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Look

WHAT'S COMING TO THE

Canadian Journal of Nursing Research!

The Canadian Journal of Nursing Research is pleased to announce a new section entitled

Focus: Research and Issues

Starting with the 1994 Fall issue (vol. 26, no. 3), our section editors will take their turn as guest editor for articles featuring an important nursing topic. This section will lend added depth to the diverse subject matter that we currently enjoy in each issue.

Over the coming months you will notice other sections being introduced periodically:

DISCOURSE, for critical thoughts on substantive issues;
BRIEFS, for research reports and commentaries;
PLAUDITS AND GRIPES, for letters to the editor;
DESIGNER'S CORNER, for tools and techniques required to build knowledge;
HAPPENINGS, for reports on innovative research and clinical programs;
BOOK REVIEWS; and
PUBLICITY for announcements of new positions, career opportunities, conferences, and so on.

This broadened format provides a more comprehensive, up-to-date coverage of issues and concerns pertinent to the development of nursing. Your comments, reflections, news items, and manuscripts will make **The Canadian Journal of Nursing Research** a truly Canadian voice for nursing research. We invite submissions for any of these sections.

Du nouveau

À LA

Revue canadienne de recherche en sciences infirmières!

La rédaction de la **Revue canadienne de recherche en sciences infirmières** est heureuse de vous annoncer la création d'une nouvelle rubrique, intitulée :

Le Point : recherche et actualité

Dès le numéro d'automne 1994 (vol. 26, n° 3), nos chroniqueurs prendront alternativement la parole en tant que rédacteurs invités sur un sujet d'importance touchant les soins infirmiers. Cette nouvelle rubrique permettra d'approfondir, pour le plus grand plaisir des lecteurs, les nombreux sujets abordés dans chacun des numéros de la revue.

Au cours des mois à venir, d'autres rubriques viendront périodiquement étoffer la publication :

DISCOURS portera un regard critique sur des questions d'envergure;
EN BREF s'intéressera aux rapports de recherches et à leurs commentaires;
ÉLOGES ET REPROCHES recevra le courrier des lecteurs;
LE COIN DU CONCEPTEUR recueillera outils et techniques d'apprentissage;
L'ÉVÉNEMENT mettra en lumière les recherches et les programmes cliniques novateurs;
PUBLICATIONS, fera le compte rendu de livres récents; enfin,
PUBLICITÉ annoncera les nouvelles nominations, les possibilités de carrière, les conférences, etc.

Ce format élargi permettra une couverture plus exhaustive et plus à jour des questions et défis touchant le développement des sciences infirmières. Vos commentaires, réflexions, nouvelles et manuscrits donneront à la **Revue canadienne de recherche en sciences infirmières** un ton résolument canadien dans le concert des publications sur les sciences infirmières. Nous vous invitons à contribuer à l'une ou l'autre des rubriques.

Upcoming Focus Issues:

Women's Health

Guest Editor: Dr. Ellen Hodnett
Submission Deadline: October 15, 1994
To appear: Winter 1994 (vol. 26, no. 4)

Family Health

Guest Editor: Dr. Kathleen Rowat
Submission Deadline: December 15, 1994
To appear: Spring 1995 (vol. 27, no. 1)

Philosophy/Theory

Guest Editor: Dr. June Kikuchi
Submission Deadline: February 15, 1995
To appear: Summer 1995 (vol. 27, no. 2)

History of Nursing

Guest Editor: Dr. Ina Bramadat
Submission Deadline: May 15, 1995
To appear: Fall 1995 (vol. 27, no. 3)

Prochains numéros:

Les femmes et leur santé

rédactrice invitée: Dre Ellen Hodnett
date-butoir des soumissions: le 15 octobre 1994
publication: hiver 1994 (vol. 26, no. 4)

La famille et la santé

rédactrice invitée: Dre Kathleen Rowat
date-butoir des soumissions: le 15 décembre 1994
publication: printemps 1995 (vol. 27, no. 1)

Philosophie et théorie

rédactrice invitée: Dre June Kikuchi
date-butoir des soumissions: le 15 février 1995
publication: été 1995 (vol. 27, no. 2)

Historique des sciences infirmières

rédactrice invitée: Dre Ina Bramadat
date-butoir des soumissions: le 15 mai 1995
publication: automne 1995 (vol. 27, no. 3)

CALL FOR PAPERS

Women's Health

Winter 1994 (vol. 26, no. 4)

Topics include but are not restricted to reproduction and gynecological health, breast cancer, abuse and assault, cultural variations, child care, aging, health promotion and illness prevention. While theoretical and literature review papers may be submitted, priority will be given to reports and research projects.

Guest Editor: Dr. Ellen Hodnett

Submission Deadline: October 15, 1994

Family Health

Spring 1995 (vol. 27, no. 1)

Topics such as families across the life cycle, transitional phases within family life, and families dealing with acute or chronic illness in one of its members are welcomed. Priority will be given to research reports. However, review articles will also be considered.

Guest Editor: Dr. Kathleen Rowat

Submission Deadline: December 15, 1994

Philosophy/Theory

Summer 1995 (vol. 27, no. 2)

Manuscripts which have the potential to stimulate discussion of issues/problems that face the discipline of nursing in the areas of philosophical thought and theory development are sought. Research/scholarly papers are invited that address critical issues/problems of a philosophical, conceptual, theoretical, or methodological nature related to the advancement of the discipline of nursing.

Guest Editor: Dr. June Kikuchi

Submission Deadline: February 15, 1995

History of Nursing

Fall 1995 (vol. 27, no. 3)

We invite submissions of manuscripts in the field of nursing history. Priority will be given to historiography, manuscripts on historical methods in nursing research, and historical biography.

Guest Editor: Dr. Ina Bramadat

Submission Deadline: May 15, 1995

Please send manuscripts to:
The Editor,
Canadian Journal of Nursing Research,
McGill University School of Nursing,
3506 University Ave., Montreal, Qc H3A 2A7

ARTICLES À PUBLIER

Les femmes et leur santé

publication : hiver 1994 (vol. 26, no. 4)

Nous vous invitons à soumettre des manuscrits portant sur le domaine de la santé. Sujets proposés (non limitatifs): techniques de reproduction et santé gynécologique, cancer du sein, abus et agressions, variantes culturelles, puériculture, vieillesse, promotion de la santé et prévention des maladies. Bien que les textes théoriques et les critiques de documents soient appréciés, la priorité sera donnée aux rapports et aux projets de recherche.

Rédactrice invitée : Dre Ellen Hodnett

Date-butoir des soumissions: le 15 octobre 1994

La famille et la santé

publication : printemps 1995 (vol. 27, no. 1)

Vous êtes invité à nous soumettre des articles sur la santé familiale. Les sujets comprendront la famille dans les différents cycles de la vie, les phases de transition dans la vie de la famille et la famille aux prises avec la maladie aiguë ou chronique de l'un de ses membres. Les rapports de recherche auront la priorité. Cependant, les articles critiques seront également pris en considération.

Rédactrice invitée: Dre Kathleen Rowat

Date-butoir des soumissions: le 15 décembre 1994

Philosophie/Théorie

publication: été 1995 (vol. 27, no. 2)

Le but de cet appel est d'obtenir des articles pouvant provoquer la discussion sur des questions ou des difficultés que rencontrent les sciences infirmières dans les domaines de la pensée philosophique et de l'élaboration théorique. Vous êtes invité à écrire des articles de recherche érudits qui concernent les questions ou les difficultés importantes de nature philosophique, conceptuelle, théorique ou méthodologique et qui son liés au progrès des sciences infirmières.

Rédactrice invitée: Dre June Kikuchi

Date-butoir des soumissions: le 15 février 1995

Historique des sciences infirmières

publication: automne 1995 (vol. 27, no. 3)

Nous vous invitons à soumettre vos manuscrits sur l'histoire des sciences infirmières. On donnera la priorité à l'historiographie, aux manuscrits traitant des méthodes historiques dans la recherche en sciences infirmières et à la biographie historique.

Rédactrice invitée: Dre Ina Bramadat

Date-butoir des soumissions: le 15 mai 1995

Prière de faire parvenir les manuscrits à la :
Rédactrice en chef
Revue canadienne de recherche en sciences infirmières
École des sciences infirmières de l'Université McGill
3506, rue University, Montréal (Québec) H3A 2A7

SUMMER EDITORIAL

History: A Way of Knowing

One aspect of our development as a discipline has been the emergence of historical inquiry as an accepted way of knowing in Nursing. Nevertheless, history's journey into the inner circle of academic nursing has not been without incident. For when the topic of history is raised in discussions – surprisingly contrary views about its "actual" contribution to the development of the discipline are likely to be expressed.

These divergent views may be exemplified by two "paradoxical fallacies" commonly held by nurses and, not uncommonly, shared by the general public. One states that "to know the past is to know the future". The other argues for leaving "what's past in the past". Whereas the former perspective offers up the lessons of history as indispensable prognosticators, the latter feigns no such pretensions, disavowing any connection between those who came before and those who will follow.

But I would argue that both views are overly simplified at a time when history is moving to gain total acceptance within the discipline. Neither stance helps history gain the credibility it requires to make a truly meaningful contribution to the nursing world. One question to ascertain then is why these unfortunate misconceptions have persisted in nursing? Perhaps, more to the point: how should history be conceptualized? As a student of history, I would like to offer some personal reflections.

Many of us were raised with the impression that history was "important" but "boring". More often than not, however, the lessons we were taught were not truly of history. What I mean to say is that history is not just a series of events, dates, and activities embedded in a certain time and place. Its main purpose is not merely to identify the important relations among past happenings. Nonetheless many of us have accepted these teachings, shaped perhaps by positivist underpinnings that have obscured a fundamental problem: the difficulty of applying the scientific method to events and relationships that lie temporally beyond the realm of direct observation and manipulation. Given this misconception of history's scientific base, it is no wonder that some of us have questioned how the past could impart relevant knowledge for today's concerns.

If history is not a record of important relations among past events, then what is it? According to Collingwood (1946) the purpose of history is to explain human actions of the past by attaining an understanding of the thoughts expressed in those actions. But first the historian must examine the event in terms of who, what, where, and when. Then, to understand "how" and "why", he moves his own thinking about the event into the imagined

cognitive domains of the historical players. To do this, the historian re-enacts in his/her own mind the thoughts that he/she is trying to discover (Collingwood, 1946). The historian uses his/her own imagination to determine those thoughts likely held by historical figures of interest. These imagined thoughts then are weighed against the evidence consisting mainly of primary documents and verbal sources. Through a testing and retesting of ideas against a documented "reality", the historian eventually creates a comprehensive world of another time and place. The historian knows with conviction what happened in the past when the evidence does not allow for another interpretation.

If we accept history as the story of human action and thought, its necessary context, can we somehow gain prescient knowledge by knowing what people were thinking in the past? How many times have we heard the saying that we must study nursing's history in order to know nursing's future? But does that imply a foretelling of our destiny?

The fact is that the historian holds no gift of prophecy and all thought is embedded in a particular constellation of actions and events that can never be fully replicated (Collingwood,1946). Notwithstanding the quality of his/her primary resources and imagination, the historian's understanding of the past ultimately is filtered through the thinking of modern times – and thus new interpretations of history will be served again and again via the unique perspectives of subsequent generations. Thus it is fair to say that the interpretation of history is always subject to change and subject to the temper of the times from which it may be seen anew. But if history does not help us to foresee the future it offers a greater gift.

History's gift is that in allowing us to know others through an historical process, we subsequently come to know ourselves as human beings: not in terms of biochemical processes and scientific variables but in terms of man's nature. Through historical accounts, we come to see ourselves reflected in the recounted experiences of others. It is these insights into man's inner world that make what happened in the past relevant to us. Discovering how others must have thought about the trials and tribulations of life tells us something of our potential as a discipline and of our individual possibilities as emissaries of that discipline. And through this knowledge comes the wisdom of humanity to deal with our present and future professional challenges.

Mary Grossman,
Associate Editor

Reference

Collingwood, R. (1956). *The idea of history.* London: Oxford University Press.

