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CONTENTS - TABLE DES MATIERES

EDITORIAL

APPLY, ADAPT OR CREATE: THE MEASUREMENT QUANDARY

In recent months I have noticed that, in their critiques, reviewers for this journal are paying increasing attention to instruments and measurement. They are frequently critical of the direct application of measuring tools that have been developed by other disciplines for the study of variables from the theoretical perspective of that discipline. Equally, they raise concerns about the use of adapted tools that may or may not maintain validity and reliability. I have been impressed with the thoughtful discussions by reviewers about quandaries in choices of instruments, and the need for researchers to be creative and innovative in their approach to measurement. For me these kinds of comments are indicative of yet a new stage of development in a rapidly expanding field of research.

We seem to have moved beyond the basic requirements of science for valid and reliable instruments. We now recognize the need to measure variables central to Nursing with instruments that are compatible with our own theoretical perspectives, and that are meaningful and reflective of clinical practice. Clinicians who wish to base practice on research findings will not wish to measure variables with esoteric methods. Similarly, instruments developed in other disciplines may not be isomorphic with variables as they are defined in nursing knowledge or practice. Psychologists, sociologists, physiologists and others have developed tests for such common psychosocial variables as anxiety, depression, coping, stress or health. Frequently these tests have been standardized on such specific categories as psychiatric patients or undergraduate university students. How meaningful are the norms for these categories for such clinical categories as people with a first myocardial infarction or a recent diagnosis of malignancy or the growing numbers of elderly people in the health care system?

There are also a number of concepts and variables of interest to Nursing that have not been studied extensively, by Nursing or other disciplines, and subsequently, methods of measurement are limited. How do we assess the impact of mouth care, progress in ambulation, a pregnant teenager's readiness for mothering, the meaning of infant cries and so on? While there are certainly more publications currently in the research literature that address the development of measures, many more are needed. As we enter this new decade I predict a significant growth in instrument development and technology, both quantitative and qualitative, in nursing science. I don't believe I stand alone in this respect. Other colleagues are evidently preoccupied with

the need for creative and innovative approaches to measurement. Indeed, Dr. Carolyn Attridge, Director of the School of Nursing at the University of Victoria, is organizing a session devoted to the discussion of innovative methods and designs, at the next National Nursing Research Conference. I believe this is a timely topic and a forum in which we may foster collaborative efforts. We are still manageable enough in Canada, in terms of numbers, to be able to establish multi-site projects for the development and standardization of instruments. In fact, we can begin this effort before the June meeting in Victoria. If you have developed, are developing, or have discovered a new or innovative method to assess a particular variable, send a brief description to *The Canadian Journal of Nursing Research* and we will publish a list of such measures. Other researchers would then be able to contact you for further information, or permission to utilize the measure and contribute to the reliability and validity data. I look forward to your responses to this request.

In conclusion, while it is inevitable that instruments specific to nursing concepts will proliferate, a word of caution is offered. Instrumentation has a way of becoming important for its own sake. Let us learn from other disciplines and keep the substantive questions in the foreground. We don't need to avoid all tools developed by others. What we need is thoughtful evaluation of measures, and appropriate application when they fit the reality of nursing and client situations. Where such measures are not available we definitely need creative, innovative researchers.

Mary Ellen Jeans

ÉDITORIAL

FAUT-IL EMPRUNTER, ADAPTER OU CRÉER NOS INSTRUMENTS DE MESURE?

Depuis quelques mois, je constate que les critiques qui collaborent à cette revue prêtent de plus en plus d'attention aux instruments de mesure des variables. Ils critiquent souvent l'application directe d'instruments de mesure mis au point par d'autres disciplines pour l'étude des variables selon une perspective théorique propre à ces disciplines. De la même manière, ils s'inquiètent de l'utilisation d'outils modifiés qui ne permettent pas toujours de maintenir la validité et la fiabilité des résultats. J'ai vivement apprécié les propos éclairés de certains critiques sur le dilemme des instruments de mesure et la nécessité pour les chercheurs d'adopter en la matière une approche créatrice et novatrice. Ce genre de commentaires marque selon moi le passage à un nouveau stade de développement dans un domaine où la recherche connaît une évolution rapide.

Il semble que nous ayons dépassé les exigences minimales de la science en matière d'instruments valides et fiables. Nous reconnaissons maintenant la nécessité de mesurer certaines variables essentielles aux sciences infirmières à l'aide de méthodes qui soient à la fois rationnelles et compatibles avec nos propres perspectives théoriques et qui reflètent la pratique clinique. Il arrive que les mesures de variables obtenues par des méthodes peu orthodoxes ne puissent être utilisées aisément par les cliniciens, qui souhaitent fonder leur pratique sur les résultats de la recherche. De la même manière, les instruments mis au point dans d'autres disciplines ne correspondent pas nécessairement de façon isomorphe à la réalité des variables qu'on utilise en sciences ou en pratique infirmières. Prenons par exemple certaines variables psychosociales courantes comme l'angoisse, la dépression, l'adaptation, le stress, la santé, etc. De nombreux tests ont été mis au point par des psychologues, des sociologues, des physiologistes et d'autres spécialistes pour mesurer ces états et particularités. Ces tests sont souvent normalisés pour des groupes précis, par exemple pour les malades psychiatriques ou les étudiants de premier cycle universitaire. Dans quelle mesure les normes peuvent-elles s'appliquer à tel ou tel groupe clinique, par exemple aux victimes d'un premier infarctus ou aux personnes chez qui on vient de diagnostiquer une tumeur maligne, ou au nombre croissant de personnes âgées qui font appel au réseau des services de santé?

Certains concepts et variables qui présentent de l'intérêt pour les sciences infirmières n'ont pas été soumis à une étude poussée dans cette discipline ou dans d'autres; aussi les méthodes de mesure sont-elles limitées. Comment

doit-on évaluer l'effet des soins buccaux, les progrès ambulatoires d'un malade, l'aptitude d'une adolescente enceinte à assumer son rôle de mère, la signification des pleurs d'un nouveau-né, etc.? Certes, les publications de recherche sont aujourd'hui plus nombreuses à s'intéresser à la mise au point d'instruments de mesure, mais il en faut davantage. Au seuil de cette nouvelle décennie, je prévois des progrès quantitatifs et qualitatifs importants en ce qui concerne les instruments et les techniques de mesure employés en sciences infirmières. Je ne crois pas être le seul de cet avis. D'autres ont de toute évidence pris conscience de la nécessité d'adopter des approches créatrices et novatrices en ce qui concerne la mesure des variables.

C'est notamment le cas de Mme Carolyn Attridge, directrice de l'École des sciences infirmières de l'Université de Victoria, qui prépare pour le prochain Congrès national de recherche en sciences infirmières un atelier sur les méthodes et conceptions novatrices. Cet atelier arrive à point nommé pour favoriser la collaboration. La population du Canada n'est pas encore si nombreuse qu'il nous soit devenu impossible d'entreprendre des projets multisites permettant de concevoir et de normaliser des instruments de mesure. De fait, ce travail pourrait commencer avant la réunion de juin, à Victoria. Si vous avez conçu ou êtes en passe de concevoir, ou que vous ayez découvert une méthode nouvelle ou novatrice permettant d'évaluer une variable particulière, veuillez nous en faire parvenir une brève description. *La Revue canadienne de recherche en sciences infirmières* publiera la liste des descriptions reçues. D'autres chercheurs pourront alors entrer en rapport avec vous pour obtenir plus d'informations ou l'autorisation d'utiliser votre méthode, et ainsi contribuer à la collecte de données sur sa fiabilité et sa validité. J'espère que vous serez nombreux à répondre à mon invitation.

En conclusion, même si la multiplication des instruments de mesure propres aux concepts des sciences infirmières est inévitable, j'aimerais faire une mise en garde. Les instruments de mesure ont tendance à prendre de l'importance en soi. Tirons les leçons de l'expérience acquise dans d'autres disciplines et tenons-nous en aux questions essentielles. Gardons-nous également de rejeter tous les instruments mis au point par d'autres. Soumettons plutôt ces instruments de mesure à une évaluation approfondie et assurons-nous d'en faire une application judicieuse lorsqu'ils sont adaptés aux réalités des sciences infirmières et aux situations vécues par le client. Lorsque ces instruments de mesure n'existent pas, il nous faut alors faire appel à des chercheurs créateurs et novateurs.

Mary Ellen Jeans

A SCALE TO MEASURE ATTITUDES ABOUT NONPROCEDURAL TOUCH

Lorraine M. Fisher and Dayle Hunt Joseph

The concept of touch has long been accepted as a basic and universal tenet of nursing practice. Many scholars have attempted to define touch within the context of its intention. Cashar and Dixson (1967) compartmentalized the use of touch into three broad but distinct categories: reality orienting, support and physical protection. Krieger (1975) further categorizes another aspect of the concept as therapeutic touch, or a laying on of hands - a method of energy transference from the healer to the patient to assist in the process of healing. Mitchell, Haberman-Little, Johnson, Van Inwegen-Scott, and Tyler (1985) and Watson (1975) limit the categories to include only instrumental and affective touch. Instrumental or procedural touch is defined as deliberate physical contact for performance of a skill.

Affective or nonprocedural touch is seen as spontaneous and not required for the performance of a nursing intervention (Mitchell, et al., 1985; Watson, 1975).

An in-depth search of the literature, on both procedural and nonprocedural touch, revealed extensive studies and research on the value of physical contact as a means of communicating, establishing rapport or developing verbal behaviour with clients. Pratt and Mason (1981, 1984) and Watson (1975) examined the touch concept from the perspective of its meaning and significance. Aguilera (1967), Burnside (1973) and Preston (1973) were able to demonstrate some measure of success in communicating through touch with regressed patients. McCorkle (1974) investigated the effects of touch as a form of nonverbal communication with seriously ill clients, and found that the use of touch is important for the client as it demonstrates the caring attitude of the nurse. Though nonprocedural touch is of major importance in the nurse-client relationship, little has been done that investigates the client's attitude to this form of touch.

Lorraine M. Fisher, R.N., M.S. is Visiting Professor at Southeastern Massachusetts University, in North Dartmouth. Dayle Hunt Joseph, R.N., Ed.D. is Assistant Professor and Assistant Dean in the College of Nursing, at The University of Rhode Island, in Kingston.

The Canadian Journal of Nursing Research *Summer 1989, 21(2), 5-14*

The following research questions were generated with the intent of learning more about the client's attitude toward nonprocedural touch.

1. Do clients feel comforted emotionally by touch?
2. Do clients feel comforted physically by touch?
3. Do hospitalized clients value touch that is separate from the required nursing procedures that involve touch?

Background

Touch is, according to Montagu (1971), the earliest, most primitive and crucial of all the basic senses. Through the touch sense, the individual is able to receive signals and stimuli from the external environment, and interpret them for the internal environment, which Montagu labels "the mind of the skin" (p. viii). Through the sense of touch, the individual perceives the most personal of all sensations (Hall, 1966). Iverson-Iverson (1983) captures the delicacy and transient nature of touch when she speaks of it as being "communicated solely between those two people caught in one moment of time" (p. 49).

Touch developmental needs

In the human embryo, touch is the earliest of the senses to develop. The fetus is surrounded by the warmth of amniotic fluid and pressured on all sides by the walls of the uterus as it grows and receives continuous tactile stimulation. Birth "is the beginning caressing of the infant in the proper way, a caressing which should continue immediately after the birth and for considerable time thereafter" (Montagu, 1971, p. 63).

Ribble (1965) noted, in her study of young infants, that they often form strong attachments to soft toys or blankets as a substitute for maternal contact. A well known study of monkeys, done by Harlow (1961), sought to measure the importance of a mother monkey's tactile characteristics. Findings indicated that frequent and intimate warm contact between mother and baby are important.

A normal, healthy child is able to establish its sexuality by using touch to explore its own body. McGaugh (1982) suggests that expressions of sexuality may be negatively influenced by the way the child perceives the mother's touch. Often, according to McGaugh, children who feel shame regarding their bodies have received negative messages from the mother's own attitude about sex and intimacy. Simon (1976) notes that many parents, confusing the message of touch with sex, particularly with young adolescents, withhold it at a time when a caring, comforting touch is most needed.

Adults, suggests Morris (1976), want to touch and be touched, but social norms exert pressure that precludes such touching. Morris further posits that adults turn to "licensed touchers", such as hairdressers and masseurs. Even though body contact is not the primary reason for seeking such services, body contact is a satisfying by-product. Hickson and Stacks (1985) found that adults who work with their hands find touch a more natural process than those involved in more sophisticated jobs.

