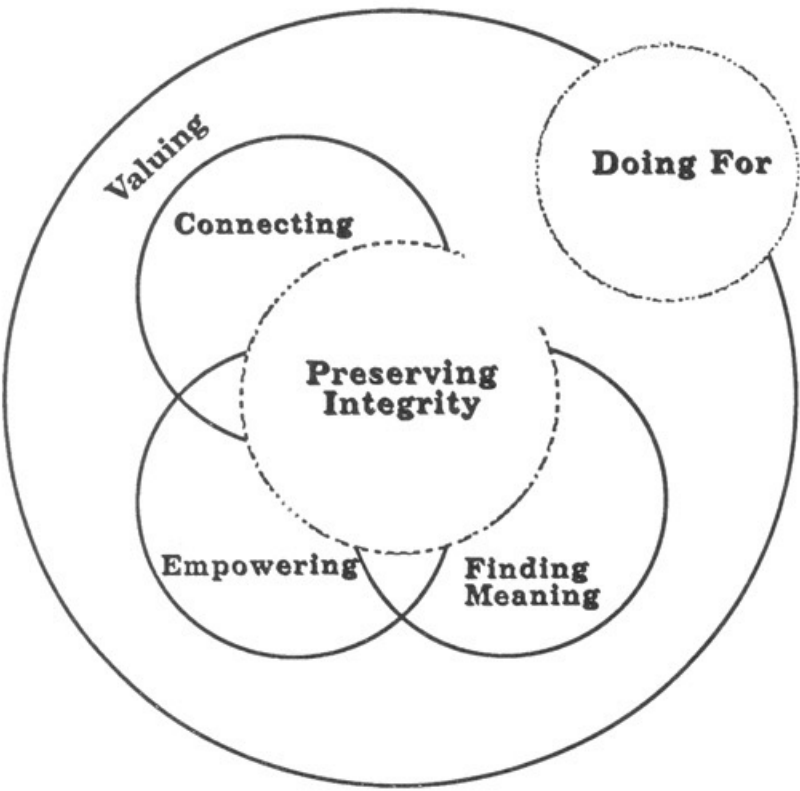


Figure 2: Effects of Overemphasis on “Doing For”

treating my patients as a very human person. And when I don't, I feel I'm definitely dehumanizing them and I'm dehumanizing myself ... it does hurt me when I know that we're treating them that way.

Another nurse expressed similar sentiments:

It seems to be an ethical problem to me because I'm caught between what I know I feel is right, which I think is an ethical situation, and between the practical implications of how I would define for myself the right to do what I consider an appropriate behavior.

Parker (1990) suggests that nurses who try to enact an ethic of care within a traditional intensive care setting feel considerable distress. Such distress may cause nurses to leave the particular work setting, or the profession itself, as exemplified by the following quotation from the ethics study:

... I know I looked after this person for three 12-hour shifts in a row and I really questioned whether nursing in this capacity, would I want it any more. It was the one time in my whole nursing that I thought, I don't believe in what we're doing...I almost quit nursing over it... you think, can't you see what's going on in here, are you so tunnelled that there's just the one thing you're involved with and you can't see the patient as a person any more...

Parker (1990) concludes that "many nurses have taken their stories underground to maintain personal integrity or to avoid devaluation. Stories once spoken with passion have been silenced...by the threat of being ignored, intimidated, or judged morally inept" (p. 39). As one nurse in the ethics study put it:

I tried to bring this up with people I worked with but I felt that there was a conspiracy of silence. That these were issues that you didn't dare look in the face because they had implications...the implications for me were that I eventually left. That was my choice. And I left under an incredible strain. I felt very alone. I stopped, quit nursing for six months. ... I just realized that it wasn't the place for me ... I couldn't justify my part in that system. So there was no room for my personal philosophy there, and I felt that what I was doing was betraying it.

Nurses in the ethics study repeatedly emphasized how their inability to provide holistic care caused personal distress. When they felt their caregiving was being

driven by technology, rather than by patient needs, they experienced feelings of confusion, anger, and hurt.

Discussion

Although numerous causes of nursing disillusionment have been suggested, researchers have found significant relationships between perceived stress, job satisfaction, and burnout symptoms (Cronin-Stubbs & Rooks, 1985; Norbeck, 1985). However, in these studies great variability of burnout symptoms was only partly explained by the measures used. Norbeck (1985) indicated that a more complete model was needed to explain the occurrence of dissatisfaction and burnout. One factor that could be considered is ethical distress, or what has been described in the current paper as an erosion of the nurse's personal integrity. According to Cameron (1986), "There are a lot of reasons for nursing burnout ... but ethical anguish has become a special weight of the past decade There may be a very strong, direct conflict between what the nurse thinks should be going on and what she's actually doing" (p. 42B).

Conclusion

The current paper used the model of supportive nursing care to explore possible reasons for the current dissatisfaction of nurses in acute care settings. The purpose was to show how one conceptualization of nursing practice could be used as a tool to examine and articulate sources of nurses' distress. It was argued that nurses whose belief system is rooted in caring and connectedness believe that this ethic is enacted in the professional context by providing complete care, which incorporates all the action components of *connecting*, *empowering*, *finding meaning* and *doing for*. When they are prevented from providing the kind of care they believe in, they experience a betrayal of personal values. The result is nurses who are disillusioned and dissatisfied.

In searching for causes of, and solutions to current problems in nursing, attention must be paid to the nurse's need to maintain personal integrity. This could prove to be a fruitful area for future research. In a study of moral decision-making among lawyers, subjects who expressed values consistent with an ethic of care experienced greater moral distress in the context of their professional lives than did those whose moral orientation was justice-oriented (Jack & Jack, 1989). In the current paper it was suggested that an ethic of care is positively related with excellence in nursing practice. However, it has also been suggested that individuals who hold an ethic of care may be at increased risk for burnout in a system that is technology- and task-oriented. It would be illuminating, therefore, to explore how moral orientation

relates to quality of care nurses' perceived stress (or distress) in particular work environments. For example, one might ask whether care or justice orientations are related to the degree of difficulty nurses experience when deciding whether to continue treatment of critically ill patients. Alternatively, one might wish to examine the association between perceived dissatisfaction, moral orientation, and the emphasis on *doing for* in the work environment.

Thus, the supportive care model could prove to be useful for formulating research questions about nurses' disillusionment. If the problems can be adequately conceptualized, it may be possible to find their solutions through research.

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**MASTER OF SCIENCE (WITH THESIS)
MASTER OF SCIENCE (APPLIED)**

These programs have been designed to prepare clinicians and researchers for the expanding function of nursing within the health care delivery system. Preparation for the teaching of nursing or the management of nursing service is also offered.

Admission requirements

Either a Baccalaureate degree in Nursing comparable to B.Sc.(N) or B.N. from McGill; or a Baccalaureate degree comparable to B.A. or B.Sc. offered at McGill (for those with no nursing preparation).

Length of program

Two years for those with nursing degrees;
Three years for non-nurses.

Language of study: English

Further information from:

Associate Director, School of Nursing
Graduate Programs
3506 University Street
Montreal, QC, H3A 2A7

Enquiries regarding **Ph.D. studies**
should also be made to the
Associate Director, Graduate Programs



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