ÉDITORIAL DE L'ÉTÉ

L'histoire : un moyen de connaissance

Un aspect de notre évolution en tant que discipline fut l'apparition d'enquêtes historiques comme moyen de connaissance reconnu dans les sciences infirmières. Pourtant, l'entrée de l'histoire dans le cercle clos des sciences infirmières ne s'est pas faite sans mal. Lorsque le sujet de l'histoire est soulevé dans les discussions, des vues étonnamment contraires sur sa contribution réelle à l'évolution de la discipline ont toutes les chances d'être exprimées.

Ces vues divergentes peuvent être illustrées par deux sophismes paradoxaux que tiennent souvent les infirmières et assez souvent le public. L'un énonce que «connaître le passé signifie connaître l'avenir». L'autre affirme qu'il faut laisser «au passé ce qui appartient au passé». Tandis que la première perspective offre les leçons de l'histoire comme étant des pronostiqueurs indispensables, la seconde feint de n'avoir aucune de ces prétentions et renie tout lien entre ceux qui sont venus avant et ceux qui viendront après.

À mon avis, ces deux points de vue sont trop simplistes au moment où l'histoire s'évertue à être totalement acceptée au sein de la discipline. Aucune de ces deux prises de position n'aide l'histoire à gagner la crédibilité dont elle a besoin pour véritablement contribuer au monde des sciences infirmières. Une question à vérifier est la raison pour laquelle ces malheureuses idées fausses ont persisté dans les sciences infirmières. Peut-être devrions-nous affiner la question : comment l'histoire doit-elle être conceptualisée? En tant qu'étudiante en histoire, je me propose de vous présenter quelques-unes de mes réflexions.

Nombre d'entre nous avons grandi avec l'impression que l'histoire était «importante» mais «ennuyeuse». Il faut dire que, bien souvent, ce qu'on nous enseignait n'était pas vraiment de l'histoire. Pour moi, l'histoire n'est pas seulement une série d'événements, de dates et d'activités fixés dans un certain endroit et à une certaine période. Son objectif principal n'est pas seulement d'établir les relations importantes entre des événements passés. Malgré cela, nombre d'entre nous avons accepté ces enseignements, façonnés peut-être par des fondements positivistes qui ont obscurci un problème fondamental, à savoir la difficulté d'appliquer une méthode scientifique à des événements et à des relations qui résident temporellement au-delà du domaine de l'observation et de la manipulation directes. Étant donné cette idée fausse du fondement scientifique de l'histoire, rien d'étonnant à ce que certains d'entre nous aient remis en question le fait que le passé puisse transmettre une connaissante pertinente aux problèmes d'aujourd'hui.

Si l'histoire n'est pas un rapport des relations importantes entre les événements passés, qu'est-elle donc? Selon Collingwood (1946), le but de l'histoire est d'expliquer les actes des êtres humains du passé en tentant de comprendre les idées exprimées à travers ces actes. Cependant, l'historien doit d'abord examiner l'événement en terme de qui, quoi, où et comment.

Ensuite, afin de comprendre le comment et le pourquoi, il déplace sa propre façon de penser l'événement vers les domaines cognitifs imaginés des acteurs historiques. Pour ce faire, l'historien rejoue dans sa tête les pensées qu'il essaie de découvrir (Collingwood, 1946). L'historien emploie son imagination à déterminer les pensées qu'ont probablement eues les personnages historiques d'intérêt. Ces pensées imaginées sont alors mises en balance avec les preuves qui consistent surtout en documents fondamentaux et en sources orales. Les idées sont ensuite mises (et remises) à l'épreuve d'une «réalité» documentée, alors l'historien finit par créer un monde global d'un autre temps et d'un autre espace. L'historien sait avec conviction ce qui est arrivé par le passé lorsque la preuve n'autorise aucune autre interprétation.

Si nous tenons pour acquis que l'histoire est celle des actes et de la pensée de l'homme, son contexte nécessaire, pouvons-nous gagner une connaissance presciente en sachant ce que les gens pensaient par le passé? Combien de fois nous sommes-nous entendu dire que nous devions étudier l'histoire des sciences infirmières de façon à connaître l'avenir des sciences infirmières? Cela implique-t-il la prédiction de notre destin?

Une chose est sûre, c'est que l'historien ne peut prophétiser et toute pensée est enchâssée dans une constellation particulière d'actes et d'événements qui ne peuvent jamais être totalement reproduits (Collingwood, 1946). Nonobstant la qualité de ses principales ressources et de son imagination, la compréhension du passé qu'a l'historien est en définitive filtrée au travers de la pensée contemporaine; ainsi, de nouvelles interprétations de l'histoire seront présentées et représentées à travers les perspectives uniques des générations suivantes. On peut donc dire que l'interprétation de l'histoire est toujours sujette aux changements et à l'humeur des époques pour lesquelles elle semblait nouvelle. Si l'histoire ne nous aide pas à prévoir l'avenir, elle nous offre néanmoins un plus beau cadeau.

Le cadeau de l'histoire est qu'en nous permettant de connaître autrui à travers le processus historique, nous en venons à nous connaître nous-mêmes en tant qu'êtres humains, pas en termes de processus biochimiques ou de variables scientifiques mais en termes de nature humaine. Par les récits historiques, nous en arrivons à nous voir réfléchis dans les récits des autres. Ce sont ces incursions dans le monde intérieur de l'homme qui donnent un sens à ce qui est arrivé par le passé. Découvrir ce que les autres doivent avoir pensé des épreuves et des vicissitudes de la vie nous renseigne sur notre potentiel en tant que discipline et sur nos possibilités individuelles en tant qu'émissaires de cette discipline. Cette connaissance nous donne la sagesse de l'humanité pour relever nos défis professionnels présents et à venir.

Mary Grossman
Rédactrice en chef adjointe

Référence

Collingwood, R. (1956) *The idea of history*. London, Oxford University Press.

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Determinants of Health-Promoting Lifestyles in Adolescent Females

Angela J. Gillis

On a examiné la relation entre la salubrité du mode de vie et la définition de la santé, la perception de l'état de santé, l'efficacité personnelle, la salubrité du mode de vie du père et de la mère, et les données démographiques sélectionnées chez les adolescentes. L'étude comptait cent quatre-vingt-quatre adolescentes et leurs parents. Le cadre conceptuel de l'étude était donné par une modification du modèle de promotion de la santé de Pender (1982-1987). Deux questions tirées du modèle conceptuel guidèrent la recherche. Les résultats démontrèrent que la salubrité du mode de vie de la mère et du père établissait une corrélation significative avec la salubrité du mode de vie de leur fille. Il existait un lien certain entre les variables prédictives de la définition de la santé (sous-échelles cliniques, fonctionnelles et eudémonistes), l'efficacité personnelle, la perception de l'état de santé et l'ethnicité, et le critère de salubrité du mode de vie de l'adolescente. Ces différentes variables représentaient 41 % de variance dans les pointages de la salubrité du mode de vie des adolescentes. Les implications pour la recherche en sciences infirmières et sa pratique sont en discussion.

The relationship between health-promoting lifestyle and definition of health, perceived health status, self-efficacy, maternal and paternal health-promoting lifestyle, and selected demographics in adolescent females was investigated. Included in the study were 184 adolescents and their parents. A modification of Pender's (1982, 1987) Health Promotion Model provided the conceptual framework for the study. Two research questions evolving from the conceptual model guided the study. Results indicated that mothers' and fathers' health-promoting lifestyles were significantly correlated with their daughters' health-promoting lifestyles. A strong relationship existed between the predictor variables of definition of health (clinical, functional, and eudaemonistic subscales), self-efficacy, perceived health status, and ethnicity, and the criterion variable of adolescents' health-promoting lifestyles. Together these variables accounted for 41% of the variance in adolescent health-promoting lifestyle scores. Implications for nursing research and practice are discussed.

Although much is known about the prevention and treatment of disease in adolescents, little is known about how adolescents view their health, and the factors that relate to their lifestyle and health behaviour choices. The research on health-promoting behaviour of adolescents in general, and adolescent females in particular, is less extensive than that dealing with adult health behaviours (Alexander, 1989; Millstein, Petersen & Nightingale, 1993).

Given that 50% of all health care costs in this country are the result of lifestyle choices, and that the adolescent population is the only age group in which the morbidity and mortality rates have continued to increase over the past 20 years (Tyson, 1990; Vernon, 1991), it is extremely important to study the determinants of a health-promoting lifestyle in adolescents. This informa-

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Angela J. Gillis, RN, Ph.D., is Associate Professor and Chair of the Department of Nursing at St. Francis Xavier University in Antigonish, Nova Scotia.

tion is critical to improving the health status of adolescents because the contribution of preventable social, environmental, and behavioural lifestyle-related factors to mortality and morbidity is greater in adolescents than it is in children and adults (Rosen, Xiangdong & Blum, 1990).

An accumulating body of evidence suggests that adolescent girls are at special risk. Compared to their male counterparts, they show higher rates of morbidity as indicated by utilization of physician services and hospitalization; they also report more mental health concerns and are more often diagnosed with major mental depressive disorders (Millstein & Litt, 1990). Although nursing has recently addressed women's health and related behavioural issues, factors that contribute to the lifestyle patterns of adolescent females need to be examined.

A growing number of investigators have explored determinants of health-promoting lifestyles in adults and elderly people (Duffy, 1993; Kerr & Ritchey,1990; Pender, Walker, Sechrist & Frank-Stromberg, 1990). Such studies suggest that cognitive-perceptual variables such as perceived health status, self-efficacy, definition of health, and modifying factors such as demographics and family variables positively influence engagement in a health-promoting lifestyle. The factors that relate to engagement in a health-promoting lifestyle in adolescents, and particularly adolescent females, are unknown. There is a paucity of studies exploring the role of cognitive health variables, family influences, and demographic factors in female adolescents' engagement in health-promoting lifestyles, and few of the studies have been framed conceptually within a health-promotion perspective. Therefore, the specific purposes of this study were: (a) to determine what relationships exist between health-promoting lifestyle in adolescent females and the cognitive-perceptual variables of perceived health status, definition of health, self-efficacy, maternal health-promoting lifestyle, paternal health-promoting lifestyle, and selected demographics; and (b) to determine which of these variables best predict a health-promoting lifestyle in adolescent females.

Literature Review

Due to the limited number of studies that address the determinants of a health-promoting lifestyle in adolescent females, a selection of studies from the adult literature is included in this review. Although a plethora of studies purport to measure health-promoting lifestyle in adolescents, most are limited to single health behaviours rather than a pattern of behaviour (Patterson & McCubbin, 1987; Riccio-Howe, 1991). Four studies were found that provide initial support for the concept of a health-promoting lifestyle in adolescents (Donovan, Jessor & Costa, 1991; Kulbok, Earls & Montgomery, 1988; Magelvy, 1987; Nutbeam, Aar & Catford, 1989). However, there

remains a need to explore the underlying structure and determinants of a health-promoting lifestyle in adolescents.

The concept of perceived health status has been examined in adolescents (Alexander, 1989; Mechanic & Cleary, 1980; Mechanic & Hansell, 1987), but no study has examined its relationship to health-promoting lifestyles in adolescent females. Pender (1987) noted that perceived health status is an important variable to consider in relation to a health-promoting lifestyle. Studies of adults have provided evidence that the better one perceives one's health to be, the greater the likelihood of engagement in a health-promoting lifestyle (Duffy, 1988, 1989; Frank-Stromberg, Pender, Walker & Sechrist, 1990; Killeen, 1989; Riffle, Yoho & Sams, 1989; Weitzel & Waller, 1990). These studies parallel the findings of Pender et al. (1990) who reported that a positive evaluation of health status was associated with a health-promoting lifestyle in a sample of 589 adult employees. In contrast, Laffrey (1986) reported that perceived health status and health behaviour choices were not related in a study of normal weight and overweight adults. Similarly, Harris and Guten (1979) in a sample of 842 randomly selected adults, found no difference in self-reported health behaviours, whether individuals reported themselves to be in good, fair, or poor health. Hence, the relationship between perceived health status and health-promoting lifestyle is not clear and warrants further study in both adolescents and adults.