Huss (1977) observed that the elderly in our society may have a greater need for touch that can be attributed to decreases in sensory modalities which tend to limit experiential capacity. Research findings considering touch and the elderly are somewhat inconsistent. It is generally accepted that touch is necessary to provide sensory stimulation and decrease feelings of loneliness and isolation in the elderly. However, a study conducted by DeWever (1977) to investigate patient's perceptions of affective touch findings, indicated that the nursing home subjects experienced discomfort from affective touch if done by male nurses. Discomfort was reported by a large percentage of the subjects in the study when nurses, male or female, placed an arm around the patient's shoulder. DeWever also noted in her study that touching a hand or arm was deemed socially acceptable by most of the subjects in the study.

Some interesting work done in the field of gerontology in the last few years has been in the adoption of small animals by residents of nursing homes. Frank (1984) suggests that the use of animals in the nursing home setting is a means of reintroducing the importance of touch, smell and warmth, as well as something to love. Contact with a soft, warm animal seems to be effective in reality orienting, as well as encouraging feelings of self-worth and purpose among the residents. This is well substantiated by Montagu (1971), whose premise is that one's earliest experiences are mediated through tactile sensations.

Touch and culture

The perception of touch varies cross-culturally and is influenced by a myriad of factors. Cultures often define the boundaries of whom may or may not be touched, when touching is appropriate and how one may respond to touching behaviour of others. Hall (1976) enlarges further on the cultural implications of touch, as being operative in accordance with elaborate secret codes. A study done by Jourard and Rubin (1968) on the relationship between self-disclosure and touch noted that Americans, in general, tend to touch only in intimate moments, and that touch is often equated with sexual intent. Touch was also noted to be greater between opposite sex pairs, and between women, than men. Also noted was the increase of touch behaviour between close friends.

Montagu (1971) observed that Anglo-Saxon linguistic groups were less demonstrative, and the higher the class distinction, the less was the ability to express through touch. People of the Romance language group appeared to be more comfortable in the use of touching behaviour, although class distinction in relation to touch were clearly observable. It is interesting to observe the actions of people on a crowded bus as they try to avoid physical contact with one another. Montagu and Matson (1979) suggest the reason for this behaviour is that, if the elements of social recognition are not present in an interaction of touch, then the act is considered out of place.

Touch and hospitalization

The needs for security, reassurance and comfort are constant human emotional requirements. Illness and hospital care are occasions in which people experience more anxiety; thus, the need for reassurance through affective nurse touch becomes extremely important.

Regression to child-like behaviour has been directly attributed to dependency induced by hospitalization (Barnett, 1972). Many patients "given the opportunity ... hold on to a hand or arm with the same tenacious clinging turmoil as a frightened child" (Dominian, 1971, p. 897). Burnside (1981) and Preston (1973), in informal studies, demonstrated some measures of success in communication through touch with patients suffering from organic disease who had regressed to earlier childhood imprinting.

Burnside (1981) maintains that, too frequently, nurses view touch as only being related to tasks, thus, conveying the message, "I have to touch you." However, nonprocedural touch, or touch that takes place when no task is involved, sends a clear message that the nurse wants to touch the client. Burnside views such touching as a powerful therapeutic intervention.

Method

This descriptive pilot study was designed to develop and test an instrument used to measure hospitalized clients' attitudes toward the nurse's use of nonprocedural touch. The study was conducted in a small community New England hospital. A convenience sample of 52 clients (17 male, 28 female and 7 who did not indicate sex) who were hospitalized on either a medical or surgical unit completed the touch questionnaire on the second day of admission.

The questionnaire, developed by Fisher, is a 15-item, Likert-type scale. Close-ended questions were chosen primarily for the ease of administration and the limited time involved in completing the questionnaire. The subjects were asked to indicate, on a 1-5 scale, which response most clearly identified their attitude regarding touch while they were hospitalized.

Clients were asked to respond with their view of the nurse's use of touch. For example, the questionnaire asks clients to respond to items similar to the following example: "When I am upset or in pain, touching by the nurse is comforting."

The use of a Likert-type scale to determine attitudes of individuals is based on the rationale that:

> The probability of agreeing with any one of a series of favorable items about an object, or of disagreeing with any unfavorable item, varies directly with the degree of favorableness of an individual's attitude. Thus, one could expect an individual with a favorable attitude to respond favorably to many items ... an ambivalent individual to respond unfavorably to some and favorably to others: an individual with an unfavorable attitude to respond unfavorably to many items. (Selltiz, 1959, p. 366)

Items for the instrument were generated by Fisher (1985, 1986) in initial investigations of the use of nonprocedural touch in an intensive care unit and in a hospital setting where clients were awaiting nursing home placement. Initially 40+ items were generated for the questionnaire. These 40+ items were then carefully reviewed by three doctoral nursing candidates for face validity. Items were specifically reviewed for clarity and for their ability to measure the dimension of touch. There was 80% agreement among the three judges on the 25 questions that were to be used for the questionnaire. The questionnaire was further scrutinized by two doctorally-prepared nursing faculty members. At this point an attempt was made to balance both positive and negative items (Nunnally, 1978) and 15 (of 20+) questions were actually used in the final version of the instrument. For this final version, there was 100% agreement between the judges.

The research packet, composed of the patient consent form, a demographic sheet and the questionnaire, was attached to the hospital discharge instruction forms. The nursing staff enlisted client cooperation by explaining the consent form and by ensuring adequate time for the client to respond.

In this pilot test of 52 subjects a wide range of scores was obtained. The results obtained on the summated rating scale demonstrated a positive attitude toward nonprocedural nurse touch among the 52 respondents in the pilot study. The maximum score that could be obtained was 75 and the lowest score achievable was 15, based upon a 15-item, 5-point scale. No score was found to be below 45 and the highest score obtained in the sample was 74. Polit and Hungler (1987) note that the summation feature of Likert scales allows discriminations among subjects who feel differently.

An alpha coefficient of 0.6805 was obtained. This modest reliability is acceptable in the early stages of instrument development (Nunnally, 1978).

A factor analysis of the instrument was carried out to examine the questionnaire in more depth and to determine construct validity. Factor analysis examines interrelationships among large numbers of variables; it is used to disentangle those relationships to identify clusters of variables that are most closely linked (Burns & Grove, 1987, p. 544). Factor analysis helps the researcher to look at variables that tend to be conceptually related.

The first phase of factor analysis is to extract factors determined by an Eigenvalue of > 1.00, with a cutoff rule of 5% of explained variance. In this study, three factors were extracted with Eigenvalues > 1.00.

In the second stage the data is subjected to a varimax rotation. This allows for clearer analysis by indicating which particular variables belong to a factor (Polit & Hungler, 1987). The loadings are usually calculated between -1.00 to + 1.00 with a cutoff point of .40 or .30. The items underlined on the factor matrix (Table 2) indicated loadings of > .40. An analysis of these factors demonstrated a clustering that delineates fine distinctions and dimensions among the questions asked, and can be so labeled.

Table 1

Eigenvalues for Touch Questionnaire

Factor	Eigenvalue	% of Variance	Cumulative %
1	5.04	33.6	33.6
2	2.89	19.3	52.9
3	1.51	10.	63.0

Table 2

Loadings of the Touch Questionnaire in a Varimax Rotation

Question No.	Factor 1	Factor 2	Factor 3
1	-.06430	.71800	.35404
2	.74857	.03658	.18714
3	.79173	-.05816	.17176
4	-.08211	.85774	-.11754
5	.67981	-.47496	-.01297
6	.89378	-.13037	-.16682
7	-.28727	.67864	.32773
8	.00398	.23646	.69225
9	.83240	-.05621	-.26999
10	-.15915	.75718	.22789
11	-.06389	.17419	.75804
12	.18682	-.03822	.70677
13	.76843	-.36131	.05913
14	.37877	-.29587	.08121
15	-.01835	.06492	.73533

Discussion

Do clients feel comforted emotionally by touch? Factor 1 addresses the client's attitude about touch. Items such as being treated like a child or making the client feel uneasy were probed. Most respondents (70%) tended to contradict the item as stated: they felt that touch is emotionally comforting.

Do clients feel comforted physically by touch? Items in Factor 2 indicated that clients do appreciate the nurse's use of nonprocedural touch. A number of respondents (87%) agreed that the nurse's touch was soothing and comforting.

Do hospitalized clients value touch that is separate from required nursing care that involves touch? Clients (75%) agreed that the use of touch makes them feel valued and personalizes their care.

These findings are of interest because they support a broader definition of the concept of touch. They confirm previous research findings regarding the psychological and physical components of touch (Barnett, 1972; Dominian,

1971; McCorkle, 1974; Montagu, 1971), and support the dimension of caring that is so necessary for the delivery of nursing care by professionals.

The result of this pilot study demonstrated that hospitalized patients held a positive attitude toward nonprocedural nurse touch, as indicated by the high scores attained by the subjects of the sample on the touch questionnaire. This data holds important information for nurses in the practice of nursing.

Nurses often enter the profession because they want to heal, whether it is the body, mind or spirit. The use of nonprocedural touch can be viewed as another tool that nurses may utilize to achieve their goals in nursing. Nurses should be educated more formally about the concept of touch, as well as about its proper employment with patients in the clinical setting as a method to achieve a more caring, holistic and meaningful practice.

Limitations

These preliminary findings are from a pilot test. This instrument should be tested on a larger, more diverse population. The setting was confined to a small community hospital. Samples from several hospitals throughout the country would provide data that can be generalized to a greater extent. Also, clients for the study tended to be from one ethnic and socioeconomic group. Most (25%) tended to be elderly: age 65 and over.

Although the concept of touch has been examined by various disciplines, this study is a beginning step toward acquisition of knowledge in an area that has just begun to be explored. Naisbett (1982) has identified the need to maintain "hi touch" humanistic care as technology continues to make health care more complex. From our first moments to our last, touch has the power to heal, comfort and soothe. It is the means by which we satisfy our most basic of human needs.

A copy of the questionnaire used for this scale is available from the authors upon request.

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RÉSUMÉ

L'évaluation des attitudes aux attouchements sans rapport avec un acte médicale

Cette enquête avait pour but de mettre au point et de soumettre à un essai-pilote un questionnaire visant à évaluer les attitudes de clients hospitalisés face aux attouchements sans rapport avec un acte médical. Un questionnaire de type Likert a été conçu pour déterminer ce qu'éprouvent les clients lorsqu'on les touche en dehors d'un acte médical, et savoir si cela contribue à leur bien-être. Les questions avaient pour but d'évaluer l'effet du toucher sur le bien-être psychologique et physique des clients. Une question portait sur les sensations que procure chez le client ce genre de toucher. Après avoir soigneusement évalué la validité du questionnaire sous l'angle du fond et de la forme, une échelle de 5 points de type Likert comprenant 15 questions a été soumise à un essai-pilote sur 52 sujets hospitalisés. On a ainsi déterminé un taux de fiabilité alpha de 0,6805. Le test s'est révélé facile et rapide à administrer. Les résultats préliminaires d'une analyse factorielle indiquent que les clients attachent de l'importance aux aspects physiques et affectifs du toucher et estiment que ce genre de geste a pour effet de personnaliser les soins qui leur sont dispensés. Ces travaux préliminaires semblent confirmer que le toucher dépasse le seul contact physique.

STAFF NURSES' PERCEPTIONS OF SUPPORT IN AN ACUTE CARE WORKPLACE

Elizabeth Lindsey and Carolyn Attridge

People entering nursing have been described as "angels of mercy" (Pines & Kanner, 1982) and as "youthful, enthusiastic crusaders" (Cherniss, 1980). During their training, nurses are told they are unique among the health care professionals because they provide continuity of care and emotional support as integral components of their work skills: they are always there, and always care (Mabbett, 1987). The reality of nurses' work sometimes comes as a shock to new graduates (Kramer & Schmalenberg, 1988). The actual work of nursing is often associated with the witnessing of unpleasant sights and odours, of human pain, suffering and death, in an atmosphere that is often noisy, brightly lit and highly technical. Nurses work around the clock and against the clock, carrying heavy responsibilities and heavy caseloads. Such experiences generally give rise to feelings of anger and worry, fear, depression, shame, embarrassment and resentment. These emotions are often considered incongruent with the "Florence Nightingale-inspired fantasy of ministering angel" (Gaskin, 1986); as a result, occupational stress and burnout are common phenomena (Attridge & Callahan, 1987; Dolan, 1987).

Individual counselling and work-related support groups have been cited in the literature as two of the better coping strategies to help alleviate some of the problems associated with stress and burnout (Adey, 1987; Campbell, 1985; Hingley & Harris, 1987; Tschudin, 1987; Weiner & Caldwell, 1983). However, Weiner, Caldwell and Tyson (1983) suggested that support groups are often introduced into the workplace without first assessing the needs of the individual nurse and the group as a whole; as a consequence, they often fail. A clearer understanding of what nurses need in the way of support is required, therefore. The study reported here examined and described nurses' perceptions of support and lack of support in the workplace, and documented the impact of these experiences on them professionally. Research questions were: what were acute care staff nurses' perceptions of support and lack of support in the workplace, and how did nurses perceive support or lack of support to facilitate or hinder their work performance?