Pender (1987) proposed that the definition of health to which individuals subscribe may influence the extent to which they engage in a health-promoting lifestyle. Several studies have examined the influence of definition of health on health behaviour in young children and adults (Altman & Revenson, 1985; Frank-Stromberg et al., 1990; Laffrey, 1986; Natapoff, 1978; Segall & Wynd, 1990), but no study has examined this variable in an exclusively female adolescent population. Most of the studies have grouped different age groups together, making it impossible to isolate the uniqueness of the adolescent perspective. In a sample of 175 adolescents, Barnett (1989) noted that definition of health was a significant predictor of engagement in a health-promoting lifestyle for middle adolescents but not for early or late adolescents.

Self-efficacy has emerged as a predictor of health-promoting lifestyles in adults (McAuley & Jacobson, 1991; Pender et al., 1990; Waller, Crow, Sands & Becker, 1988; Weitzel, 1989; Weitzel & Waller, 1990). Efficacy perceptions have been repeatedly correlated with positive health behaviours such as cessation of cigarette smoking or exercise initiation (Davis, Jackson, Kronenfeld & Blair, 1987; DiClemente, 1981). These studies have focused on adult populations, and more specifically, on those located in treatment and rehabilitation programs. The concept of self-efficacy in adolescents and its role in influencing participation in health-promoting lifestyles remain to be explored, as only one

study has examined this relationship. Barnett (1989) concluded from a study of 175 early, middle, and late adolescents that self-efficacy was the only cognitive-perceptual variable that consistently predicted health-promoting lifestyles.

The role of parents and family in shaping the adolescent experience is widely embraced by developmentalists, and has become an increasingly important focus of study to understand the sources of unhealthy behaviour (Millar, 1991; Proia, Hester & Connor, 1987; Turner, Irwin & Millstein, 1991). However, few empirical investigations have focused on the role of parental lifestyle in influencing positive behaviours in their adolescents. The majority of studies in this area have focused on younger preschool and school-age children (Cohen, Felix & Brownell, 1989; Dielman, Leech, Becker & Horvath, 1984). Only two studies in the literature explored the relationship between adolescent health behaviours and parental modelling of health behaviour (Riccio-Howe, 1991; Donovan, Jessor & Costa, 1991). They concluded that greater modelling of health-enhancing behaviours by parents was associated with higher levels of involvement in health-related behaviours in adolescents. Further research on this subject is warranted.

Conceptual Framework

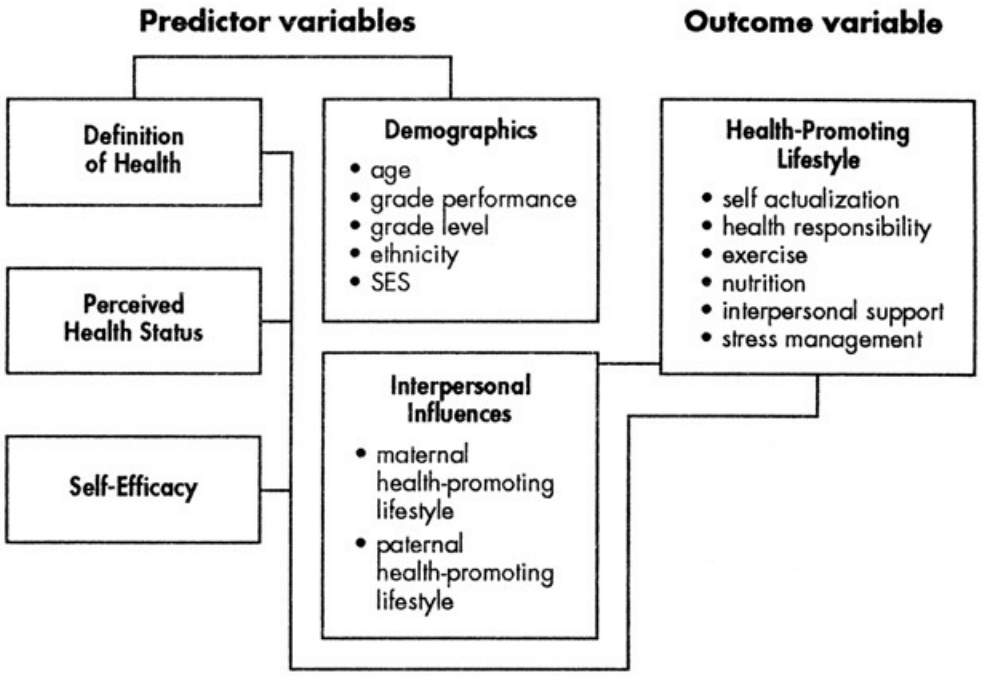
A modification of Pender's Health Promotion Model (Pender, 1982, 1987) provided the framework for this study. An exploratory paradigm of the relationships examined in this investigation is presented in Figure 1, and is intended as a correlational model, not a hypotheses-testing model. Although Pender's model has been tested with a range of adult populations (e.g., Duffy, 1993; Pender et al., 1990; Stuifbergen, Becker & Sands, 1990; Weitzel & Waller, 1990), it is this author's opinion that there is insufficient empirical or theoretical evidence in the literature to support its use as a hypothesis-testing model with adolescents.

Pender's model postulates that the likelihood of engaging in health-promoting behaviour is related to three sets of variables: (a) cognitive-perceptual variables, including the importance of health, self-efficacy, definition of health, perceived health status, perceived benefits of health-promoting behaviours, and perceived barriers to health-promoting behaviours; (b) modifying variables, including demographics, biological characteristics, interpersonal influences, situational factors, and behavioural factors; and (c) cues to action.

The Health Promotion Model forms an efficient organizing framework for studying the relationship between a health-promoting lifestyle in adolescent females and perceived health status, definition of health, self-efficacy, maternal health-promoting lifestyle, paternal health-promoting lifestyle, and selected demographics. The modified Health Promotion Model (Figure 1)

Figure 1

Modified health-promotion model



depicts a positive relationship between: (a) a health-promoting lifestyle and the cognitive-perceptual variables of definition of health, perceived health status, and self-efficacy in adolescent females; and (b) maternal and paternal health-promoting lifestyles and adolescent health-promoting lifestyles. The demographic variables are hypothesized to act as modifying factors of the cognitive-perceptual factors.

Research Questions

Based on the present state of knowledge and the conceptual framework of the study, the following questions were posed:

1. What are the relationships of maternal and paternal health-promoting lifestyles to a health-promoting lifestyle in adolescent females?
2. Of the following variables – perceived health status, definition of health, self-efficacy, maternal health-promoting lifestyle, paternal health-promoting lifestyle, and selected demographic characteristics – what are the best predictors of a health-promoting lifestyle in adolescent females?

Method

Design and Sample

A descriptive correlational design was used to explore the study questions. A stratified random sampling frame based on school and grade level was used to select a sample of 7th- to 12th-graders from two county schools in eastern

Nova Scotia. Junior high (grades 7,8,9) formed one stratum, and senior high (grades 10,11,12) the other stratum. A random sample was selected from each stratum using a table of random numbers and an enumerated master list of student names for each grade level provided by the school principals.

Criteria for inclusion in the study were: (a) ability to speak, read and understand English, (b) female adolescent attending junior or senior high school, (c) an intact mother-father dyad, (d) subjects' assent, and (e) parental consent to participate. Exclusion criteria included the presence of any chronic, debilitating emotional or physical illness such as severe heart disease or schizophrenia in the adolescent or the parent dyad. Individuals with these diagnoses were excluded so that such conditions would not confound interpretation of the findings.

Based on a power analysis for multiple regression analysis, the required sample size was determined to be 175 adolescent girls and their mothers and fathers. An oversampling of 50% ($\underline{N} = 262$) was done to account for attrition. Of the initial 262 sets of questionnaires distributed, 217 (83%) were returned. However, 33 of the returned sets were not usable because of missing data or the presence of a severe illness in the subjects. Therefore, the final sample consisted of 184 adolescents and their mothers and fathers.

Methodological triangulation (Woods & Catanzaro, 1988) was accomplished by collecting and analyzing qualitative data from a subset of eight adolescent females to enrich the quantitative data and contribute to a further understanding of variables that influence a health-promoting lifestyle. Only the quantitative part of the investigation is reported in this paper.

The adolescents ranged in age from 12 to 19 years, with a mean age of 15 years ($\underline{SD} = 1.70$). They were primarily Caucasian (95%), although other ethnic groups were represented. Parents ages ranged from 24 to 64 years, and their educational levels were from less than 7th grade to graduate school. All of the fathers and the majority of the mothers (52%) were employed outside the home. The median and mode family income was in the $30,000 to $39,000 range. The study sample reflects the adolescent population of the area.

Instruments

Health-Promoting Lifestyle Profile. Health-promoting lifestyle was defined as a "multidimensional pattern of self-initiated actions and perceptions that serve to maintain or enhance the level of wellness, self-actualization, and fulfillment of the individual" (Walker, Sechrist, & Pender, 1987, p. 77). The health-promoting lifestyle of each parent and adolescent was measured by the Health-Promoting Lifestyle Profile (Walker et al., 1987), a 48-item,

summated rating scale that measures six dimensions of the pattern of actions and perceptions that maintain and enhance the level of wellness of the individual. The dimensions include: self-actualization, health responsibility, exercise, nutrition, interpersonal support, and stress management. The 4-point response format to each item (1 = never to 4 = routinely) measured the respondent's self-reported health-promoting behaviours: the higher the total score, the better the health-promoting lifestyle of the individual.

Walker et al. (1987) reported a Cronbach's alpha of .92 for the total scale, with alphas on the subscales ranging from .70 to .90. A Pearson r was reported as .93 for the total scale, and ranged from .81 to .91 for the subscales. The Health-Promoting Lifestyle Profile has been used in previous studies with adolescents (Barnett, 1989; James, 1988), and produced a total internal consistency of .90 to .91, with alphas on the six subscales ranging from moderate to high. The alpha coefficients in this study ranged from .92 to .93 for the adolescents, mothers, and fathers.

Laffrey Health Conception Scale. Personal definition of health was measured by the Laffrey Health Conception Scale (Laffrey, 1986), which is based on Smith's (1981) description of health. It includes four dimensions: clinical (Clinical Health Conception Subscale), functional (Functional Health Conception Subscale), adaptive (Adaptive Health Conception Subscale), and eudaemonistic (Eudaemonistic Conception Subscale).

The Laffrey Health Conception Scale is comprised of 28 items in a Likert scale format (1 = strongly disagree, 6 = strongly agree). An individual's score was obtained by summing the seven items in each dimension, and then by summing all 28 items. Reliability, content, and construct validity results for the Laffery Health Conception Scale have been reported by Laffrey (1986). The present study produced reliability coefficients ranging from .81 to .82 for the subscales and .90 for the total scale. Others who have used the Laffery Health Conception Scale with young, middle, and late adolescents reported internal consistency coefficients for the total scale ranging from .87 to .91, and for the four subscales, internal consistency coefficients ranged from .75 to .91 (Barnett, 1989).

Perceived Health Status. Health status is defined as the individual's assessment of their level of health and well-being, and was measured by the Health Scale, a subscale of the Multilevel Assessment Instrument (Lawton, Moss, Fulcomer & Kleban, 1982). The self-rated Health Scale had four items, each with three or four response alternatives in a checklist format. The highest possible total score was 13, with a higher score indicating better health status. An internal consistency alpha coefficient of .76 and a test-retest reliability of .92

for the four-item scale was reported by Lawton et al. (1982). They also provided indications of criterion and construct validity. In the present study the alpha coefficient for the Health Status subscale was .58. A Spearman-Brown correction to eight items produced an alpha of .77 for the Health Status subscale.

Self-Efficacy. Self-efficacy defined as the belief that one is capable of performing the required behaviour necessary to produce a desired outcome (Pender, 1987, p. 62), was measured by scores on the General Self-Efficacy Subscale (Scherer et al., 1982). Total scores on this 17-item Likert instrument range from 17 to 85, with the higher end of the range indicating greater self-efficacy. The present study produced a reliability coefficient of .85. Scherer et al. (1982) and Scherer and Adams (1983) reported an alpha of .86 for the subscale and reported indicators of content, criterion, and construct validity. Others who have used the Self-Efficacy Scale with adolescents reported coefficient alphas ranging from .83 to .86 (Walker, Sandor & Sands, 1989).

Demographics. Sociodemographic data were collected on age, grade in school, school performance, ethnicity, parents' occupations, and annual household income.

Procedures

After parental and adolescent consent forms were received, the investigator administered a set of questionnaires to the adolescents in the auditorium/library of their respective schools at a prearranged and mutually agreeable time. The instrument packet contained the following: a demographic sheet, the Health Scale, the Laffrey Health Conception Scale, the General Self-Efficacy Scale, and the Health-Promoting Lifestyle Profile. The adolescents completed the instruments independently and placed the completed packet in the box provided. Upon completion of the questionnaires each adolescent was given two sealed envelopes: one for each of her parents. The envelopes contained a demographic sheet, the Health-Promoting Lifestyle Profile, and a letter explaining how to complete the questionnaires and when to return them to the investigator via their daughter. Each parent was asked to refrain from discussing any responses with their daughter or spouse until all the questionnaires were returned to the investigator at school one week later.

Data Analysis and Results

Data were analyzed using descriptive statistics and stepwise multiple regression with backward elimination of variables. Significance was accepted at the .05 level. The backward elimination procedure was selected for this study because the current state of knowledge of determinants of health-promoting lifestyles in adolescent females provides insufficient empirical or theoretical

evidence to support building a model based on independent variables. Through variable-selection methods based on statistical considerations, the backward elimination procedure begins with a model containing all the independent variables and then eliminates those that are of little use to the regression equation (Norussis, 1988). This procedure is useful for predicting a criterion variable, (in this case, adolescent health-promoting lifestyle), when there is limited knowledge of which independent variables are good predictors.

A residual analysis was conducted to measure the error of prediction of the adolescent's Health-Promoting Lifestyle Profile scores. It consisted of a normal probability scatterplot of standardized residuals in which the observed values were plotted against their expected values. Inspection of the computed plot provided evidence that the assumptions of normality, linearity, and homoscedasticity were met (Norussis, 1988).

What are the relationships of maternal and paternal health-promoting lifestyles to a health-promoting lifestyle in adolescent females?

To answer research question 1, a correlation coefficient was calculated. The Pearson correlation coefficient between mothers' Health-Promoting Lifestyle Profile scores and their daughters' Health-Promoting Lifestyle Profile scores was .28, $\underline{p} < .01$. Similarly, the fathers' and daughters' Health-Promoting Lifestyle Profile scores were significantly but weakly correlated ($\underline{r} = .16$, $\underline{p} < .05$). Thus, the relationship between the mothers' and daughters' Health-Promoting Lifestyle Profile scores was stronger than was the relationship between the fathers' and daughters' Health-Promoting Lifestyle Profile scores. To determine if the strength of these two relationships were statistically different from each other, a Fischer r to z transformation was performed. Results produced a Z score of 1.26 which was not statistically significant.

What are the best predictors of a health-promoting lifestyle in adolescent females based on: perceived health status, definition of health, self-efficacy, maternal health-promoting lifestyle, paternal health-promoting lifestyle, and selected demographics?

In response to research question 2, a stepwise multiple regression with backward elimination of variables was used to determine the relationship of the predictor variables with the criterion variable of the adolescent's Health-Promoting Lifestyle Profile scores. The procedure began with a model containing all the predictor variables: perceived health status, definition of health, self-efficacy, maternal health-promoting lifestyle, paternal health-promoting lifestyle, and selected demographics. The marginal T was used to delete the variable with the smallest T value if this value was below the predetermined critical value of T. When a variable was dropped, a new regression equation was calculated using the remaining variables and the marginal T test. The

Table 1

Multiple regression of predictor variables with the criterion variable, Health-Promoting Lifestyle Profile in adolescent females (n=184)

Predictor variables	B	Beta Weight	Part Correlation	Percent Explained	t
Ethnicity	−11.570	−.172	−.16	5.5	−2.82
General Self-efficacy Scale	.413	.283	.26	9.3	4.33
Health Status	1.260	.137	.13	4.5	2.17
Functional Health Conception Subscale	.603	.224	.15	7.3	2.54
Eudaemonistic Health Conception Subscale	.717	.238	.17	7.7	2.85
Clinical Health Conception Subscale	−.421	−.208	−.19	6.7	3.18

R .64
R^2 .41

process continued until all the predictor variables left in the model were significant. The removal criterion for each predictor was that the maximum probability of F-to-remove was significant at the .05 level.

Forty-one percent of the variance in the adolescent's Health-Promoting Lifestyle Profile scores was accounted for by the combined influence of Eudaemonistic Health Conception Subscale (7.7%), Functional Health Conception Subscale (7.3%), Clinical Health Conception Subscale (6.7%), General Self-Efficacy Scale (9.3%), Health Status (4.5%), and ethnicity (5.5%) (Table 1). The overall F (6, 177) of 18.88 was significant at the .001 level. Of the individual variables, the General Self-Efficacy Scale had the greatest impact in predicting the adolescent's Health-Promoting Lifestyle Profile. A multiple correlation of .64 indicated a strong relationship between the predictor variables (self-efficacy; eudaemonistic, functional, and clinical definitions of health; perceived health status; and ethnicity) and the criterion variable the adolescent's Health-Promoting Lifestyle Profile. The remaining independent variables of maternal Health-Promoting Lifestyle Profile, paternal Health-Promoting Lifestyle Profile, and the demographic variables of age, grade level, grade performance, and family socioeconomic status did not significantly predict adolescent Health-Promoting Lifestyle Profile scores.

Discussion

The modified Health Promotion Model (Figure 1) was used solely as a general conceptualization of relationships rather than as a causal model to be tested with an adolescent population. From the data analysis, there is evidence that the following variables were positively and significantly correlated with the

adolescent's Health-Promoting Lifestyle Profile: functional and eudaemonistic definitions of health, self-efficacy, perceived health status, mother's health-promoting lifestyle, and father's health-promoting lifestyle. Clinical definition of health and ethnicity were negatively related to the adolescent's Health-Promoting Lifestyle Profile (beta weights of –.21 and –.17 respectively).

Perceived self-efficacy emerged as the strongest predictor of the adolescent's Health-Promoting Lifestyle Profile. This finding adds to the empirical support in the literature for the role of self-efficacy as a predictor of health-promoting lifestyle in adolescent (Barnett, 1989; De Vries, Dijkstra & Kuhlman, 1988; Levinson, 1986) and adult samples (Pender et al., 1990; Strecher, DeVellis, Becker & Rosenstock, 1986; Weitzel, 1989; Weitzel & Waller, 1990). The fact that self-efficacy is a significant predictor of the adolescent's Health-Promoting Lifestyle Profile may be related to developmental changes in the teen years. Adolescents are at an age where they are beginning to assume increased responsibility for their health and to expect greater mastery of personal and environmental factors that influence health. They view themselves as being independent, self-reliant, and able to make their own choices rather than conform to the opinions of others (Millstein, Petersen & Nightingale, 1993). These developmental changes appear to encourage sustained efficacy feelings. The findings of the current study suggest that if nurses can facilitate adolescent females' positive perceptions of their self-efficacy related to health behaviour skills, they may be more likely to initiate actions that enhance health-promoting lifestyles.

In keeping with the findings of Barnett (1989) who studied middle adolescent boys and girls, the current study provides support for the role of definition of health as an important predictor of the adolescent's Health-Promoting Lifestyle Profile. The current results are also consistent with a number of studies using adult subjects (Laffrey, 1986; Segall & Wynd, 1990; Volden, Langemo, Adamson & Oechsle, 1990).

No other studies have examined the influence of the specific subscales of the Laffrey Health Conception Scale on the adolescent's Health-Promoting Lifestyle Profile. However, the results of the current study are in keeping with the findings of Frank-Stromberg, Pender, Walker & Sechrist (1990) who reported that defining health as the presence of wellness (measured by a wellness subscale of health conception) was a significant predictor of Health-Promoting Lifestyle among adults with cancer.

The combined influence of functional, eudaemonistic, and clinical health conceptions accounted for 21% of the variance in the adolescent's Health-Promoting Lifestyle Profile scores. However, although clinical definition of health emerged as a significant predictor of the adolescent's Health-Promoting

Lifestyle Profile scores, its negative beta weight indicates that adolescents who defined health narrowly as the absence of illness were less likely to engage in a health-promoting lifestyle. A clinical view of health may not be congruent with a health-promoting lifestyle in adolescents. Both the functional and eudaemonistic subscales represent a positive view of health. Their retention in the regression equation suggests that adolescents whose definition of health includes wellness and the ability to fulfill socially defined roles are likely to engage in health-promoting lifestyles.

The findings suggest that definition of health can act as a motivator for engaging in health-promoting lifestyles. Health should be explored with adolescents as a concept over which they have control and personal responsibility: an opportunity for them to exercise autonomy by committing to health-promoting patterns of behaviour such as exercise and good nutrition. This should facilitate a sense of independence in decision-making and promote the adoption of healthy lifestyles.

The adaptive subscale did not contribute to predicting the adolescent's Health-Promoting Lifestyle Profile despite a highly significant zero-order correlation with the adolescent's Health-Promoting Lifestyle Profile ($r = .41$, $p < .01$). Caution must be used in interpreting this finding due to high inter-correlations (.70–.74) among the functional, adaptive, and eudaemonistic subscales of the Laffery Health Conception Scale. Due to multicollinearity, the variance shared by the three subscales may not have left enough unique variance for adaptive health conception to remain in the equation. It may still be important to consider, but when looked at in combination with the other subscales, it contains redundant information.

The results of this study are consistent with those of Donovan, Jessor & Costa (1991) who reported significant correlations between maternal modelling of health behaviour and involvement in health-related behaviour by female adolescents. According to Bandura's (1986) Social Learning Theory, vicarious experience or the role of modelling the behaviour of others can generate expectations that the on-looker also will be able to perform the activity. Traditionally, women in our culture, and particularly mothers, have assumed responsibility for promoting health and preventing disease in themselves and their families (Rosenstock, 1974). It appears that in the current sample of traditional families from a rural setting, mothers' and fathers' lifestyles influence the lifestyles of their adolescent daughters. Therefore, nurses should place more emphasis on health education of parents, and adolescents as future parents, and be aware that the health-promotion in adolescents also encompasses attention to parents' Health-Promoting Lifestyle Profile. Nurses should take advantage of opportunities to support

parents in modelling healthy lifestyles and to make them, especially mothers, aware of the link between their own health-promoting lifestyles and that of their daughters.

The results of this study provided limited support for the relationship of ethnicity to the adolescent's Health-Promoting Lifestyle Profile. However, given the disproportionate representation of Caucasian and non-Caucasian subjects, no general conclusions about ethnicity can be made.

A stepwise multiple regression analysis was employed in this study because it was assumed that model testing was premature. To date, there have been few scientific investigations of the determinants of a health-promoting lifestyle in adolescent females. Hence, there has been insufficient evidence to build an explanatory model of health-promoting lifestyles in this population.

The findings of this study are but a beginning in the search for understanding adolescent females' health-promoting lifestyles. Further research is recommended. The findings of the current study should be tested using hierarchical multiple regression analysis to determine direct and indirect predictors of Health-Promoting Lifestyle in adolescent females. Such theory testing would eventually lead to the development of a health-promotion model for adolescents. Broader subject selection criteria, heterogeneous sampling from rural and urban areas, and the perspective of adolescents who leave school before graduation should be incorporated in future studies. School drop-outs are quite likely to have different thoughts and patterns of lifestyle that should be investigated to fully understand the determinants of a Health-Promoting Lifestyle in adolescents.