A. Elizabeth Lindsey, B.S.N., M.A. is Visiting Assistant Professor in the School of Nursing, and Carolyn B. Attridge, R.N., Ph.D. is Director of the School of Nursing, at the University of Victoria, in British Columbia.

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Literature Review

Nurses working in a busy general hospital are required to function under considerable stress (Hingley & Harris, 1987) and they must cope with many conflicting stresses in the daily rounds of their activities. Often, nurses consider themselves treated like subordinates, rather than colleagues, and they perceive that they have little say in the decision making process. That is, they function under policies that others have created and are aware of holding professional responsibility and accountability without having the authority or support in exercising necessary initiatives (Fisher, 1985).

At the key point of contact in the network of patient care, nurses must deal with role conflicts among the attendant professions as well as among themselves. Also, nurses are at the prime point of contact with patients and are often required to try to reconcile conflicts between their patients' needs and the institutional policies.

In British Columbia, the limiting of government funding, in an effort to control health care costs, has contributed greatly to nurses' work-related stress. Attridge and Callahan (1987) cite the following stresses.

> Increasing nurse-patient ratios, shortages of, or ill-functioning equipment and materials, ward closures with resulting crowding of available space, reduction of inservice education opportunities at a time when the acuity and complexity of patient care is increasing (p. 7).

The conclusion or prolonged and chronic stress is burnout. This term has been labelled "the syndrome of the 1980's" (Maslach, 1982). It has been used to describe the decrease in quality and quantity of work performed by a person on the job (Paine, 1982). While every occupation carries with it the possibility of burnout, the service and helping professions are seen to be particularly susceptible (Farber, 1983). There appears to be a lack of consensus on the definition of burnout. However, Dolan (1987) accumulated the following essential elements of the burnout syndrome

> Decreased energy, shown by an inability to keep up with the work pace; decreased self esteem manifested in a sense of personal failure related to work; output exceeding input, whereby the individual perceives a greater expenditure of him/herself into a job for an even smaller profit or reward; a sense of helplessness/hopelessness and being unable to perceive alternate ways of functioning; cynicism, negativism in relation to self, others, the job, institutions, etc; and a feeling of self depletion (p. 3).

Maslach (1976) suggests that the occurrence of burnout is rooted, not in the relatively permanent traits of the individual, but in the specific social and

situational factors that can be changed. Much of the stress in hospital nursing is an inherent feature of the job. Nevertheless, creating a nursing environment that improves the staff's health is a salient goal which will benefit not only the practitioners and the organization, but the patients as well (Gentry & Parkes, 1982; Noroian & Yasko, 1982; Stillman & Sasser, 1980).

Social support has the potential to mitigate stress and burnout and improve health (Cassel, 1976; Cobb, 1976; Dean & Lin, 1977; Gottleib, 1983). Although social support is not a panacea for occupational stress, evidence suggests that social support can ameliorate the effects of stress in nursing (Constable & Russell, 1986; Cronin-Stubbs & Rooks, 1985; Firth & McEntee, 1984).

The study of social support has been applied to the workplace and the advantages of work-related support have been reported by many nursing researchers. Gray-Toft and Anderson (1983) suggest that support groups will decrease staff turnover, while Fell and MacCarthy (1986) recommend support as a way of increasing staff effectiveness by teaching conflict management. It has been found that work-related support will increase job satisfaction (Carnevale, Annibale, Grenier, Guy & Ottini, 1987; Dolan, 1987) and that support groups provide an opportunity to consult with others about patient care and augment nursing knowledge (Teark, 1983; Webster, 1983).

Attridge and Callahan (1987), in researching a quality work environment for nurses, found the highest ranking item identified by the nurses to be "supportive, amiable, enthusiastic colleagues". In a similar study, concluded in 1989, Attridge and Callahan asked nurses what they needed to redesign their work environment; they identified positive work relationships as the second highest ranking need.

Although there is extensive coverage in the nursing literature on the subjects of stress, burnout and the beneficial effects of work-related support, what is less evident is what nurses perceive their support needs to be. In what work situations do nurses feel the need for support and what is the result of that need? Do they perceive themselves to be supported or unsupported? Who are the persons involved in supportive or unsupportive behaviour, and what is the impact of support or lack of support on nurses' work performance? If these factors were better understood, then more effective work-related support could be planned, implemented and evaluated.

Method

The sample consisted of acute care registered staff nurses who had returned to university to complete their Bachelor of Science in Nursing degrees. The volunteers were told that they would be required to give specific details

about significant supportive and unsupportive incidents in their work. A consent form was signed. Strict confidentiality was assured by the designation of a code number to identify the reported incidents and all other identifying characteristics were removed.

Thirty nurses participated in the study (29 female and one male). Their ages ranged from 24 years to 53 years (mode 26 years) and their experience in the nursing profession ranged from one year to 23 years (mode five years). Experience was in a variety of acute care settings ranging from medicine to intensive care and the provinces from which the incidents were reported included British Columbia, Ontario, Alberta, Manitoba, Yukon and the Northwest Territories.

Data were collected using the *Critical Incident Technique*, a qualitative research method developed by Flanagan (1954). This technique is a form of interview research designed to collect an extensive range of incidents from people who are in a position to report their experiences. The procedure for collecting data does not consist of a single rigid set of rules governing data collection; instead, it is a flexible set of principles which may be modified and adapted to meet specific research needs (Flanagan, 1954).

Evidence of reliability and validity of the *Critical Incident Technique* has been provided by Andersson and Nilsson (1964). Validity of the category titles and definitions was judged by two university professors with extensive experience in using and analyzing the technique. Categories were re-sorted, redefined and clarified until the two university professors and the researcher agreed that the categories were a true representation of the data. Reliability in the placing the incidents under the appropriate category headings was tested by three independent judges. Each judge was given 20 randomly selected incidents and the average percentage of agreement between the researcher and the judges was 86.6%, consistent with Andersson and Nilsson (1964) who suggested a level of agreement between 75% to 85%. According to Flanagan (1954), an incident was considered critical if it made a significant contribution, either positively or negatively to the general aim of the activity. In the present study, the criterion for significance of an incident was whether or not the event facilitated or hindered the nurses work performance. The actual questions used to elicit details of facilitating or hindering events were as follows.

1. Tell me about a time in your work as an acute care staff nurse when you felt significantly supported or unsupported. What were the circumstances surrounding the event?
2. Who else was involved? Who was the person (or persons) you found particularly supportive/unsupportive?
3. How did you feel as a result of this incident?

4. In what way did the event facilitate or hinder your work performance?

In this way, the interview was directed towards concrete events rather than opinions or speculations. This procedure was continued until the subject indicated that she had no further incidents to report.

The participant interviews were tape recorded and the incidents were then transcribed onto individual index cards. The categorization was organized according to: who was supportive or unsupportive (the reported responsible agent); in what situation or circumstance the support need arose; and what outcomes occurred, (that is, was there a facilitating or hindering effect on the nurse's work performance?).

Results

One hundred and eighty-four incidents were identified, 95 were of a supportive nature and 89 were considered unsupportive. These are discussed according to the agent, the action and the outcome.

Table 1

Agent Categories

Agent	Supportive	Unsupportive	Total
Head Nurse	30	14	44
Staff Nurse	25	19	44
Doctors	13	22	35
Nursing Administrators	3	13	17
Supervisors	7	12	19
Medical Team	8	5	13
Patients' Relatives	7	0	7
Hospital Administrator	1	3	4
Para Nursing Personnel	1	1	2
TOTAL	95	89	184

Agents

Table 1 identifies the influential agents. Head nurses and staff nurses were the agents most frequently involved: in the majority of the reports, they were supportive in their actions. Physicians were the third most often cited agents and their actions were reported to be predominantly unsupportive. Higher nursing administrators (i.e. nurse administrators and supervisors) were reported to be two and a half times more unsupportive in their actions, whereas patients' relatives were reported to be entirely supportive. The medical team, hospital administration and paranursing personnel had a fairly equal mix of both supportive and unsupportive actions.

Actions

Eight action categories were developed. They described the situations the nurses were in when their support needs arose. Table 2 displays the category title and definitions, the number of incidents reported in each category as well as the numbers that were considered to be either supportive or unsupportive in nature.

An overall examination of the findings shows that nurses reported feeling most supported when the need for acknowledgement of their value and expertise was the issue. One nurse remarked on this experience of support when she told of a time when a grateful relative wrote to the Director of Nursing about her kindness and expertise: "This is what keeps us coming back, it's what makes it all worthwhile, it's when I know I am in the right profession." Support was also evident in situations of work-related emotional stress and in collegial work relationships and in these two categories, the support came from other staff nurses.

Nurses reported feeling predominantly unsupported in issues concerning their control over work, and physicians were most often cited as the unsupportive agents. One nurse commented on her feelings of frustration in this regard when she said, "It's awful when you know what should be done, but you feel compelled to follow orders that you know are not right for the patient." Similarly, nurses reported feeling unsupported when the availability of resources was the issue, and in this category, nursing administrators were reported to be the unsupportive agents. There were almost an equal number of supportive and unsupportive incidents reported in the categories of vulnerable or humiliating work circumstances, in work and career advancement and in the conflicts concerning nurses' work and personal life needs.

Outcome

The outcome for nurses varied considerably, depending on whether they considered themselves to be supported or unsupported. For the supportive

Table 2

Situation Categories and Incident Frequencies

Value/Respect for Nursing Expertise and Quality Patient Care
Situations where recognition of work and the quality of the nurse and/or her work are the issue.
Total: 38 Supportive: 28 Unsupportive: 10

Control Over Work
Situations in which the nurse's ability to control her own work (i.e., apply her knowledge, implement decisions, pursue a particular role, or work in her best judgement) is at issue or is challenged.
Total: 31 Supportive: 4 Unsupportive: 27

Work-Related Emotional Stress
Situations in which the work-related emotional needs of the nurse are paramount.
Total: 16 Supportive: 17 Unsupportive: 9

Vulnerable/Humiliating Work Circumstances
Situations in which the nurse's professional self is threatened (i.e., she is vulnerable or humiliated and needs to be protected or defended) as in perceived error circumstances.
Total: 24 Supportive: 13 Unsupportive: 11

Collegial Work Relationships
Situations where the issue is the need for competent, committed and trustworthy colleagues, working cooperatively together as a cohesive unit, recognising the work-related needs of one another.
Total: 23 Supportive: 16 Unsupportive: 7

Resource Availability
Situations where the adequacy of the human resources support (i.e., adequate staff/patient ratio) and the safety of the nurse or her work environment are in question.
Total: 19 Supportive: 6 Unsupportive: 13

Work/Career Advancement
Situations where the professional development, advancement of nursing practice, and educational needs (i.e. adequate orientation and inservice, continuing education and special grooming) of the nurses are the issue.
Total: 17 Supportive: 8 Unsupportive: 9

Work and Personal Life
Situations where the nurse's personal life and needs and the demands of her work are in conflict.
Total: 6 Supportive: 3 Unsupportive: 3

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incidents, nurses talked mostly of a heightened self-esteem, greater self-confidence and a motivation to work to the best of their ability. Whereas, if they perceived themselves to be unsupported, they felt anger, frustration, disinterest and a lack of motivation to give optimal patient care. Seventeen of the 89 unsupportive incidents produced surprising results. That is, although the nurses perceived themselves to be unsupported in their work, they reacted by becoming more assertive, behaving as a patient advocate and being determined to work harder to improve their work conditions. Conversely, three nurses, although they perceived themselves to be supported at work, reacted negatively by feeling inadequate that they should need such assistance and support.

Nurses reported the unsupportive incidents to have the greatest impact on their work performance. Eighteen nurses reported leaving their jobs as a result of a specific unsupportive incident. That is, 60% of the nurses interviewed changed their place of employment because they experienced a lack of support at work. This supports the importance or work related support found in the literature.

Discussion

The high incidence of job turnover is a critical finding. In 1987, the nurse vacancies in British Columbia reached a seven-year high (RNABC, 1988) with a vacancy rate of 38% in general acute care and 30% in critical care (RNABC, 1987). Messages from the media and professional organizations clearly indicate that this nursing shortage is nationwide at this time. What can be done about this problem? Nurses need support at work and strategies must be initiated to create a more supportive atmosphere. Inservice education on assertiveness training and on relaxation and stress management techniques could be implemented. As well, strategies could be devised to help nurses deal with their emotions and, when appropriate, express their feelings more freely. Cognitive restructuring could be taught to help nurses alter their negative thoughts and responses and to think more clearly in relation to themselves and their health care setting. Peer support training could be introduced into the workplace and the formation of support groups encouraged. Finally, individual counselling should be introduced into the workplace and, where necessary, a referral service available through the occupational health departments.