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Mental Health Consumers as Public Educators: A Qualitative Study

Rozsa Gyulay, Bronwyn Mound and Elizabeth Flanagan

Le présent projet de recherche qualitative a documenté le phénomène de l'intérêt, c'est-à-dire le sens subjectif de la participation des usagers dans les cours des étudiants au secondaire. L'objectif de cette étude était double : premièrement, découvrir le sens des différents vécus à travers l'analyse des descriptions faites par les participants et deuxièmement, documenter le processus pas-à-pas de la conduite de la recherche qualitative en sciences infirmières. La collecte de données incluait les observations sur le terrain, les entrevues semi-structurées, les questions ouvertes et les observations de six clients-participants atteints de graves troubles psychiatriques. Les entrevues ont été enregistrées au magnétophone et couchées sur papier. Toutes les observations sur le terrain et les entrevues ont été transcrites mot à mot. Les techniques de parenthétisation, d'intuitionnisme, d'analyse et de description ont été employées pour identifier et rassembler les unités de sens naturel et pour synthétiser le(s) sens focal(aux) (Banonis, 1989). Les phénomènes importants sont les suivants : expérience positive, amour-propre rehaussé et introspection. Les résultats de cette étude confirment que la collaboration entre les infirmières et les usagers peut avoir une influence positive sur la guérison du participant atteint de maladie mentale.

This qualitative study documented the subjective meaning to mental health consumers of participation in high school students' education sessions. The purpose was two-fold: to uncover the meaning of human experiences through the analysis of participants' descriptions, and to document the step-by-step process of conducting qualitative nursing research. Data collection included field notes, semi-structured interviews, open-ended questions, and observation of six mental health consumers with major psychiatric illnesses. Interviews were recorded in both handwritten and audio forms. All field notes and interviews were transcribed. Techniques of bracketing, intuiting, analyzing, and describing were employed to identify and cluster natural meaning units, and to synthesize the focal meaning(s) (Banonis, 1989). The key phenomena were: positive experience, increased self-esteem, and introspection. The results indicate that a collaborative relationship between nurses and mental health consumers can be a growth-promoting experience for the consumers.

Consumer participation is increasing within all aspects of the mental health system. (The terms *consumer, participant,* and *user* are used interchangeably in the current paper to refer to an adult who is receiving treatment for a diagnosed psychiatric illness.) Consumers and health care professionals are working together as part of a growing movement toward consumer empowerment. Hutchison, Lord and Osborne-Way, (1986) addressed the concerns of consumers and offered strategies for increasing their participation; these included building non-professional peer networks of support, and accessing community resources. Church and Reville, (1989), discussed relevant issues such as unbalanced power relationships and organizational entrenchment. A first

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Rozsa Gyulay, R.N., M.S., and Bronwyn Mound, R.N., M.Ed., are Service Chiefs and Nurse Case Managers in the Continuing Care Division at Clarke Institute of Psychiatry, Toronto, Ontario. Elizabeth Flanagan, R.N., B.Sc.N., is Nurse Case Manager in the Continuing Care Division at Clarke Institute of Psychiatry, Toronto, Ontario.

step in reducing obstacles to equitable power relationships is to identify consumers who are willing to discuss the problems they experience within and outside the service system. The June 1989 issue of Canada's Mental Health was dedicated to consumer issues. Increasing numbers of consumers are actively involved in program planning, have an input on committees and boards at hospitals, and are affecting decisions that determine future policies.

Although there are considerable political and social pressures to increase the involvement of consumers, there has been little or no research to investigate the impact that such involvement has on the consumers themselves. As noted by Church and Reville (1989), user involvement in Canadian mental health services is in an embryonic stage and existing initiatives are generally undocumented. The current study gathered information about the experiences of consumers who spoke to Grades 11 and 12 high school students as part of an educational forum, entitled "Beyond The Cuckoo's Nest". The purpose of the program was to increase the students' knowledge of mental health and psychiatric illnesses, and reduce negative attitudes toward the mentally ill. Professionals and consumers worked in partnership as educators of the students. The educational methods used were observational, didactic, experiential, and interactional (Mound & Butterill, 1992). During the teaching session two or three consumers described the experiences and situations they faced as persons with a psychiatric disability. They talked with the students informally about how they had dealt with their illnesses, and responded to students' many questions about their difficulties. These sessions had been conducted by the investigators at the Continuing Care Division of the Clarke Institute of Psychiatry, in Toronto since 1988.

Initially, consumers were informed about the purpose of these educational sessions and invited to sit in and observe. If they expressed interest in participating, mock teaching sessions were held with a nurse case manager. These rehearsals helped consumers to attain the comfort level needed to interact with students in an educational forum. The actual sessions took place in the hospital auditorium with 100 to 200 students and their teachers. Each consumer spoke with the students for about 25 minutes. Some consumers participated once or twice, but many volunteered to participate on an ongoing basis. One consumer brought her children, some invited other consumer friends, and others invited their parents. Three investigators participated in and observed many sessions of this education program. After completing the first year, the researchers' impressions were that these experiences had a positive influence on, and were important to the consumer themselves. However, at this point, understanding of the phenomenon was limited by the anecdotal nature of the evidence. Plans to continue these forums provided the opportunity for a more systematic and thorough investigation.

Purpose and Research Question

The purpose of this study was to increase understanding of the influence on consumers of their participation in educational sessions, to tap directly their expertise and experience, and to describe and evaluate the meaning of their participation. The research question was: What is the meaning of the experience for consumers who participate in public education?

Method

The goal of our study was to uncover the meaning of human experiences through the analysis of participants' descriptions (Parse, Coyne & Smith, 1985). In other words, the investigators were concerned with the "what" and not with the "why" (Kruger, 1981). A phenomenological qualitative research method was chosen because it was best suited to document and interpret the "totality" of consumer participation in the educational sessions from the participants' viewpoint or frame of reference (Leininger, 1985). The experiences of the participants were explicitly considered by using their oral descriptions, and these constituted the raw data (Parse, Coyne & Smith, 1985).

Study Sample

The sample consisted of 4 males and 3 females between the ages of 31 and 45. All had a primary diagnosis of a long-standing (10–20 years) schizophrenia or bipolar affective disorder and were receiving ongoing outpatient and intermittent inpatient treatment in the Continuing Care Division of the Clarke Institute of Psychiatry, where the investigators were working as case managers. In addition, some of the participants had a dual diagnosis of substance abuse. Consumers were encouraged to volunteer to participate in the research project because positive relationships already existed between the consumers and investigators. Potential candidates constituted an opportunistic sample (Field & Morse, 1985): they met the criteria of speaking English, had participated in the high school students' educational sessions a minimum of three times, and had the ability to verbally describe their experiences, thoughts, and feelings. The sample size was kept small because each participant created a large amount of verbal data that had to be transcribed verbatim and analyzed (Sandelowski, Davis & Harris, 1989). One of the seven individuals withdrew from the study and from the educational sessions. Unfortunately, he did not share his reasons for withdrawing and declined to be interviewed.

Participants were given a clear explanation of the nature and purpose of the study and how the data would be collected. They were informed that there was a time commitment, that their participation in the educational sessions and in the study were voluntary, and that in no way would their participation influence their individual psychiatric treatment. They could withdraw from

the study at any time and continue to participate in the educational sessions if so desired. Only the investigators would know the identity of participants; their right to confidentiality would be protected by using their initials. After the data analysis was completed the tape recorded interviews were to be erased. Participants were warned that they might experience some anxiety with the disclosure of feelings related to personal experience. On the other hand, they were told they might benefit by the knowledge that their input could contribute toward increasing understanding of consumer participation in public education. A written consent was signed by each participant and, prior to data collection, a comprehensive research proposal was submitted to the Institute's Research Review Committee on the use of human subjects. After some initial modification, the proposal was re-submitted and the Review Committee approved the study. The nature of the data collected did not require the use of the subjects' medical charts.

Data Collection

Participant observations and semi-structured interviews were conducted with three female and three male consumers at mutually agreed upon times. Each investigator conducted two one-to-one interviews. The researcher socialized with the participant at the beginning of each interview, to establish a rapport with them (Kruger, 1981). Open-ended questions were asked to explore the consumer's own perceptions of the audience and their reactions during the public speaking experience; participant's satisfaction with the presentation; and the meaning that verbal, written, and general feedback had for the participant. The following types of open-ended questions were used: What has it been like for you to participate in the educational sessions? Why have you participated in the educational sessions? What was your general impression of the audience? What do you think the reaction of the audience was to your presentation? How did your participation influence the audience's attitude towards psychiatric illness? How do you feel about reading the feedback on the evaluation forms? In what way does the feedback change your image of yourself? What factors would discourage you from participating or encourage you to participate? These exploratory open-ended questions helped to probe the benefits and disadvantages of participation as perceived by the consumers, and provided adequate flexibility for them to expand on their experiences. If either the researcher or the consumer had difficulty in understanding what was said, the question was repeated without paraphrasing so that leading the participant could be avoided. Deliberate attempts were made to conduct the interviews in an informal and non-directive manner aimed at minimizing the interviewers' influence on the participants (Kruger, 1981).

The interviews were recorded in both handwritten and tape-recorded form and subsequently transcribed. The use of tape-recordings enhanced the

accuracy of the transcripts (Field & Morse, 1985). Investigators employed the techniques of bracketing and intuiting during the data collection process. Bracketing refers to the technique of laying aside assumptions to allow the lived experience to be seen (Oiler, 1982). The investigators disciplined themselves to keep original assumptions and judgements separate in order to remain open to the emerging data. Although it is impossible to be totally free of bias, this technique helped reduce bias. Intuiting refers to the process of coming to know the phenomenon from the participant's perspective (Parse et al., 1985) so that the investigator is looking at the experience with wide-open eyes. This required concentration and strict adherence to the surfacing meaning, and involved openly looking, listening, and feeling in order to ascertain the uniqueness of the phenomenon of interest (Parse et al., 1985), in this case, consumers' participation in public education sessions. Thus, empathic and intuitive modes of awareness were deliberately and purposefully employed in the data collection (Oiler, 1982).

Field notes were meticulously recorded immediately after the interviews to ensure accurate recall of the contextual factors, because social situations influenced the content of data collection (LeCompte & Goetz, 1982). These notes recorded the investigator's thoughts and feelings about the interviews, including the effect of the investigation on the participant, observations about their verbal and non-verbal behaviour, and contextual factors.

Data Analysis

Skodol Wilson (1985) defines analysis as the process of separating data into parts for the purpose of answering the research question and communicating the answer to others, mainly in narrative, rather than in numerical form. The investigators sought to achieve group consensus throughout all aspects of the data analysis by individually and collectively reviewing and analyzing the transcripts, and discussing emerging concepts/categories. After data analysis, the validity of the findings was checked with participants to ensure that their perspectives were portrayed accurately. Such rigor was necessary to ascertain that the findings reflected the described phenomenon and had been clearly articulated. Burns and Grove, (1987) define rigor as the striving for excellence in research, associated with discipline, scrupulous adherence, and strict accuracy.

A narrative text was accumulated from the written field notes and transcribed interviews. Prior to transcribing the tape-recorded interviews, investigators alone and afterwards, together, replayed the tapes and listened attentively to participants' responses (tone and volume of the voices, pauses, hesitation, etc.) to the open-ended questions and also to the content of what was described, and compared these with the interviewer's notes. Changes in voice tone, significant pauses, and laughter were noted on the tapes. After inter-

views were transcribed, each investigator checked and corrected the transcripts of her own tape-recorded interviews and inserted notes and comments in the margin. One copy of each of the six transcribed interviews was secured in a safe place against loss, and one copy distributed to each investigator.

Bi-weekly meetings were held for investigators to analyze the data. Each transcript was read and re-read to allow the researchers to become familiar with the data. The techniques used to gain some understanding about the meanings of each participant's experiences were contemplative dwelling (Parse, et al., 1985), the undistracted repeated reading of the transcript, along with intuiting, analyzing, and describing. This process allowed the researchers to identify and cluster natural meaning units or scenes (Banonis, 1989, p. 39) in the transcript. Clustering is the grouping together of related events, processes, or settings to gain better understanding of the phenomenon (Woods & Catanzaro, 1988).