Professions such as nursing, which attracts individuals with high ideals, are particularly vulnerable to the dangers of employee burnout (Pines & Kanner, 1982). The costs of preparing competent nurses are high - too high to loose them through high turnover rates resulting from job stress. Support groups, assertiveness training, relaxation and stress management, cognitive restruc-

turing and individual counselling are all strategies to help reduce the impact of job stress and support nurses in their work.

> We must learn that nurses are people, not machines. Machines don't need support. People do, and they give it best when they get it for themselves, P.R.N." (Jones, cited in Shendell-Falik, 1985, p. 15)

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RÉSUMÉ

Sentiment que les infirmières des unités de soins intensifs ont d'être aidées

Cette étude a pour objet d'élaborer et d'examiner un ensemble complet de catégories décrivant le point de vue des infirmières affectées aux unités de soins intensifs au chapitre de l'aide qu'elles reçoivent dans le cadre de leurs fonctions. La technique des incidents critiques a été utilisée en vue d'obtenir des renseignements sur 184 incidents survenus à 30 infirmières; 8 grandes catégories ont été établies qui décrivent les situations spécifiques vécues par les infirmières au moment où celles-ci ont eu besoin d'aide. Les infirmières reçoivent de l'aide lorsque le besoin de reconnaître leur valeur et leurs compétences se fait sentir, dans le cadre de leurs relations de travail ou de situations émotives stressantes liées au travail. Les infirmières déclarent ne recevoir aucune aide lorsqu'elles ont l'impression de n'exercer aucun contrôle sur leur travail ou lorsque l'enjeu a trait à la disponibilité des ressources. Les incidents qui n'ont débouché sur aucune forme d'aide sont ceux qui exercent la plus grande influence sur leur rendement et 60 % des infirmières interrogées indiquent avoir quitté leur emploi pour cette même raison. Des recommandations ont été formulées afin d'aider les infirmières à exploiter des stratégies leur permettant de surmonter leurs problèmes et la création de groupes d'aide professionnelle et de services de counseling a été suggérée.

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WHO THE DICKENS BROUGHT SARAI GAMP TO CANADA?

Joyce M. MacQueen

In 1843, in his novel *Martin Chuzzlewit*, Charles Dickens created a character named Sarai Gamp, a nurse - elderly, uncaring, alcoholic. Most nursing students in Canada learn about Sarai Gamp and the dark period of nursing in England; the tendency is to assume that our nursing history mirrors that of England. Early Canadian nurses have been described as Sarai Gamps. But is it fair to tar early Canadian nurses with this brush? The purpose of this paper is to compare conditions in mid-nineteenth century Britain and Canada and to determine how and why Canadian nursing history differs from that of Britain.

Review of the Literature

Indeed, the historical accounts of two early Canadian Hospitals, the Kingston General Hospital (Angus, 1973) and the Montreal General Hospital (MacDermot, 1940), contain references to their early nurses as Sarai Gamps.

In the history of the Montreal General Hospital School of Nursing, Sir William Osler is quoted as saying:

> When I entered the Montreal General Hospital, where I began the study of medicine in 1868, we had the old time nurses.... Many of them were of the old type so well described by Dickens, and there are some of the senior medical men present who remember the misery that was necessary in connection with that old-fashioned type of nurse. (MacDermot, 1940, p. 7-8)

MacDermot (1940) quotes another physician with the caution that "due allowance must be made for the natural vigour of his style" (p. 8). This physician claimed, "In my day [the late 'sixties and after] age and frowsiness seemed the chief attributes of the nurse, who was ill-educated and was often made more unattractive by the vinous odour of her breath" (p. 8). However, given hospital conditions (understaffing, poor plumbing, rats), it is perhaps unfair to criticize the appearance of the nurse.

Joyce M. MacQueen, B.N., M.Ed., M.Sc. is Associate Professor in the School of Nursing, at Laurentian University in Sudbury, Ontario.

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In his study of the nineteenth-century Canadian hospital, S. Shortt (1983) concludes that, "Canadian hospital historiography can legitimately borrow insights from British and American scholars" (p. 10). He reaches this conclusion after careful consideration of the evidence presented by these scholars. In his work, *The Canadian Hospital in the Nineteenth Century: An Historiographic Lament,* Shortt laments both the quantity and the quality of secondary material on Canadian hospitals. He claims that "it generally fails to transcend hackneyed judgments...exemplified by the curt dismissal of nineteenth-century nurses as 'for the most part coarse and ignorant women'" (p. 4).

Purpose of the Paper

Physicians' descriptions of early nurses are easy to find, but we must not rely solely on these physicians' retrospective recollections. Was Sarai Gamp really a fair image of nurses in mid-nineteenth century Canada, or was the label a reflection of difference in social class between the nurse and the individual describing her? The purpose of this paper is to examine characteristics of those nurses (prior to the beginning of hospital training programmes) and to compare these characteristics to those of British nurses of the same period.

Definitions

Before we begin our examination of nineteenth century nurses, it is important to identify what is meant by "nurse" in that period. Clearly, any definition based on training or registration is precluded. Dingwall, Rafferty and Webster (1988) refer to this definitional problem as one of "nurses before nursing" (p. 4). In order to arrive at a meaningful definition, they examine "what...the care of the sick consist[ed] of in the early nineteenth century and who gave it" (p. 6). The four categories of worker that these British authors identify are: members of the sick person's household; handywomen working either in the home or in hospitals; private nurses working either in the home or in the hospitals; and male medical attendants. Handywomen and private nurses "were independent, self-employed workers...distinguished mainly by whether they were providing a cheap service for the poor or a premium service for the better-off" (p. 7). They caution that "it would probably be a mistake to draw too strong a distinction between handywomen and private nurses" (p. 16).

In her study of American nursing, Susan Reverby (1987) identifies five groups that were classified as nurses in the period before nurses' training: the child nurse or nursemaid, the wet nurse, the midwife, the general healer or herbalist and "most commonly, ...a woman summoned to aid in the care of the sick and infirm" (p. 13). Reverby found that "age and marital status...separated the nurse from domestic servants or other working

women.... Most white women who sought wage labor were in their twenties, whereas nurses tended to be in their thirties or forties" (1987, p. 15).

It is interesting and surprising that neither Reverby nor Dingwall and his associates have a category of nun as nurse. Only by stretching the meaning of their categories is it possible to fit nuns into their schema. In the British context it is understandable that Dingwall, Rafferty and Webster (1988) do not include the category of nun in their definition of nurse for the mid-nineteenth century though they do examine the influence of sisterhoods on the development of nursing. That Reverby (1987) does not include nuns in her definition of nursing is problematic and suggests that she was relying on British scholarship rather than American evidence.

In this paper the term "nurse" will be used for anyone who is listed as that in a census tract or on an institutional list of employees or on a list of nuns whose work was with the ill. If possible, child nurse (nursemaid), domestic servant and midwife will be categorized separately.

Method

In order to understand the context of nursing in the mid-nineteenth century, a brief general comparison of the demographics, the social characteristics and the organization of medical and hospital care in Britain and Canada was carried out. For demographic data, the census year 1851 was chosen because it was the census closest to the mid-point of the century and because it is the year of the British census that Nightingale presents.

Demographic data on nurses were collected to answer the following questions: How many nurses were there? What was their age and marital status? Did they work in homes or in institutions?

Demographic data are not as readily available for Canadian nurses as it is for British. Canada did not exist as a political unity in 1851, though census information is available for sections of Canada. Because of this difficulty, only a section of Canada was studied: Upper Canada (now the province of Ontario) was chosen.

In the Canadian census, the population is described in terms of age, marital status, religion, country of birth, education and occupation. Occupation is given in five classes-agricultural, commercial, domestic, industrial, professional. Nursing was not separated out (though midwifery was), suggesting that it did not constitute a significantly large group. The census also contains the numbers employed in various factories and institutions (for example: mills, distilleries, pot and pearl asheries, churches), but not hospitals. Therefore, some other method of discovering information about nurses had to be

employed, even though this information would not have the accuracy of a census. Information was obtained from census enumerations for hospitals (these figures represent the patients in the hospital and might include staff living in the hospital), sisterhood records and manuscript census tracts.

Census manuscripts are handwritten documents that list the names of individuals by household, and that state age and occupation. The Upper Canada census manuscripts for 1851 have been lost, therefore the 1861 manuscript census tract was used. For purposes of a comparison with British nurses, and on the advice of the provincial archivist, a sample population was chosen. The ward of St. Andrew's in Toronto, an urban area (population 5,581), was selected because it was the most likely to contain nurses. The county of Essex (population 14,937) was selected as a rural area.

Findings

Canada and Britain differed demographically and socially. As well, there were differences in the organization of medical and hospital care.

In the mid-nineteenth century Britain was densely populated, with many urban centres. The population of Britain was over 21 million, with roughly 600,000 more women than men. In London the population exceeded three million, with 200,000 more women than men. This difference increased with age.

In contrast, the population of Canada was sparse and largely rural. For example, the population of Upper Canada was 952,004, approximately one-third the population of London. There were more men than women in the country as a whole, though some areas had slightly more women than men. The populations of cities such as Montreal (57,715), Toronto (30,775) and Kingston (11,697) were small in comparison with the populations of cities in England.

Demographic contrast between Britain and Canada during this period is reflected in the social characteristics of the two countries. Unlike Canada, Britain was industrialized and was, in fact, experiencing the effects of an industrial revolution that had fostered a wealthy middle class and a suffering lower class. Middle-class women did not work for wages outside the home though they engaged in philanthropic enterprises. Maggs (1983) explains the philanthropic enterprises on the basis of surplus women in the middle classes. Poor women, of course, had to do whatever they could to survive. They worked in mines and factories and in the homes of the wealthy. When a woman could no longer work in the mines and factories because of age, she still had to support herself. Nursing and prostitution were two "natural" areas of work for women. Consumption of alcohol was generally widespread

and there were many campaigns against alcoholism (Harrison, 1971). Dickens brought age, alcoholism, nursing and, possibly, prostitution together in the character of Sarai Gamp.

Canada did not have as distinct a class system as Britain, but there certainly were "ladies" who formed benevolent societies and poor women who worked for a living. Because men outnumbered women in the population, fewer women were required to support themselves. Statistics on alcoholism for the mid-nineteenth century are not available but, on the basis of 1871 data (Popham & Schmidt, 1958) and from the 1895 *Report of the Royal Commission on the Liquor Traffic in Canada*, we may assume that there was concern about alcoholism.

Britain had many large hospitals, mainly for the poor, and these had a clear organizational structure. For example, the 1819 history of St. Thomas's Hospital in Southwark describes the duties of each level of worker (Golding, 1819). In the case of nursing, there are the matron, the sister or head nurse and the nurse. However, regardless of the position, they were all classified as female domestics. Nurses' duties in 1819 did not sound unlike current nursing responsibilities. For example, the instructions for the head nurse state the following.

> You shall carefully place all the medicines for outward applications distinctly from those for internal use, and administer to the patients under your care the medicines prescribed by the physicians and surgeons of this hospital, or which shall be delivered to you by the apothecary for that purpose; and, when called upon, you shall be ready to acquaint the physicians, surgeons, or apothecary, with the effects of such medicines during their absence, so far as falls within your observation. (Golding, 1819, p.203)

The drinking of beer was common practice, possibly because of the lack of good water, and nurses were given regular rations of beer in addition to their salaries (Williams, 1980).

The earliest hospitals in Canada, such as the Hôtel Dieu in Montreal (1644), were those founded by Roman Catholic sisters. Public hospitals were developed, usually by groups of women. For example, the Montreal General Hospital began as a four bed hospital set up by the Female Benevolent Society in 1818 (MacDermot, 1940). In Kingston a Compassionate Society operated a hospital during the winter months (it closed from May to November). This eventually became the Kingston General Hospital (Angus, 1973). These early hospitals had few attendants. The Montreal General Hospital, with 72 beds, was staffed with a matron, two nurses, a house surgeon/apothecary, an orderly and a cook (MacDermot, 1940). Nursing was

very hard work, in very unpleasant circumstances, and many nurses contracted diseases from their patients and died. The Montreal General had seven matrons in 15 years; four of these died in office (three of typhus and one of "fever"). MacDermot (1940) says that most of the nurses were married women (p. 5). In Canada, as in Britain, nurses were given rations of beer. For example, female employees (of which there were approximately three) at the Montreal General Hospital received *seven* gallons of beer a week (MacDermot, 1940). There are also records of nurses being discharged for inebriety and immorality.