Unsuccessful attempts were made to use the large margins of the transcript and coloured highlighter pens to note the common descriptive expressions and recurring elements of the data (Field & Morse, 1985). Both methods proved to be inadequate to manage the large volume of data. Therefore, the investigators developed their own data sorting method (Field & Morse, 1985). Initial broad concepts/categories were identified and written on separate sheets of full-size writing paper. According to Burns and Grove, 1987, a concept/category is a word or idea to which abstract meaning is attached. Investigators then studied each participant's description, writing all natural meaning units – descriptive expressions, persistent words, phrases, and paragraphs – under the initially identified broad concepts/categories. A descriptive expression is a statement that completes an idea about the lived experiences (Parse et al., 1985). This method was found to be stimulating, and facilitated data sorting. After collecting all significant words, phrases, and descriptions from the six transcripts, the investigators eliminated the statements, phrases, and words, in each identified concept/category that communicated similar meaning (Parse et al., 1985). After the data were collected and analyzed, investigators conducted an extensive computer-aided literature search. In phenomenological investigations the literature review is delayed to ensure that the study is truly grounded in the data (Cobb & Hegemester, 1987), so that information in the literature does not influence the researcher's objectivity (Burns & Grove, 1987).

Findings and Discussion

Eight common elements or broad concepts/categories emerged from the data: respect, acceptance, new role, self-esteem, commitment, stigma, self-reflection, and altruism. The following direct quotations from the transcripts capture the meaning of the eight concepts/categories.

Respect. Participants talked about their positive experiences in the educational sessions with the high school students. They perceived respect from the students that was expressed verbally and behaviourally:

"I was given the opportunity to say my piece without interruption. The students showed respect, they were interested in knowing about me..."

"...liked the audience's reaction, they were nice to us, they didn't call us mental patient or psycho or anything like that. They just see that we're down to earth people like everybody else."

"...and I got praised about standing up on stage and talking...I think they picture us as not just ex-psychiatric patients but as people who have lives outside of here, with their jobs and family."

Acceptance. The following quotes from the consumers were clustered under the category of acceptance:

"They seem to react pretty well to what we had to say. They expect to find people who looked mentally ill...They expect to find people who are different from them and then they find out that we're not. I think they were pleasantly surprised about how we appear and how we present ourselves."

"...they didn't make me feel like an outcast. I was accepted. I felt wanted and cared about by the students. Their reaction made me feel that I wanted to come back."

"The students were attentive. They take to heart what you say to them... they made me feel at home."

New Role. Participants referred to themselves as teachers of the students. They clearly identified a new role for themselves that was different from the traditional patient role:

"I was educating the students by telling them what happened to me. I participated in the sessions to promote awareness about lack of education in mental illness."

"Before teaching the sessions I would think about what I was going to be saying in a coherent form, that it makes sense to the students."

"...it gives you a really good feeling to know that what you are doing is educating, giving people a better insight."

Self-esteem. Consumers gave a positive account of their experiences. They used feeling words to describe the challenge of participation in public education, and its impact on their self-esteem:

"...I felt pride! They [students] told me I have done quite well. Delivering those talks to the high school students made me feel worthwhile."

"I have never before gotten in front of a group of high school students by myself and just talked to them. I felt like I achieved something. It boosts my ego definitely, because my ego isn't very good."

"I felt satisfaction, doing it [teaching]. I suppose in reflecting on myself, it reflects that I am a positive and intelligent person and do a good job."

Commitment. Participants were favourably influenced by their experiences; what they were doing was important to them and to the students. They valued their participation, became interested in continuing, and described commitment to their teaching activities:

"I had to quit the sessions to go to work but every once in a while I will take leave of absence for one morning so that I could attend the teaching sessions."

"I do it [teach] twice a month because I am aware of the lack of education. I would do it [teaching] whether there was an honorarium or not, because work is healthy, and it's a sense of responsibility to those kids."

"I just want to, as you say in the sessions, debunk some myths about mental illness because I live in this society and whether it is good or bad, I am still in it...so the better it is, the better I am off. I can't think of anything that would discourage me from participating."

Stigma. Consumers increased their visibility while working collaboratively with mental health professionals. They talked about the stigma of being a mental health consumer and its impact on them. They described a strong desire to reduce the stigma by humanizing their experiences through their participation in public education sessions:

"We are not just labels...but people behind the labels. I want to do my bit to relieve [the] stigma of mental illness in our society."

"My example of stigma is loss of jobs because of psychiatric history. Just try, just try to find a job when you have to put details of past employment and why you were off when you apply for a job – and after you have tried that – you will have the answer about stigma."

"[The] stigma is less with educated people; it's more from the older people...the stigma in society is atrocious and even relieving a tiny bit of it would be instrumental in helping."

Self-reflection. Participants were willing to share personal experiences of mental illness with the students, and this was rewarded by positive feedback from the students. This process allowed consumers to look at themselves from a different perspective. They began to look inward and described their experiences:

"I spoke from my heart and my soul. It [teaching] helps with my self-examination about my morals, my gripes with my illness as well."

"This experience [talking with students] makes me kind of reflect on what it has been for me to be a schizophrenic from the very first symptoms to today, working and living with it, and also talking about it."

"We have problems that are different from their [students] problems, but on the whole, we have the same aspirations and goals like making money, having a good laugh, having friends, having a job. They see that we have just the same hope as them."

Altruism. Consumers described their commitment to educate the future generation and change societal views of mental illness. They reflected on their social conscience and unselfish attitudes:

"If I can help one person out there, it would have been helpful, useful, worth my while."

"I don't want them [students] to go through what I've been through ...hope that they don't make the same mistakes or even if they do, there is hope."

"...because I am concerned that maybe one or two of those kids are going to have mental illness and they are not going to know what to do and maybe my experience will help them."

Conceptual maps of the findings were constructed based on the eight broad concepts/categories identified. Investigators linked the eight categories and their attributes (Figure 1), and identified the focal meanings of consumers' experiences that described the phenomenon.

Figure 1

Linking of eight broad categories

• respect	• acceptance	• new role	• commitment	• self-esteem	• stigma	• self-reflection	• altruism
Positive Experience		Increased Self-Esteem			Introspection		

A second version of the conceptual map was constructed (Figure 2) to help demonstrate more clearly the interactive nature of the process through which the synthesized meaning of the study emerged: positive experience, increased self-esteem, and introspection.

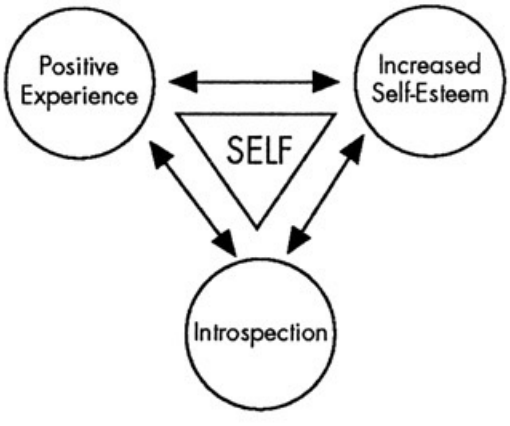

Figure 2

Synthesized focal meanings

Consumers repeatedly described the positive experiences associated with their participation in public education. They referred to the respect, acceptance, positive feedback, interest, and encouragement they had received from the students,and to the fun they had experienced. Such positive reinforcement from the students greatly influenced consumers' feelings about themselves and their performances. They described feelings of pride, achievement, and satisfaction, summarized by one of the participants as: "...All the positive stuff, incredible how much positive feedback I got. It's really encouraging ...They said the highlights of the sessions were my thoughts, ...I felt pride... I felt valued by the students." Participants described their new roles, as public educators: "It was challenging and satisfying,...It was uplifting...It made me feel that I wanted to come back." They attached personal value to their input and committed themselves to education: "My main reason for participating is to teach the kids,...this generation should be better informed." Participants shared their perception that the stigma of mental illness is less common among educated people. "I have suffered from misunderstanding and people not wanting to know anything about my condition." They felt optimistic about their influence on the future generation and expressed a desire to create a better society.

As participants became more comfortable in articulating their experiences, the encounter between consumer and audience deepened. Self-disclosure of subjective experiences not only informed the students about mental illness, but led the consumers toward an internalized process which the investigators referred to as introspection. Communicating about an illness that was deeply felt uncovered intense emotions and personal meanings: "This is deeper, it's my deepest experience of my own being which is not my soul, but the second deepest thing which is my illness, and communicating and explaining how I deal with it and how I don't deal with it."

Consumers talked about their need to communicate the pain and anguish they felt. They related the pain not only to the trauma of the acute phase of their illness, but also to the suffering they experienced in living with a long-term mental disability: "I shared my experiences of pain and being different...they saw what it is really like." Participants, by revealing their pain to the students, not only gained insight into their own world of mental illness, but created a profound experience for themselves, transforming former devastation into an experience of personal growth.

Participants' descriptions of their experiences signalled the beginning of a process of personal growth by transcending the devastating effects of illness. The investigators believe that depth of the experience, personal growth, and optimism for the future are elements crucial to the person's recovery. This recovery process affects the dimension of wholeness within the person.

Participants discovered meaning in relating their personal experiences of the illness. Although the illness remained, they became engaged in a growth process through self discovery as opposed to becoming entrenched in the sick role. As Haines (1986, p. 119) states: "The concept of total rehabilitation encompasses the building of meaning into the recovery process which exceeds the isolated restoration of bodies and minds."

To the best of the investigators' knowledge, no published studies exist that address consumers' participation in public education and the impact of such experience on consumers. However, numerous studies in the literature have shown that negative portrayals of mental health consumers in the media reinforce the stigma of mental illness, and that education (whether formal or public) helps to reduce the stigma. Wahl and Harman (1989) surveyed 487 members of the National Alliance for the Mentally Ill (NAMI) in 20 states. The majority of participants identified stigma as a concern for their families and for their mentally ill relatives. Media depictions, film portrayals, and news coverage were seen as significant contributors to the stigma. Provision of factual information about mental illness was helpful for reducing stigma. Hyler, Gobbard, and Schneider (1991) also showed that movies and television programs contributed to the development of society's negative attitude and stigmatization of the mentally ill persons. The authors claimed that "helping to bring the etiology of stigmatizing stereotypes to public awareness constitutes an important service to the public" (p. 1048).

In a survey of 514 people in Finland, Ojanen (1992) concluded that older, less educated people had more negative attitudes toward the mentally ill than did younger, more educated people. Page (1983) reported that persons who made reference to their mental illness or hospitalization were prejudiced against and less successful in obtaining housing. Desforges and colleagues (1991) based their study on the hypothesis that contact with a stereotyped, stigmatized group member positively effects prejudiced students' attitudes. Undergraduate students participated in learning sessions with confederates who were depicted as former mental patients. It was found that after the study session, initially prejudiced attitudes had changed to more positive ones.

Mansouri and Dowell (1989) noted that education of the long-term mentally ill was associated with decreased perception of stigma and that attitudes were linked to self-concept and psychological distress. The authors suggest that: "Programs that create a nonstigmatizing environment can successfully reduce the perception of stigma of the participants" (p. 89). Todres (1989) described a self-help Toronto-based clearinghouse as a community-based model of service delivery characterized by marked participation of the mental health consumer. The model emphasized face-to-face social interactions and educating the community about the value of mutual-aid/self-help

groups. Everett and Steven (1989) examined barriers to consumers' participation in a high-support housing research project. They addressed strategies for minimizing barriers between professionals and consumers. Consumers concluded that their experience was positive; they gained knowledge about different types of housing and identified new skill areas that contributed to their increased self-confidence and self-esteem. Peterson (1986) described a successful psychosocial rehabilitation program offered by a rural clubhouse. Patients were integrated into the community by training them to assume alternative roles and build the new roles into a positive self-concept. Clark, Goering, and Tomlinson (1991) gave account of clients' positive response to role demands, challenge, activity, and normalizing expectations.

Francell (1994) in his editorial poses the question: Why have attitudes changed so slowly in spite of the tremendous growth in advocacy for persons with severe mental illness? He asserts that changes in terminology are needed to increase public awareness: "A patient who has schizophrenia or manic-depression should not be described as 'mentally ill' but [as] having a neurobiological disorder" (p. 409). He advocates increased public education and awareness efforts to improve the lives of people with neurobiological disorders.