In 1851 there were few hospitals in Canada, and those that existed were small in comparison with British hospitals. For example, in Upper Canada the three largest hospitals were the Toronto General Hospital, the Kingston General Hospital and the Kingston Hôtel Dieu. Altogether these three hospitals had fewer than 150 beds (*Census of the Canadas, 1851-52).*

Despite these demographic, social and health care differences between Britain and Canada, nurses in both countries have been similarly described as Sarai Gamps. What is required is a more factual description of the nurses in both countries.

Table 1

Great Britain Nurses - Census 1851

Age Group	Not Domestic	Domestic Servant
5- 9 years		508
10-14		7,259
15-19		10,355
20-29	1,441	10,711
30-39	2,468	4,176
40-49	4,971	2,674
50-59	7,438	2,029
60-69	6,367	1,081
70-79	2,314	305
80+	458	41
All ages	25,466	39,139

Florence Nightingale (1860), in an Appendix to her Notes on Nursing, presents the census for nurses in Great Britain in 1851 (Table 1). In the census, nurses are placed in two categories, domestic servant and not domestic. In all there were over 60,000 nurses. Nurses in the domestic servant category were very young, some as young as five-to-nine age category. Non-domestic nurses were older, in fact much older. Many were over 65 years of age, and some even over 80 years of age. These data support the Sarai Gamp image in terms of age. Maggs (1983) estimates that there were fewer than 1,000 hospital nurses in Britain in this period "taking a crude nurse/patient ratio of 1:6 and the estimates made by others of bed-provisions" (p. 6).

However, the appropriateness of the Sarai Gamp image as a description of even the British mid-nineteenth century nurse is being questioned. Williams (1980) presents descriptions of nurses from several British physicians of the time that do not accord with the Gamp image. She takes, as further evidence, the fact that Elizabeth Fry sent her home nurses into the hospital for training and accepted the hospital system as it was.

> The characterisation of the hospital nurse as 'Sarah Gamp' was created at the time to support philanthropic claims for changes that were based on different ideals and different social arrangements from those that obtained, and that it is a reputation rather than a set of facts that has become incorporated into popular nursing history. (Williams, 1980, p.58)

Williams' hypothesis may be true for Canada, too. Even though William Osler described some nurses as Dickensian, he also gave examples of other kinds of nurses: "One, a Miss Lancashire, was in looks the old-fashioned Dickensian nurse, but in behaviour, in devotion and in capability equal to the best I have ever met." (MacDermot, 1940, p.8)

How does the number of Canadian nurses and their ages and marital statuses compare with what is presented in the British information? Because of the difficulty with Canadian census data described earlier, the number of nurses in Upper Canada can only be estimated. In order to arrive at this estimate, four categories were considered: midwives, nurses employed in hospitals, nuns and nurses employed in private homes.

Midwives. The census for 1851 gives the number of midwives in Upper Canada as 17.

Nurses employed in hospitals. The following enumerations are listed for each hospital in Upper Canada (these figures may include staff living in the hospital): for Toronto, the General Hospital (71), the General Dispensary and Lying in Hospital (12), the Maternity Hospital (4), the Lying in Hospital

(15); for Kingston, the General Hospital (32), the Hôtel Dieu (45). On the basis of published hospital histories (Angus, 1973; Clarke, 1913; MacDermot, 1940), we know that there were between three and five nurses in a 70 bed hospital. This means that probably no more than 15 nurses worked in general hospitals in Upper Canada. On the basis of Maggs's estimate of a 1:6 nurse/patient ratio, as many as 30 nurses might have been working in general hospitals. Although lunatic asylums were large (approximately 350 patients in Toronto), they had fewer nurses than general hospitals. The occupational census for Upper Canada for 1851 lists four lunatic asylum keepers in Toronto. The 1861 manuscript census for the Malden Lunatic Asylum lists six nurses as well as several asylum keepers. Therefore, a distinction was made between asylum keeper and nurse. There was a spread in age for the hospital nurses. For example, the six nurses listed for the Malden Lunatic Asylum in Essex County were 19, 21, 21, 27, 29 and 46 years of age.

Nuns. These were young women who were sent from their mother houses to Upper Canada. In 1845, Mother Bourbonniere and four nursing sisters arrived in Kingston from Montreal to establish the Hôtel Dieu (Gibbon & Mathewson, 1947); in 1851 the first four Sisters of St. Joseph arrived in Toronto from the United States (Sisters of St. Joseph Motherhouse). By 1861, there were approximately 60 Sisters of St. Joseph, but that number also included those who were teaching. The 1861 manuscript census for Essex County lists only four Sisters of Charity. The number of nuns nursing in Upper Canada in 1851, therefore, undoubtedly was small and was divided between hospital and community work.

Nurses employed in private homes. The only way of finding this information was to go through the census manuscripts laboriously, name by name; then, for those listed as nurses, to distinguish, on the basis of surname and family structure, those who were family members and those who were employed in the household as nurses. In St. Andrew's 11 women were listed as nurses and one as a nurse maid. Probably seven of these were employed as nurses in the households in which they were enumerated. That is, these women appeared to be household employees rather than family members. All of these households had young children, and most of them also had servants and cooks listed. It seems likely, then, that the major responsibility of the person listed as nurse was the care of children but not general household work. In Essex County, eight nurses were in the census; six of these were with the asylum, and probably only one was employed in a private home. Clearly, in rural Essex County (including the town of Windsor), it was not common to hire nurses for private households; in wealthy, urban St. Andrew's however, it was.

If one extrapolates from the number of nurses in this population sample of 20,518 to Upper Canada as a whole (population 952,004), it is possible that

between 300 and 400 nurses worked in private households in Upper Canada. However, given regional differences within Upper Canada, this is a tenuous estimate.

The age of nurses in Canada differed from those in Britain. A reading of hospital histories relating to the mid-nineteenth century (Toronto General, Kingston General, Montreal General) suggests that hospital nurses were relatively young compared with British nurses and were mostly married or widowed. According to the manuscript census of 1861 for the ward of St. Andrew's and Essex County, of the eight who were employed in households, the five youngest were single (ages 15, 19, 20, 26, 33), and the three oldest were married (ages 38, 38, 52). Of those listed as nurse or matron, but not likely employed in a private household, four were single and nine were either married or widowed. Their ages ranged from 19 to 69, but only two were over 50 years of age.

Discussion

The demographic and social differences between Canada and Britain lead one to suspect differences between the nurses as well. The description of Canadian nurses as Sarai Gamps (elderly, uncaring and alcoholic) relates probably only to a very small number of individuals. The description, for example, is inaccurate in terms of age. In Canada, nurses employed in private households were older than the young children listed as domestic nurses in the British census, but they were not elderly. Hospital nurses were not as old as their British counterparts, and the nursing sisters (nuns) who had recently arrived in Upper Canada were young.

Some nurses in Canada probably were uncaring and these fit the description of Sarai Gamps. However, the literature also contains descriptions of nurses who were caring and expert at their work. The quality of care given by nuns was never in question. Dolan, Fitzpatrick and Herrmann (1983) claim that in the early nineteenth century "almost the only good hospital nursing was done by religious orders" (p. 137).

And, finally, even though some Canadian nurses were discharged from their duties because of alcoholism, it is important to note that they were *discharged,* suggesting that the alcoholic nurse was not tolerated in the Canadian system.

Conclusion

The conclusion may be drawn that the description of Canadian nurses as Sarai Gamps related to very few individuals and was used merely as a convenient retrospective label to bolster the importance of hospital training for

nurses. The findings in this paper emphasize the difference in number, age and marital status between Canadian and British nurses in the mid-nineteenth century. They also demonstrate the importance of examining Canadian historical evidence before borrowing insights from British scholars.

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RÉSUMÉ

Qui a introduit Sarai Gamp au Canada?

En 1843, Charles Dickens crée le personnage de Sarai Gamp, une infirmière âgée, négligente et alcoolique. Au Canada, les chroniques d'hôpitaux évoquent souvent des infirmières à la Sarai Gamp. Cette image est particulièrement tenace bien que de récentes études aient remis en question sa pertinence, même en Grande-Bretagne. Sarai Gamp est-elle un portrait juste de l'infirmière canadienne du XIXe siècle? L'objet de cet article est d'examiner certaines caractéristiques propres aux infirmières du milieu du XIXe siècle au Canada. Faute de données censitaires pour cette période, cet article ne porte que sur les infirmières du Haut-Canada. Les données sont analysées en fonction du contexte social prévalant en Grande-Bretagne et au Canada avant d'être comparées aux données qui correspondent aux infirmières britanniques, pour la même période. Les résultats font ressortir des différences notoires au chapitre de l'effectif, de l'âge et de la situation matrimoniale entre les infirmières canadiennes et britanniques du milieu du XIXe siècle.

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NURSES' VERBAL EMPATHY IN FOUR TYPES OF CLIENT SITUATIONS

Joanne K. Olson and Carroll L. Iwasiw

Nurses are constantly confronted with the emotions that clients experience in health care situations: their responses can affect client outcomes. Although nurses' communication skills have been studied, their empathy responses to specific types of client situations have not been investigated.

The purpose of this study was to investigate whether differences exist in staff nurses' verbal empathy in response to clients who experience pain, depression, anxiety or anger – four situations common in health care. This investigation was part of a larger study of nurses' communication skills.

Literature Review

Therapeutic relationships in nursing

Therapeutic nurse-client relationships have been addressed in the nursing literature since the time of Florence Nightingale (1859). Several early nursing theorists described nursing as a relationship between a nurse and a client (King, 1981; Orlando, 1961; Peplau, 1952; Travelbee, 1971). More recent nursing theorists have not specifically described the nature of a therapeutic nurse-client relationship, but such a relationship is implicit within their theories (Neuman, 1982; Newman, 1986; Orem, 1985; Rogers, 1970; Roy, 1976).

Empathy

Empathy is one of the most essential and complex variables in communication (Forsyth, 1980; Gagan, 1983; Kalisch, 1973; La Monica, 1981; Rogers, 1957; Stetler, 1977). The concept has been described in the literature for over 100 years (Gladstein, 1984).

Some authors have described empathy as interpersonal perception or intuition, the ability of one individual to know or predict the emotions of another

Joanne K. Olson, B.Sc.N., M.S. is Assistant Professor and Carroll L. Iwasiw, B.N., M.Sc.N. is Associate Professor in the Faculty of Nursing at the University of Western Ontario in London, Ontario.

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(Cline & Richards, 1960; Cronbach, 1955; Hobart & Fahlberg, 1965). Empathy has also been described as a vicarious emotional response to the perceived emotional experiences of others (Mehrabian & Epstein, 1972). Northouse and Northouse (1985) referred to understanding the feelings and thoughts of another. Kalisch (1977) has expanded these definitions to include a verbal component: empathy is the accurate perception of the feelings of another person and the ability to communicate this understanding back to him.

Others have defined empathy as the helper's understanding of both the client's feelings and the circumstances to which the client attributes those feelings, and the communication of this understanding back to the client (Brammer, 1985; Carkhuff, 1977; Egan, 1986; Gerrard, Boniface & Love, 1980). Rogers (1957, 1958, 1961) has described empathy as having three components: affective (sensitivity), cognitive (observation and mental processing) and communicative (helper's response). These definitions have led to behavioural training models and behavioural evaluations of empathy skills.

Attempting to be supportive, helpers may make statements such as, "don't worry" or "you shouldn't feel that way". These statements are antithetical to empathy because they discount or negate the feelings and deny the client's right to experience those feelings (Gerrard & Buzzell, 1980). Such statements are hurtful to the client and may prevent further productive conversation (Gazda, Walters & Childers, 1975).

Empathy levels of nursing staff

The affective and cognitive components of communicative empathy have been assessed in nurses. Truax and Millis (1971) reported that registered nurses (RN's) were generally low in empathy in comparison to 12 other occupational groups. In contrast, Forsyth (1978) found that the majority of nurses' scores on the *Hogan Empathy Scales* were in the middle and upper range. Medical-surgical nurses had the lowest mean scores and psychiatric nurses the highest mean scores (compared to hospital administrators and psychiatrists) on the empathy scales of the *California Psychological Inventory* (Brown & Hunter, 1987). Bagshaw and Adams (1986) reported that RN's employed in nursing homes had a mean score of 183 on the La Monica's (1981) *Empathy Construct Rating Scale*. Scores can range from -252 (low empathy) to +252 (high empathy).

These studies have assessed the prerequisites of the communicative component of empathy. However, this predisposition cannot be interpreted as a measure of actual practice. Furthermore, the potential for a bias of social desirability is present in the self-rating instruments used.

The communicative component of empathy (verbal empathy) has only been assessed in a few studies. In response to the *Behavioural Test of Interpersonal Skills* (BTIS), RN's obtained verbal empathy scores of less than 60% (Iwasiw & Olson, 1985; Olson & Iwasiw, 1987). Pennington and Pierce (1985) studied the correlations between verbal empathy and demographic variables, and found that younger staff with moderate lengths of experience were the most empathic.

The lack of opportunity for on-going dialogue with simulated clients on the BTIS and the presence of observers in Pennington and Pierce's study may have affected the nature of subjects' responses. No conclusions can be drawn about quantitative levels of empathy and client outcomes.

Outcomes of the health professional-client relationship

Favourable psychological client outcomes (Ben-Sira, 1976; Bent, Putnam, Kiesler & Nowicki, 1976; Korsch & Negrete, 1972), such as client satisfaction and behavioural client outcomes (Becker, Drachman & Kirscht, 1972; Kincey, Bradshaw & Ley, 1975; Ludy, Gagnon & Caiola, 1977), particularly compliance, have been related to positive client-health professional relationships. More specifically, some link has been established between the use of therapist empathy during psychotherapy and positive client outcomes such as increased self-concept and client satisfaction (Mullen & Abeles, 1972; Sweet, 1984; Truax and Mitchell, 1971; Truax et al., 1966; Truax, Witmer & Wargo, 1971; Williams, 1979). McKay, Hughes and Carver (1986) reported that nurses' use of empathy was related to increased patient self-disclosure. However, the outcomes cannot be attributed solely to the health professional's empathy. Health professional-client relationships are complex and occur within changing contexts. Studies employing techniques of multivariate analyses are required to determine the relative importance of the variables affecting client outcome.

Therapeutic relationships have been identified as an important aspect of nursing practice. Empathy has been recognized as essential to a therapeutic relationship, although precise links between levels of helper empathy and client outcomes have not been described. No literature was found which addressed nurses' communication skills and empathy specifically, in response to different types of client situations.

Conceptual Framework

Concepts

Nurse. The nurse is a knowledgeable, thoughtful professional who has the desire and the skills to be of assistance to clients. While focussing on the

client's concerns and perspectives, the nurse suspends personal needs. The nurse employs a wide range of knowledge to assess and interpret the client's behaviour, and responds in a manner that is intentionally helpful. The interaction with the client is continually evaluated by the nurse and the relationship is terminated when mutually established goals have been achieved.

Clients. Clients are individuals who possess the capabilities of all people, but who require and seek the assistance of others expected to be of help in alleviating or preventing a health problem. Clients strive to maintain their uniqueness in the potentially depersonalizing health care system. Acceptance of help may be dependent upon how well the nurse supports their view of themselves as unique and valued individuals.

Therapeutic nurse-client relationship. A therapeutic nurse-client relationship is one in which the nurse assists the client to express thoughts, feelings and concerns. The relationship is focused on the client's perspective of the situation causing concern and the reactions resulting from that perspective. The goals of the relationship are for the client to feel less isolated, to feel accepted as a unique individual and to learn new ways of coping with or managing the situation. A therapeutic relationship is purposeful in nature.

Verbal empathy

Empathy has been identified as one of the major elements in establishing the trust that is essential to a therapeutic relationship (Rogers, 1958, 1961). Verbal empathy is the statement of the accurate understanding of another's feelings and the reason the other believes he is experiencing those feelings. It is based upon a desire to understand, the ability to listen accurately, the ability to interpret another's statements and behaviour and the ability to state this interpretation back to the client. This definition emphasizes the communicative component of empathy. Verbal communication is essential because a helper's knowledge of the feelings and experiences of the other is of little value unless successfully communicated (Stetler, 1977). A predisposition to help and a silent, internal understanding are inadequate bases for a therapeutic relationship. Verbal empathy by the nurse must be both an initial and an on-going response in a therapeutic nurse-client relationship.

Relationship of the concepts

When the nurse and client meet in a health care situation, the client expresses thoughts, feelings and needs in many ways. Through the nurse's verbal responses of empathy, clients know that the nurse is able to view the situation from their perspectives. Verbal empathy will encourage the client to trust the nurse and to disclose further. The cycle of client disclosure and the nurse's verbal empathy form the basis for a therapeutic relationship.

Definitions

Verbal empathy is: the accurate restatement of the feeling and content of another's message. Terms used in the hypotheses are:

Content: The reason for the speaker's feeling.

Feeling: Any relevant general (e.g. upset) or specific (e.g. angry) reference to the speaker's feeling.

Don't Feel: Any attempts to suppress or discourage expression of the speaker's feeling (Gerrard & Buzzell, 1980, p.43).

Hypotheses

No literature was found about nurses' empathy in different types of client situations; as such, it was expected that nurses would be equally empathic in all situations. The specific hypotheses were:

1. There will be no differences in scores for the category "content" in client situations of pain, depression, anxiety, and anger.
2. There will be no differences in scores for the category "feeling" in client situations of pain, depression, anxiety, and anger.
3. There will be no differences in scores for the category "don't feel" in client situations of pain, depression, anxiety and anger.

Method

Sample

Settings comprised six acute care hospitals and two community health agencies in two Ontario cities. Full-time RN's who had been employed as staff nurses for at least one year, and who were graduates of Canadian nursing programs, were the target population. Staff nurses were defined as nurses who spent at least 75% of their time in direct patient care.

The population consisted of 840 staff nurses. Every second eligible diploma nurse by clinical area and all baccalaureate nurses in the acute care agencies were invited to participate. All nurses in the community agencies were asked to participate. It was hoped that this procedure would yield approximately similar numbers of hospital- and community-based baccalaureates to meet other study purposes. The data-producing convenience sample was composed of 66 volunteer nurses.

The age range of the sample was 23 to 59 years, with 71.3% between the ages of 25 and 34 years. Over one-third of subjects had 1-5 years of nursing practice and over one-third had 6-10 years of practice. All 28 community health nurses and 14 acute care nurses had a baccalaureate nursing degree. Twenty-four acute care nurses had a nursing diploma.

Instrument

The *Behavioural Test of Interpersonal Skills* (BTIS) was used. It . . . "is a test that can be used to assess the interpersonal/ interviewing skills of any health professional. The half-hour test consists of 28 common patient and health professional situations which have been role-played by actors and actresses and recorded on color videotape" (Gerrard & Buzzell, 1980, p. 1). There is a 30-second silence on the videotape that allows subjects to respond after each situation. Specific clinical knowledge is not required for effective responses. In each situation, the actor's feelings are apparent, through either statements or behaviour. The reason for the feelings is stated.

Content validity of the BTIS was established through an extensive literature review and input from 68 health professionals. Fair concurrent validity of the "feeling" category was established through peer ($r = .38$) and supervisor ($r = .33$) ratings of psychiatric nurses and nurses enrolled in graduate study. In the same study, fair concurrent validity ($r = .33$) was established for the category "content" through peer ratings. A fair negative correlation ($r = -.33$) was established between the "don't feel" category and supervisor ratings on the rating scale dimension "knows how I feel". Construct validity of the "feeling" ($p = .004$) and "don't feel" ($p = .001$) categories was demonstrated by comparing scores of two "known to be different groups" (Gerrard & Buzzell, 1980).

The BTIS includes two of each type of the following client situations.

Pain - The client refers to physical pain and feelings of discouragement or fear: "It's a dull nagging pain. I don't know what else I can tell you. It just goes on and on night and day. I don't think it's ever going to go away."

Depression - The client has a sad facial expression and makes a statement referring to his unhappiness: "Even since my surgery life hasn't been the same. I don't know where to turn. I wonder if it's worth going on."

Anxiety - The client expresses a vague dread or apprehension and has a worried facial expression: "I feel so weak. What am I going to do? Will I ever get better? Just look at me, I can hardly sit up without getting dizzy. What am I going to do, what am I going to do?"

Anger - The client is shouting and has tense facial muscles: "I'm sorry but I've got to sound off to someone and you're the first one in here. I can't understand why I'm not getting more care. This is the third day I haven't had any help with my walking. I'm trying to get better and nobody's helping me."

Data collection

Data were collected at the agencies employing the subjects over five months. One community health agency allowed nurses to use work hours for study participation. Individual appointments were made for data collection. Subjects were alone and audiotaped as they responded to the BTIS. There were no interruptions during audiotaping. Written consent and demographic data were obtained.

Scoring procedures

Each communication behaviour (feeling, content, don't feel) was scored as being present or absent in the subject's response to each of the eight client situations. A total of 528 situations were scored. Scoring was done by the principal investigators, who had established inter-rater and intra-rater scoring reliability prior to the study. Kappa statistics for reliability ranged from 0.85 to 0.98 on each scoring category. This same level of inter-rater and intra-rater scoring reliability was confirmed during the study, using ten randomly selected rated tapes.

Results

Hypotheses were tested with pair-wise comparisons of the different situations. A two-tailed Wilcoxin matched-pairs, signed-ranks test was used. To maintain a Type 1 error level of .05, individual comparisons carried Type 1 errors of .0083 to allow for multiple comparisons.

Hypothesis 1 was supported. There were no significant differences in nurses' scores in the category "content" for the four types of situations. The mean "content" score was 7.87 (60.56%) on 13 situations.

Hypothesis 2 was not supported. For the category "feeling", nurses obtained higher scores in situations of pain ($X = 8.65$) than depression ($X = 4.53$) ($Z = -3.881$; $p = .0001$); higher scores in situations of pain than anxiety ($X = 4.00$) ($Z = -3.466$; $p = .0005$); and higher scores in situations of anger ($X = 5.33$) than depression ($Z = -3.599$; $p = .0003$).

Hypothesis 3 was not supported. For the category "don't feel" nurses obtained higher scores in situations of anxiety than pain ($Z = -3.481$; $p = .0005$) or depression ($Z = -3.133$; $p = .0017$). They also obtained higher "don't feel" scores in situations of anger than pain ($Z = -2.912$; $p = .0036$) or depression ($Z = -2.856$; $p = .0043$).

Mean scores for each communication behaviour in the four types of situations are reported in the Table.

Table 1

Table Mean BTIS Scores in Four Client Situations

BTIS Categories	Pain	Depression	Anxiety	Anger
Content	7.19(55.3%)	8.96(68.95%)	7.57(58.25%)	7.77(59.75%)
Feeling	8.65(66.5%)	4.53(34.85%)	4.00(30.75%)	5.33(41.00%)
Don't Feel	0.49(3.80%)	0.592(4.55%)	2.99(23.00%)	1.87(14.40%)

Discussion

The major finding is that nurses do respond with differing levels of verbal empathy in four types of client situations. The discussion will address each communication behaviour in the four types of client situations.

Content

The content portion of the clients' messages was restated with similar frequency in all types of situations. "Content" scores were higher than "feeling" scores in three situations. Clients explicitly stated the reasons for their feelings on the BTIS and nurses may have found it relatively easy to restate the content. Furthermore, because a verbal response was required, nurses may have responded to the content, even when they found the expressed feeling difficult to identify or accept. Restating the content conveys some understanding of the client's perspective of his situation. This aspect of verbal empathy contributes to the therapeutic nurse-client relationship.

Feeling

Nurses were able to identify "feeling" more frequently in situations of pain than in situations of anxiety and depression and more frequently in situations of anger than depression. On the BTIS, feelings of pain and anger are blatantly expressed. However, in situations of anxiety and depression, the nurse had to interpret voice tone, facial expression and body posture, as well as content, to identify the more covert feelings. Recognizing what is not being said requires more skill than identifying overt emotion (Carkhuff, 1977).

Accurate reflection of the client's feelings is an aspect of verbal empathy. Because nurses were able to communicate the client's feelings of pain and anger back to him, they may be better able to establish a therapeutic relationship with these clients than with anxious or depressed clients.

Don't feel

Although "don't feel" responses were infrequent, nurses did respond with "don't feel" statements in situations of anxiety more than in situations of pain or depression, and in situations of anger more than those of pain and depression. It may be that angry and anxious clients cause anxiety in the nurse because there are no direct physical interventions that can be offered. As a means of gaining control, nurses may first attempt to deal with these clients by trying to suppress the clients' feelings.

Nurses are cognizant of the need to assess pain, and there are specific interventions to offer. As well, it would be illogical to tell some one not to feel pain. For these reasons the feelings of pain may have been more acceptable to the nurses.

Depressed clients made no implicit or explicit requests; they merely described their situations. These clients may not have evoked feelings of inadequacy in the nurse, so no attempt was made to change their outlook for the nurse's own benefit.

The "don't feel" responses are probably used to meet the nurse's needs. These responses are non-therapeutic because they do not validate the client as an unique individual who is entitled to his own feelings and perspectives. "Don't feel" responses are antithetical to verbal empathy.