Conclusion

In the current paper, the authors presented a phenomenological study of six mental health consumers who had shared their knowledge and personal experiences with high school students. The qualitative research techniques of bracketing, intuiting, abstracting, and describing were used to cluster data into categories/concepts or natural meaning units that were further synthesized to describe the focal meaning of consumers' participation in public education. Conceptual maps helped to identify the subjective experiences of consumers as public educators: positive experience, increased self-esteem, and introspection. Empowerment of consumers occurred as they described their own experiences and became adept at interacting with the audience of high school students. They took on a new role as the educators of the public and became interested in an ongoing teaching/learning experience with the high school students. Their participation became purposeful as they shared their experiences and knowledge of coping with mental illness. In return, they gained respect and acceptance from the students. These experiences prompted positive feelings and self-evaluation. In summary, by stepping out of the traditional patient role and becoming actively involved as program participants, consumers entered into a new challenging path towards their own recovery. Written evaluations from the students and teachers indicated that public education is a powerful intervention strategy for reducing stigma and stimulating awareness of mental health issues. An interview with the one individual who withdrew from the study might have contributed to a more balanced

view on the public speaking experiences. These findings clearly indicate that the participation of consumers in public education was a positive, growth-promoting experience. This was congruent with the researchers' earlier stated assumptions that these experiences had a positive influence on consumers. A collaborative relationship between consumers and professionals can lead to a mutually satisfying experience.

The impact of high school education events on lasting changes in students' attitude towards mental health consumers remains to be explored. In addition, the usefulness of the program as an adjunct to classroom teaching should be evaluated by teachers and curriculum planners.

The investigators found that the phenomenological paradigm was effective in uncovering the meanings for consumers of their participation in high school education sessions. The researchers hope that their description of the step by step process of conducting a qualitative phenomenological research project will benefit other professionals.

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Changes in Employment Status: The Experiences of Ontario Registered Nurses

Robert D. Hiscott

À partir des données collectées au cours d'un sondage téléphonique auprès de mille cinquante-six infirmières autorisées en Ontario, le présent article examine le statut professionnel sur une certaine période (emploi à plein temps, à mi-temps ou occasionnel) des infirmières à travers une analyse détaillée des différentes formes de changement ou de mobilité dans le statut professionnel. Cette étude considère tant les formes internes (au sein de l'établissement) qu'externes (entre deux emplois) de modifications dans le statut professionnel. Les données de l'étude révèlent que plus de trois-quarts des répondants rapportent au moins un changement dans le statut professionnel au cours de leur carrière, et plus de la moitié rapportent deux changements ou davantage sur la période donnée. On a étudié les indicateurs de changement dans le statut familial (tous deux rapportaient des changements dans le statut matrimonial et le fait d'avoir eu des enfants durant leur carrière) et on a constaté de fortes associations avec les différentes mesures de changement de statut professionel externe. On a remarqué que la durée de l'emploi était fortement associée aux occasions de changement de statut professionnel interne. On discute les implications d'une plus grande flexibilité dans le statut professionnel au sein des établissements de soins.

Telephone survey data were collected from 1,056 Ontario registered nurses to examine employment status (full-time, part-time, casual employment) of nursing professionals over time, through a detailed analysis of different forms of employment status change or mobility. Both internal (within-job) and external (between-job) forms of employment status change were investigated. The survey data revealed that the average duration of employment careers was 16.7 years (±9.2 years), 78.5% of survey respondents reported at least one change in employment status over the course of their working careers, and 54.9% reported two or more changes over time. Changes in family status (changes in marital status and having children during employment career) were shown to be strongly associated with greater external employment status mobility. The duration of jobs was found to be strongly associated with greater internal employment status mobility. Implications for improved flexibility in employment status within health care settings are discussed.

The employment experiences of Canadian nursing professionals have changed significantly over time. Such changes can be attributed to various factors related to both the individual and the employment system. Health care institutions such as hospitals and nursing homes, which have traditionally served as the major employers of nursing professionals, are adjusting their overall nursing staff complements and mix to suit their needs. Dramatically changing economic realities (with declining transfers to institutions from all levels of government), as well as shifting needs or demand for health care services (as illustrated by the relatively recent growth in community or home-based health care services) are among the reasons for these adjustments. At an

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Robert D. Hiscott, Ph.D., is Associate Professor in the Department of Sociology, at the University of Waterloo, in Waterloo, Ontario.

individual level, nursing professionals faced with changing circumstances in traditional employment settings are reaching their own decisions and taking actions to achieve greater control over both personal and working lives. The high levels of employment mobility in the nursing profession are the end result of change at all levels.

The current paper explores the forms of change or mobility in one key employment dimension – employment status (whether full-time, part-time or casual) – using data collected from a large representative survey of Ontario registered nurses. This research was designed to provide a more thorough understanding of patterns of employment mobility among Ontario nursing professionals over the duration of their careers. The specific goals were to conduct a comprehensive investigation of all forms of mobility in various employment dimensions, and to improve understanding of the role exit process – the process of leaving a job. To obtain this information, detailed questions were posed to survey respondents on every job held since the time of completion of basic nursing training. By capturing complete career portraits of nursing professionals it is possible to assess changes in employment mobility over time, and enhance our general understanding of the reasons for the role exit process.

Changes in employment status have undergone dramatic shifts over time. Employment status involves much more than the number of work hours per week; it can also reflect the centrality or marginality of the work role and have implications for employment income, fringe benefits, and degree of autonomy and control in the work organization. Employment status can also be linked to long-term career prospects (such as opportunities for internal promotions to administrative-level positions), as well as more intrinsic job factors (such as level of job security and preferential treatment in assignment to wards or departments).

Literature Review

The dramatic growth in part-time status employment is one of the most significant trends in employment over time. Using labour force survey data, Campling (1987, p.6) showed that part-time employment increased from a modest 3.8 % of total employment in 1953, to 16.6% in 1985. Based on 1986 Organization for Economic Cooperation and Development (OECD) data, McKie (1992) also found that high proportions of the labour force were employed on a part-time basis in the United States (17.4%) and the United Kingdom (22%). McKie (1992, p.30) observed that a sizeable proportion of part-time employment in Canada is involuntary: "Data suggest that if a large supply of new full-time positions were created, there would be an outflow of approximately one-third of part-time workers to full-time status."

Much of the growth in part-time employment status over time has been found in female employment. While this is especially the case in the United Kingdom where part-time employment is almost entirely a female phenomenon, McKie (1992) also found that approximately one-third of all women in the Canadian labour force were employed part-time throughout the 1980s. Although McKie (1992) noted that there is a balance of advantages and disadvantages to part-time work for both employees and employers, other writers have emphasized the negative factors. In an analysis of the legal position of "atypical workers" (including both part-time and casual or temporary employees), England (1987, p. 58) concluded that they "... are subjected to a broad range of inferior treatment, compared with traditional employees, under the three major legal regimes governing work relations, namely the individual employment contract, the employment standards legislation and the collective bargaining legislation." Coates (1988, p. 97) goes further, stating that "there is no comprehensive policy on part-time work in force in Canada and few public policy measures to protect or promote equal treatment of part-time employees."

The nursing profession in Canada is predominantly female in composition and has experienced dramatic growth in part-time employment over time. Paddon (1992) reported that in Canada, part-time employment of nurses grew from 30% in 1970 to 40% in 1990. White (1992) observed that part-time employment in nursing has increased much more rapidly than overall part-time employment in Canada.

Although part-time employment has increased in most occupations, Duffy and Pupo (1992) believe that many women continue to opt for traditional female careers such as nursing in part because transition to part-time status is far more common and accepted. They observe that "in professional categories traditionally dominated by males – medicine, law, business, accounting, and tenured university appointments – there is little or no conversion to part-time, except among those nearing retirement or those who, as independent practitioners, voluntarily reduce their hours of work" (Duffy & Pupo, 1992, p. 88).

Part-time employment in the nursing profession is reportedly closely associated with various socio-demographic factors. A recent Goldfarb survey of Ontario registered nurses revealed that full-time nurses tended to be single; part-time nurses were more likely to be married with children (The Goldfarb Corporation, 1988). It was also found that part-time nurses tended to have been in the nursing profession for a longer time (1988).

Similarly, a recent survey of members of the Royal College of Nursing (Seccombe & Ball 1992) found that 52% of qualified nurses with dependent children were working part-time, compared to only 16% of those without

dependents. A strong age effect was also observed; older nurses (especially those more than 25 years) had much higher levels of part-time employment than younger qualified nurses (1992). In another British survey of members of the Royal College of Nursing, Buchan and Seccombe (1991) found that part-time employment was more common among married and older nursing professionals than among single and younger ones. They also reported that among nurses who anticipated a career break in the future, over 60% expected to return to work on a part-time basis after the break.

There are problems associated with the dramatic growth in part-time employment in the nursing profession over time. Paton and Lobin (1992, p.328) stated that the recent percentage increases "... may reflect changes in market conditions, available positions, health care funding priorities and lifestyle choices," and concluded that the trend could lead to nursing shortages in future. In an earlier analysis of the Ontario nursing staffing crisis of the late 1980s, Meltz and Marzetti (1988, p. 44) concluded that the shortage was partially a function of the dramatic increase in part-time employment in the profession, "... requiring recruitment of more individuals to fill the same number of full-time equivalent slots."

White (1992) contended that there has not been a labour shortage problem within nursing but rather a very high turnover rate. He discussed serious problems in hospital settings (still the predominant place of employment for nursing professionals) and the consequences, including shorter working hours, strikes, and outright resignations. He concluded that nurses are increasingly choosing to work on a part-time basis "... as a flight from the steadily intensifying labor process" which involves both the content of the work and the time constraints (1992, p. 291). However, he contended that the ultimate consequences of increased part-time employment in the nursing profession are negative since it "... lessens [nurses'] power and weakens their demands for change" (1992, p. 288). To illustrate, White reported that part-time hospital nurses often claimed that they were assigned to the worst shifts.

Duffy and Pupo (1992, p. 206) concluded that hiring part-time employees "... extends the practice of cheapening labour initiated with the detailed division of labour and the process of deskilling." They observed that this is especially true in hospital settings where "... the intensification of work, the use of computerized patient monitoring, and the subdivision of the professional nurse's role into a series of smaller tasks are related to the growing use of part-time nurses and floaters" (p. 207). This ultimately results in reduced time for personal interactions with both patients and co-workers. Finally, White (1992, p. 291) observed that for part-time nurses, "lack of familiarity with units, patients, and procedures potentially decreases the possibility of their delivering quality care, while making work more difficult for the full-timers."

Hence, the marked growth of part-time employment in the nursing profession has led to increased problems for practising nurses.

Method

A stratified probability sample was drawn from the population database of all registrants with the College of Nurses of Ontario (CNO). The sample was stratified using four categories from a newly developed professional role exit typology, reflecting the extent to which nursing professionals were inside or outside of the nursing profession prior to survey interviewing. These four professional role exit categories used for stratifying the sample were: active nursing professionals (those currently employed in the nursing profession), transients (those unemployed but still registered with CNO), dual professionals (those registered with CNO but reporting employment outside of the nursing profession), and true outsiders (those less than 50 years old who had let their registration with CNO lapse within the preceding three years). The stratified sample design provided for over-sampling of the latter three categories to assure adequate numbers of nursing professionals in the final sample who had exited the nursing profession in varying degrees. For the purposes of this paper (given the desire to generalize findings to the full population of Ontario registered nurses), post-stratification weighting was applied to all cases, serving to reproduce the same overall proportions for each role exit category as found in the general population of Ontario registered nurses.

A mail-out package was sent to 2,050 prospective survey respondents informing them about the nature of the research project prior to contact by one of the telephone survey interviewers. One-third (34.8%) could not be contacted, usually due to unpublished or untraceable telephone numbers (since CNO records did not include home telephone numbers). Hence, numbers had to be traced individually for those nursing professionals who did not respond to the initial mail-out package. Of the 1,336 prospective respondents contacted by one of the telephone interviewers, 280 (21%) refused to participate in the project, while 1,056 (79%) completed a telephone interview. Comparisons of sample to population data revealed that the final weighted stratified sample is representative of the larger population of Ontario registered nurses on various background attributes, including sex and age.