Verbal empathy and client situations

Nurses seemed most likely to establish the basis of a therapeutic relationship with clients experiencing pain. They responded with verbal empathy to these clients. Although they may have had the desire to help, nurses were least empathic with anxious clients, possibly because they had difficulty in interpreting and accepting these clients' statements and behaviours. Clients' trust and self-disclosure may be limited (McKay, Hughes & Carver, 1986). As a consequence, feelings of isolation and heightened anxiety may result and the potential benefits of the nurse-client relationship will not occur.

Conclusions

Differences do exist in staff nurses' verbal empathy in response to four types of client situations. Nurses most frequently identified the feelings expressed in situations of pain and anger. They most frequently attempted to suppress the feelings of anxiety and anger. However, nurses were consistent in their restatement of the content of the message in situations of pain, depression, anxiety and anger.

Continuing education should be directed at nurses' verbal empathy skills, particularly with angry and anxious clients. Nurses should see these clients as people seeking assistance with health problems and to whom they can offer help.

Study findings may be biased by the fact that community health nurses were over-represented in the sample. A self-selection bias may also have existed if only those nurses who felt confident about their communication skills and comfortable with audiovisual equipment volunteered to participate. The lack of opportunity for on-going dialogue may have influenced the subjects' responses.

This study has added to the literature about nurses' empathy by investigating the variable of type of client situation. The client situations were general in nature and not related to a specific clinical area. In addition, the study sample was composed of nurses from many clinical areas. Therefore, the study may have broader application than previous research into nurses' empathy.

Further studies should be undertaken to determine the range of client variables that influence nurses' use of verbal empathy. More research should be conducted to study nurses' verbal empathy in clinical situations. As well, the client outcomes of nurses' verbal empathy should be investigated further.

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RÉSUMÉ

L'empathie chez les infirmières: quatre situations types

Cette étude cherche à déterminer s'il existe des différences au niveau de l'empathie verbale dont les infirmières font preuve face à la douleur, à la dépression, à l'angoisse et à la colère de leurs patients. L'empathie est la faculté de s'identifier à quelqu'un et de ressentir ce qu'il ressent. Les réponses au *Behavioral Test of Interpersonal Skills* (BTIS) de soixante-six infirmières bénévoles ont été enregistrées. Les cassettes ont ensuite été évaluées en suivant les directives propres au BTIS. La douleur et la colère sont des situations face auxquelles les infirmières affichent la plus grande faculté d'empathie. Elles font preuve par ailleurs d'une grande cohérence dans la reformulation des raisons qui motivent les quatre différents types de situations. Elles essaient davantage d'apaiser l'angoisse et la colère. En conclusion, l'empathie dont les infirmières font preuve varie d'une situation à l'autre; ces résultats devraient avoir une certaine influence sur les programmes d'éducation permanente.

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Editors

Edward Bennett, Ph.D.
Department of Psychology
Wilfrid Laurier University

Barry Trute, D.S.W.
School of Social Work
University of Manitoba

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THE RELATIONSHIP BETWEEN SOCIAL SUPPORT, LIFESTYLE BEHAVIOURS, COPING AND HEALTH IN THE ELDERLY

Jenny Ploeg and Sandra Faux

Promotion of health in the elderly has become a priority as both the number and proportion of older persons in our population escalates. Social support is a critical variable.

There is diversity in definitions of social support in the literature (Cobb, 1976; House, 1981; Weiss, 1974). Weiss (1974) proposed that only social relationships could provide certain requirements for well-being in humans. He identified the following six categories of relational provisions or components of social support: attachment; social integration including a sense of companionship; opportunity for nurturance or being responsible for another; reassurance of worth; a sense of reliable alliance particularly from family; and the provision of guidance. Like Weiss (1974), many authors have emphasized the multidimensional nature of social support and have recommended its measurement in this context (Barrera, 1981; Starker, 1986).

There are two principal process models that describe the relationship between social support and health, a main or direct-effect model and an indirect-effect or buffering model. In the buffering model, social support protects the individual from the potentially harmful effects of life stress (Cobb, 1976). In the direct-effect model, social support exerts a positive influence on health that is independent of the experience of stress. Some authors have suggested that there is evidence that both of these process models operate in the social support-health interaction (Cohen & Wills, 1985; Turner, 1981). They suggest that main and indirect effects of social support are exerted upon both physical and psychological health.

Researchers have examined the direct relationships between social support and physical and psychological health in the elderly. Blazer (1982) has found that perceived social support, or the individual's objective appraisal of sup-

Jenny Ploeg, R.N., M.Sc.N, is Supervisor of the Seniors Program, in the Public Health Nursing Division, Hamilton Wentworth Department of Public Health Services, in Hamilton, Ontario. Sandra Faux, R.N., Ph.D., is Assistant Professor in the Faculty of Nursing, at the University of Western Ontario, London.

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port, has a high predictive value for mortality in persons over 65 years, after a 30-month interval. He suggested that perceived social support may be particularly significant in later life when environment is very influential in disease onset and aging individuals perceive themselves to be more vulnerable (Blazer, 1982).

Turner, Frankel and Levin (1983) have examined the associations between social support and psychological well-being in a sample of 989 physically disabled community residents, aged 18 to 92 years. Psychological well-being was measured in terms of such symptoms as anxiety, depression and anger. Findings were indicative of a modest, but reliable, association between social support and psychological well-being.

Other investigators have failed to find significant relationships between social support and physical or psychological health in the elderly (Fuller & Larson, 1980; Laschinger, 1984). These inconsistent and inconclusive findings have been attributed to differences in the conceptualization of the social support variable as well as to design and measurement difficulties (Norbeck, 1981; Rock, Green, Wise & Rock, 1984).

Social support is also thought to have an indirect relationship to health through associations with lifestyle behaviours and coping. These latter variables have been shown to be directly linked to physical and psychological health. Several investigators have described the relationship between health and such lifestyle behaviours as exercising, eating a balanced diet and receiving regular medical follow-up. Belloc and Breslow (1972) have reported that functional health status was significantly related to lifestyle practices, independent of age, sex and economic status, in a group of 6,828 adults. A study conducted by Mechanic and Cleary (1980) revealed that both psychological well-being and subjective health status were positively associated with lifestyle behaviours in adults. Other investigators have made the link between social support and lifestyle behaviours. Hubbard, Muhlenkamp and Brown (1984) have reported a strong, positive association between perceived social support and lifestyle behaviours in a group of 97 older adults. These findings suggest that social support may exert an indirect "positive" effect upon health through an influence on lifestyle behaviours.

Moos (1984) has developed a conceptual framework that describes the linkages between social support, coping responses and health. In this framework, social climate factors, including social support, influence exposure to stress and the selection of coping responses; these in turn have an impact upon health and well-being. Billings and Moos (1981) have found that, in a sample of 194 families, both active cognitive coping methods and social support were significantly and negatively associated with mood (depression and anxiety) and physical symptoms (headaches and insomnia).

The purpose of this study was twofold: to explore the direct relationships between social support and health and to explore the indirect relationships between social support and health through variables of lifestyle behaviours and coping in a sample of elderly persons living in the community. The proposed relationships between the study variables are illustrated in Figure 1.

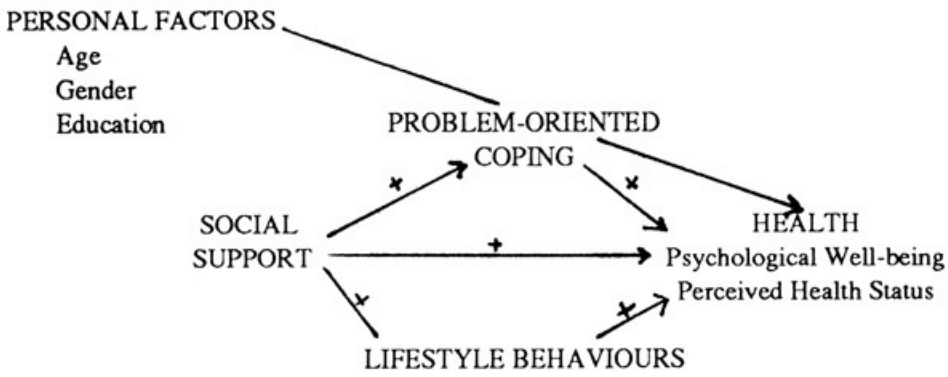

Figure 1
Hypothesized model of the relationships between social support, lifestyle behaviours, coping, health and personal factors.

Method

Sample

A total of 50 elderly persons was studied. Twenty-five subjects were randomly selected from a public health nursing agency, and 25 subjects constituted a convenience sample from a seniors' community centre. These two centres were used in order to obtain a sample of the elderly that represented both well seniors (seniors' community centre) and seniors with physical or other types of limitations in health status (public health agency). The variable *centre* was used to refer to the sample source of either the seniors community centre (0) or the public health agency (1). The sample criteria included the following: adult aged 65 to 80 years, subject able to speak and understand English and subject does not reside in a nursing home.

The mean age of the subjects was 72.5 years. Ten subjects (20%) were male and 40 (80%) were female. All of the subjects were Caucasian. Eleven subjects (22%) were married and 39 (78%) were unmarried. Of the unmarried subjects, 85% (n= 33) were widowed and 15% (n= 6) were separated, divorced, or never married. The mean educational level was 10.2 years: 32% of the subjects had eight or fewer years of education. Nineteen subjects (38%) reported a total annual income of less than $10,000 and an

additional 16 subjects (32%) reported an annual income that ranged from $10,000 to $15,000.

Instruments

The five measures used in this study included measures of perceived social support, lifestyle behaviours, coping, psychological well-being and perceived health status. Demographic data were collected for age, sex, marital status, ethnicity, education, occupation and income.

Personal Resource Questionnaire (PRQ 85). Perceived social support was measured using the PRQ-II, an instrument based on Weiss's (1974) model of relational provisions (Brandt & Weinert, 1981). Subjects rated each of the 25 items on a seven-point Likert-type scale ranging from "strongly disagree" (1) to "strongly agree" (7). A total social support score was calculated by adding the scores of 25 items, with higher scores reflecting higher levels of perceived social support. Crohnbach's alpha for the PRQ-Part II has been reported as .87 (Weinert, 1987); in this study Crohnbach's alpha was .90.

Personal Lifestyle Questionnaire (PLQ). The PLQ is a measure of the extent to which individuals engage in certain lifestyle behaviours (Hubbard, Muhlenkamp and Brown, 1984). The 24 items relate to six categories of lifestyle behaviours: exercise, nutrition, relaxation, safety, substance use and general promotion. Subjects rated the frequency with which they practised certain lifestyle behaviours using a four-point Likert-type scale ranging from "never" (1) to "almost always" (4). Scores for the 24 items were added so that higher scores were reflective of more positive lifestyle practices. The reported total scale alpha was .76 (Hubbard et al., 1984); in this study Crohnbach's alpha was .34.

Jalowiec Coping Scale (JCS). The JCS is a 40-item instrument that was used to measure coping behaviours (Jalowiec, 1984). The 40 coping behaviours are grouped into one of two subscales: problem-oriented coping behaviours, such as goal setting and trying to maintain control and affective-oriented coping behaviours such as crying and getting mad. Subjects rated the frequency with which they used each of the 40 coping behaviours on a five-point Likert-type scale ranging from "never" (1) to "almost always" (5). Scores for each of the two subscales were calculated by summing the values for corresponding items. Higher scores were indicative of more frequent use of those coping behaviours. Jalowiec, Murphy, and Powers (1984) reported an alpha coefficient of .86. In this study, the alpha coefficients for the total scale and the problem-oriented and affective-oriented subscales were .83, .80 and .67 respectively.

Affect Balance Scale (ABS). Psychological well-being was measured by the ABS (Bradburn & Caplovitz, 1965). The ABS is composed of ten items, five

of which reflect positive affect and five of which reflect negative affect. The positive affect subscale relates to such positive mental health feelings as being pleased, proud and excited. The negative affect subscale relates to mental illness factors, such as depression. The format of the questionnaire is that of a three-point Likert-type scale with possible responses including "never", "sometimes" and "often". Higher scores in the positive and negative subscales were indicative of more positive and more negative affect. The alpha coefficients for the positive and negative affect subscales were .83 and .81 respectively (Bradburn, 1969). In the current study, the alpha coefficient for the positive affect subscale was .64 and for the negative affect subscale.65.

Perceived Health Status. Perceived health status was measured by two items. Subjects rated their current health status on a four-point Likert-type scale ranging from "very poor" (1) to "very good" (4). Subjects also rated their health status, in comparison to others their age on a three-point Likert-type scale ranging from "worse than average" (1) to "better than average" (3). The two scores used for perceived health status are referred to as *current health* and *comparative health*, respectively.

Procedure

The nurse-investigator used a table of random numbers to select 25 subjects from a list of 210 eligible subjects who had been referred to the public health nursing agency over a six-month period. Subjects were sent two introductory letters about the study, one from the director of nursing and one from the investigator. Subjects were then contacted by telephone and home visits were scheduled to collect the data. Thirteen subjects to whom letters had been sent were not interviewed for reasons which included death, (n = 3), relocation (n = 3), admission to nursing home (n = 2), refusal to participate due to illness (n = 2) and other reasons (n = 3). The investigator visited the seniors' centre, four times on random days and at random times, in order to select a convenience sample of 25 subjects.

All subjects who agreed to participate in the study signed consent forms. All of the questionnaires were presented in interview format; six 5" x 8" cards were typed for the subjects to hold and refer to when answering questions involving Likert-type scales. Interviews took an average of one hour to complete.

Results

Data analysis was completed by using SPSS. Independent t-tests, Pearson Product Moment Correlation coefficients and multiple regression analyses were computed. Statistical significance for all tests was .05.

Differences between samples

The mean scores of the two sample centres for the study variables are compared in Table 1. The differences between the two samples were examined using independent t-tests. No significant differences were found between the two samples in the demographic variables, social support scores, lifestyle behaviour scores and coping subscales. Subjects selected from the public health agency rated their perceived current health status as significantly lower than did subjects from the seniors' centre ($t(48) = -3.23$, $p < .05$); they also rated their perceived comparative health status as significantly lower than did subjects from the seniors centre ($t(48) = -2.71$ $p < .05$). Subjects from the public health agency reported significantly lower scores on the positive affect subscale ($t(48) = -1.98$, $p < .05$) and significantly higher scores on the negative affect subscale($t(48) = 2.75$, $p < .05$) of the ABS.

Table 1

Mean Scores of Sample Centres for Study Variables

Variable	Mean Scores	
	Seniors Community Centre	Public Health Centre
Age	72.28	72.80
Education	10.12	10.36
Social Support	136.92	130.20
Lifestyle Behaviours	73.97	72.32
Affective Coping	58.32	61.20
Problem Coping	44.04	43.28
Current Health	3.24	2.68
Comparative Health	2.64	2.20
Positive Affect	6.40	5.20
Negative Affect	1.80	3.44

The two samples were combined for further analyses. The means, standard deviations and range of possible scores for the study instruments appear in Table 2.

Table 2

Subject Means and Standard Deviations for Study Instruments

Instrument	Mean	Standard Deviation	Range of Possible Scores
PRQ-Part II-Social Support	133.3	23.3	25-75
PLQ-Lifestyle Behaviours	73.1	7.0	24-96
JCS-Problem-Oriented Coping	43.7	9.9	15-75
JCS-Affective-Oriented Coping	59.8	10.5	25-125
ABS-Positive Affect	5.8	2.2	0-10
ABS-Negative Affect	2.6	2.3	0-10

Relationships between study variables

Pearson Product Moment Correlation Coefficients were computed to determine the relationships between the variables of centre, social support, lifestyle behaviours, problem and affective-oriented coping, positive and negative affect, current health and comparative health status (See Table 3). The variables of social support, lifestyle behaviours and problem-oriented coping were significantly and positively associated with positive affect. Social support and lifestyle behaviours were significantly correlated with perceived current health and comparative health and were negatively associated with negative affect. Furthermore, social support was significantly correlated with both lifestyle behaviours and problem-oriented coping strategies.

The demographic variables of age, sex and marital status were not significantly related to any of the variables in the correlation matrix. Education and income were only significantly correlated with problem-oriented coping, $\underline{r} = .26$ and $\underline{r} = .24$, respectively.

Table 3

Variable Correlation Matrix

Variables	Variables	CE	SS	LI	PC	AC	PA	NA	CH
Centre	(CE)[a]								
Social Support	(SS)	-.15							
Lifestyle	(LI)	-.21	.48**						
Problem Coping	(PC)	-.04	.28*	.22					
Affective Coping	(AC)	.14	.07	.18	.59**				
Positive Affect	(PA)	-.28*	.54**	.27*	.25*	.08			
Negative Affect	(NA)	.37**	-.43**	-.38**	-.11	.21	-.32*		
Current Health	(CH)	-.42**	.27*	.24*	.16	-.09	.42**	-.36**	
Comparative Health	(COM)	-.36**	.48**	.53**	.17	.00	.54**	-.33*	.54**

* $p < .05$: ** $p < .01$.

[a] Abbreviations in parentheses refer to corresponding variables.

Table 4

Multiple Stepwise Regression of Comparative Health, Positive Affect, Lifestyle and Problem Coping

Dependent Variable	Independent Variable	Standardized Regression Coefficient	R^2	F	p
Comparative Health	Centre	-.18*	.13		
	Lifestyle	.40*	.35	12.77	.0000
Positive Affect	Centre	-.10	.08		
	Social Support	.38*	.33	11.81	.0001
Lifestyle	Centre	-.14	.04		
	Social Support	.46*	.25	8.01	.0010
Problem Coping	Centre	-.04	.00		
	Social Support	.28	(ns)		.0542

*$p < .05$

Multiple stepwise regression analysis provided an estimate of the percentage of variance in any one dependent variable that could be accounted for by certain independent variables (See Table 4). In each regression model, the variable of centre (referring to the sample source) was entered first, in order to control for the effects of this variable (Polit and Hungler, 1987). Apart from centre, only those variables with a significant ($p < .05$) standardized correlation coefficient were entered into the regression model.

A significant proportion (35%) of the variance of perceived comparative health status was accounted for by the variables of centre and lifestyle. As can be seen from Table 4, the variable of centre accounted for 13% of the variance in comparative health. The variable of lifestyle accounted for the remaining 22% of the total 35% variance in comparative health. The variables centre and social support together accounted for 33% of the variance in psychological well-being or positive affect. Excluding the effects of centre, social support alone accounted for 25% of the variance in positive affect. A substantial amount of the variance in lifestyle behaviours (25%) was accounted for by centre and social support. Social support alone accounted for 21% of the variance in lifestyle behaviours. Social support was not a significant factor in explaining the variance in problem-oriented coping strategies; nor was coping a significant factor in explaining health.

Limitations

Some caution should be exercised in the interpretation of the study findings. Part of the sample was non-random in nature and the total sample size was quite small. The sample itself was somewhat biased in that it included only seniors who were service users of either the public health agency or the seniors community centre. Further, the study design was cross-sectional and did not permit assessment of any changes in variables over time. Finally, the reliability coefficients of the ABS and the PLQ were found to be relatively low for this sample of elderly persons, as compared to other studies (Hubbard et al., 1984: Bradburn, 1969) conducted with adults. This may have been because of the limited variability of instrument scores and the small sample size of the study.

Discussion

In this group of community-dwelling elderly, social support was found to have a strong, direct relationship with health as well as significant, indirect relationships with health through the variables of problem-oriented coping and lifestyle behaviours. Elderly clients who reported higher levels of social support reported much higher levels of perceived health. Further, health perceptions have been shown to be a significant predictor of mortality in the elderly (Mossey & Shapiro, 1982). Thus, the strong linkages found between

perceived health and social support suggest that social support may play a vital role in the maintenance of physical health in the elderly.

Social support was also strongly associated with psychological well-being in this sample of the elderly. Consistent with the findings of Turner, Frankel and Levin (1983), social support was negatively related to negative affect factors such as anxiety and depression. Thus, the higher the level of perceived social support, the less likely the person was to experience anxiety or depression. Not only was social support found to be significantly correlated with positive affect, but it also accounted for 25% of the variance in positive affect in the regression analysis. Study findings suggest that social support may have positive effects upon the mental health of the elderly. As Turner, Frankel and Levin (1983) note however, it is also probable that psychological well-being will affect the perception of social support and, perhaps, the ability to use and strengthen this support. Thus, while the model of the proposed causative linkages between study variables (Figure 1) is based on major findings in the literature, it does not reflect the possible circular relationships of variables upon one another.

Social support was found to have a positive relationship to health through the variable of lifestyle behaviours. It was highly correlated with lifestyle and accounted for 21% of the variance in this factor. Lifestyle behaviours were, in turn, strongly associated with both physical and psychological health in the elderly. Lifestyle accounted for 22% of the variance in perceived comparative health status. These results suggest that elderly persons with higher levels of perceived social support engage in more positive lifestyle behaviours; thus they rate their health at higher levels. The possibility exists, however, that elderly persons who perceive their levels of health to be high and who practise more positive lifestyle behaviours may then establish more supportive relationships leading to higher levels of perceived social support. Once again, we cannot preclude the possibility of a circular relationship between variables.

While social support was strongly correlated with problem-oriented coping, it did not account for a significant proportion of the variance in this variable. A significant relationship was found only between problem-oriented coping and the positive affect measure of health. Further, problem-oriented coping did not account for a significant amount of the variance in any of the measures of health. Cwikel, Dielman, Kirscht and Israel (1988) have found active or problem-oriented coping styles to be more strongly related to mental health status than to subjective or physical health. They suggest, however, that time plays a major role: active coping, along with social integration, exert positive effects first on psychological health, then on subjective health and, ultimately, over time, on physical health. The cross-sectional design of this study precluded such longitudinal investigations. Furthermore, it may be

that coping plays a more significant role during periods of stress. Thus, if the study sample was in a period of relatively minimal stress, coping would not account for a significant amount of variance in health.

The demographic variables of age, gender and marital status were not significantly related to any of the study variables. This was not consistent with the findings of other researchers. For example, Hubbard, Muhlencamp and Brown (1984) found that married subjects reported higher levels of social support. The lack of significant findings may be attributable to the small sample size and the narrow age range (65-80 years) of subjects in this study.

This research underlines health professionals' need for greater emphasis on interpersonal resources and social support in health promotion strategies. Assisting clients to identify and effectively utilize available sources of social support has the potential for increasing levels of perceived social support and indeed, for improving health. Working with aging individuals to build and maintain supportive relationships must be accepted as a central role for health care professionals. Family and significant others, who are the major sources of social support for seniors, should be co-participants with the client and the health care professional in the planning and provision of care. Another strategy may involve the referral of elderly clients to such resources as seniors' centres and volunteer visiting services where opportunities for the development and maintenance of social relationships are provided. Because seniors centres frequently provide physical activity programs as well as social programs, involvement in such centres may improve both social support and positive lifestyle behaviours, thereby promoting health of seniors. Health care professionals can be effective advocates for accessible community programs that offer seniors opportunities for both social support and for participation in positive lifestyle behaviours. Finally, professionals are encouraged to foster the attitude within the community that elderly persons can practise healthy behaviours that have a positive influence on their well-being.

Future research should include a longitudinal study design that assesses the changes in, and effects of, these study variables over time. The effectiveness of intervention strategies to improve social support upon the health of individuals should also be assessed (Crawford, 1987: Norbeck & Tilden, 1988).

This study has identified the relationships between social support, lifestyle behaviours, coping and health in a sample of elderly persons. Health care professionals are challenged to be innovative and visionary in applying these results to the promotion of health of the community-based elderly population.

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RÉSUMÉ

La corrélation entre les services sociaux et l'état de santé des personnes âgées

La corrélation entre les services sociaux et l'état de santé des personnes âgées n'a pas été établie de façon logique ou concluante. Il y a donc lieu d'analyser la question plus en profondeur non seulement en raison de la proportion croissante de personnes âgées dans la population totale, mais également de l'utilisation accrue des services de santé associée au vieillissement. On a donc étudié la corrélation existant entre les services sociaux, les modes de vie, les facultés d'adaptation et l'état de santé d'un échantillon de 50 personnes âgées de 65 à 80 ans. Divers questionnaires ont été administrés aux sujets sous forme d'entrevue pour mesurer les variables suivantes: services sociaux (questionnaire sur les moyens personnels), bien-être psychologique (échelle d'équilibre affectif), modes de vie (questionnaire sur les modes de vie), facultés d'adaptation (échelle d'adaptation de Jalowiec); état de santé perçu et certaines variables démographiques. On a établi des corrélations positives et significatives entre les services sociaux d'une part, et l'état de santé perçu et le bien-être psychologique d'autre part. Les services sociaux comptent pour 25 % de l'écart sur le plan de l'affect positif. Des corrélations positives significatives ont également été établies entre les services, les modes de vie et les facultés d'adaptation devant un problème. Étant donné les corrélations multiples et significatives qui existent entre les services sociaux, les modes de vie et l'état de santé, il est possible que les interventions du personnel infirmier visant à raffermir les services sociaux ou à améliorer le mode de vie aient un effet bénéfique sur l'état de santé des personnes âgées.

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