Telephone surveys were conducted with the aid of the CASES CATI (Computer-Assisted Telephone Interviewing) system developed at the University of California, Berkeley. The CATI system requires that the survey instrument be converted into a computer program which, once fully tested and debugged, allows telephone interviewers to conduct surveys by reading questions from pre-programmed computer screens. The CATI system is designed to assure that only relevant questions are posed to respondents, and

that the sequence and wording of survey questions is standardized for all respondents. It served to increase the speed of data collection and data coding/processing (through combined operations) while reducing interviewer/respondent burden. The CATI system was especially useful for streamlining data collection procedures through a repeatable programmed roster. The program was designed to cycle through the same series of questions and capture detailed standardized employment information on every job held by respondents from the time they had completed their basic nursing training.

Since the primary purpose of this survey was to investigate employment mobility in the nursing profession, most of the questions related to employment classification for every job reported: employment status, position type, employment place or setting, and primary responsibility or specialty area. In addition, registered nurses were asked to report if there had been internal changes in working time arrangements over the duration of each job held. The detailed questions were designed to tap both external (between-job) and internal (within-job) dimensions of employment mobility.

Telephone surveys were conducted with 1,056 Ontario registered nurses between spring and fall of 1992. Comparable to the profile for the larger population of Ontario registered nurses, the vast majority of the sample of registered nurses (98.3%) were female, and their ages ranged from 23 to 72 years, with an average of 42.1 years (median = 42; SD = 9.7). More than three-quarters (76.6%) of respondents were married at the time of interviewing, 11.1% were single, and smaller proportions were separated, divorced, and widowed. The duration of employment careers ranged from 1 year to 43 years, with an overall average of 16.7 years (median = 16; SD = 9.2).

Data were collected on a total of 5,123 jobs held by respondents, which is an average of 4.8 jobs per nursing respondent. There was a considerable range, from 1 job to as many as 22 jobs reported by individual registered nurses. For every job held, respondents were asked to report their employment status at the time of starting the position, and up to three[1] subsequent internal changes in employment status that occurred during the course of that employment. The reasons for internal changes in employment status were also probed.

Self-reported employment status of surveyed nursing professionals was captured using standard categories of full-time, part-time and casual status. However, the use of standard employment status categories is not without problems. There was considerable variability in the number of working hours reported by registered nurses within each of these categories. The average number of hours reported by full-time workers[2] was 40.1 hours per week (SD = 5.7 hours). For part-time employees, the average weekly hours was 24.1 hours (SD = 9.1 hours), and for casual status workers, the average was 22.1 hours (SD = 11.5 hours).

Internal (within-job) changes in employment status represent only one part of employment status change; external (between-job) changes are also a critical component. It is essential to distinguish between internal and external forms of employment status change since they differ significantly both in terms of overall magnitude and career impact.

To simplify the analysis of change on the employment status dimension, changes were crudely classified as either increases (from casual or part-time to full-time, or casual to part-time) or decreases (from full-time or part-time to casual, or from full-time to part-time) in employment status.

Findings and Discussion

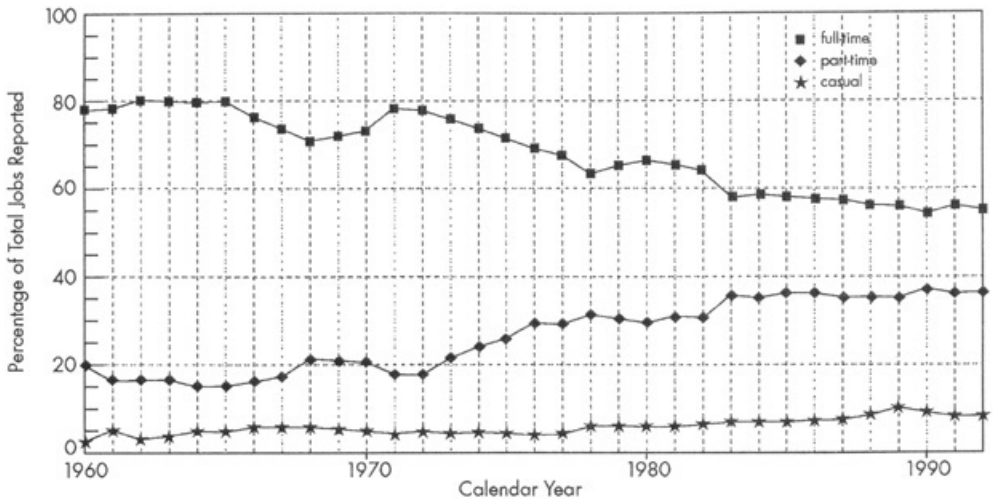
It is useful to begin with an overall profile of employment status to identify significant trends over the years. Figure 1 shows employment status category percentages over time. It was possible to slice the survey data to determine the specific employment status of reporting nursing professionals in a given year. It is important to recognize, however, that the number of survey respondents represented, gradually increased over time from 138 in 1960, to 1,008 in 1992. This is simply a function of the sample design; there were relatively few respondents employed 30 years ago, whereas most registered nurses held jobs in the 1990s. Despite this variability in base numbers reporting across calendar years, it is possible to look at the overall trends in employment status over time.

This sample of Ontario registered nurses experienced changes in employment status that were consistent with previous analyses of the nursing profession. The percentage of full-time employment declined from approximately 80% during the early 1960s to approximately 55% in the 1990s. Over the same time period part-time employment increased from less than 20% to approximately 35%. The percentage of casual employment increased very modestly over the full 32-year period, but remained less than 10% during all calendar years. Although there are modest peaks and valleys in these percentage distributions over time, it was during the 1970s that full-time decline and part-time growth were most evident. Casual employment remained at very low levels during that decade, with modest growth occurring subsequently.

To some extent, the trends evident in Figure 1 are attributable to the age structure of the sample. There is a natural maturation process, since respondents have aged with each subsequent year. The average age of the small subset of nursing professionals employed during the 1960s was much lower than the average age of the larger sample base employed at the time of interviewing in 1992. This serves to confound the trends, since age has a significant independent impact on employment status (Figure 2).

Figure 1

Employment status profile by calendar year



In Figure 2 cross-sectional techniques are applied to look at the percentage distribution of employment status, controlling for the age of nursing respondents. The trends are more dramatic than in Figure 1: percentage full-time employment declines significantly with increasing age, while part-time employment increases markedly. Percentage casual employment shows a mixed trend, with gradual decline after the early 30s. The most marked shifts occur during the 20s, which usually represents the first decade of employment for newly trained registered nurses. During this decade, distribution shifts of close to 30% are evident. Beyond age 30, changes in full-time and part-time employment are much more modest. By the late 50s, the percentage of part-time employment surpasses full-time employment for this sample of data. However, this should be interpreted with cautioun since there were less than 100 surveyed nurses included in the sample in each of the upper age categories. The strong trends evident during early careers (covering ages 22 to 30) were based on at least 832 respondents.

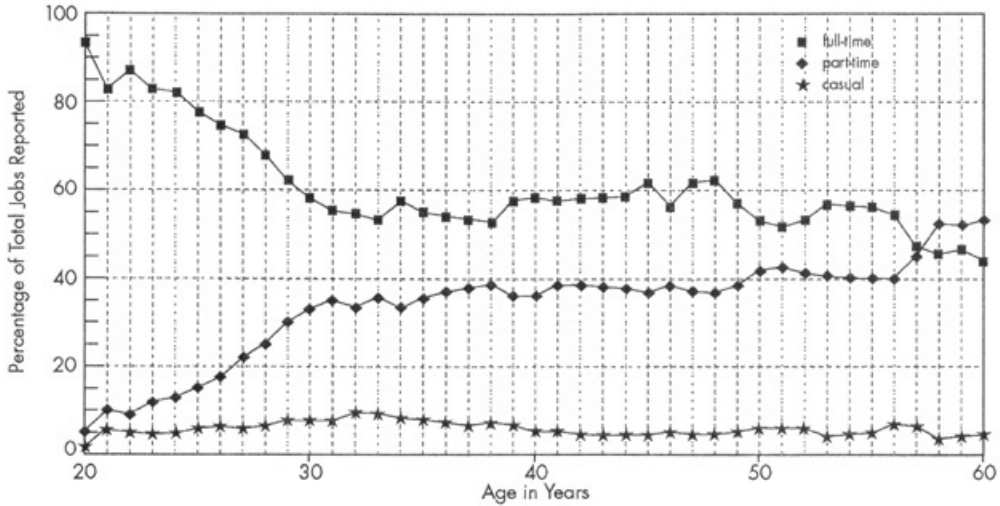
The overall employment status profiles by age and calendar year only provide a partial picture of the actual magnitude of change in this employment dimension. They underestimate employment status mobility, since they do not account for temporary switching of status or multiple changes during a given year. More detailed information on all employment status changes was collected. Table 1 provides summary statistics for both internal and external changes, as well as the types of status changes (increases, decreases or combinations of both).

Beginning with internal status changes, those changes that occur within the same job, there is a roughly even split between the total numbers of reported status increases and decreases: 52% versus 48%. Approximately 34.7% of the individuals in the sample reported increases in status at some point in their careers; 33.3% reported decreases in status. Relatively modest proportions reported more than one increase (7.0%) or decrease (5.4%) over time. The vast majority of internal employment status changes were voluntary in nature. Of all reasons cited, 61.3% were personal in nature, with the most common being pregnancy and child care. The remaining 38.3% of explanations were job-related, ranging from requests by employers (6.1%), to the need for more money, and reducing job stress.

Turning to external status mobility, employment status changes that occur between jobs, there were 64% more external employment status changes reported than internal status changes. Further, 58.9% of these changes were decreases in employment status. This pattern is also reflected in the percentage of individuals affected: 38.6% reported one or more external increases, and 53.1% experienced at least one decrease in their employment status over the course of their careers (Table 1).

Figure 2

Employment status profile by age



Survey respondents were also queried about the reasons for leaving each of their reported jobs. Again, there was strong evidence for the voluntary nature of external employment mobility among nursing professionals. Of the total of 4,125 jobs (for which reasons were reported) left by these registered nurses, only 3.2% were reportedly left as a result of a decision by the employer, 2.4% by mutual decision of the respondent and employer, and 94.4% were left voluntarily. Of the total of 5,953 reasons cited for leaving jobs[3], only 2.1% specified a desire to change employment status, and an additional 3.9% left because of hours or shifts, which is closely related to employment status. The magnitude of differences between internal and external employment status change is especially evident from the totals (combined increases and decreases in status to reflect any employment status change). Of the surveyed registered nurses, 60.9% reported at least some external employment status change, and 35.5% revealed they had experienced two or more external changes over time. For internal employment status changes, these figures were 51.9% and 20.3%, respectively. The maximum numbers of changes reported by individual respondents are also notably higher for external (13) than for internal (7) employment status changes.

When internal and external employment status changes are pooled (the last column of Table 1), one finds that 59.6% reported at least one increase in status, and 71.5% at least one decrease in status over the course of their careers. Decreases in status are therefore more common than increases, with much of this difference due to external status changes. Finally, when all kinds

Table 1

Percentage of Ontario registered nurses reporting employment status changes over the course of their careers**

Type of employment status change	Internal • status changes	External • status changes	Internal or external
No increases (%)	65.3	61.4	40.4
One increase (%)	27.7	25.9	32.9
Two or more increases (%)	7.0	12.7	26.7
Maximum number of reported changes	4	6	8
No decreases (%)	66.7	46.9	28.5
One decrease (%)	27.9	34.6	40.1
Two or more decreases (%)	5.4	18.5	31.4
Maximum number of reported changes	5	7	7
No increases or decreases (%)	48.1	39.1	21.5
One increase or decrease (%)	31.6	25.4	23.6
Two or more increases or decreases (%)	20.3	35.5	54.9
Maximum number of reported changes	7	13	14

* Internal changes in employment status occur within a single job, while external changes occur between jobs.

** All percentages are based upon the total sample of 1056 registered nurses.

of changes are pooled – internal and external, increases and decreases – one finds that 78.5% of surveyed registered nurses experienced some kind of employment status change during their careers, with 54.9% reporting two or more changes.

Given the overall high magnitude of employment status change and the trends by age, it is useful to explore mobility patterns by family status indicators. These are by no means the only important variables for understanding employment status mobility, but they do reflect kinship responsibilities that would undoubtedly impinge upon nurses' working schedules. The 20s age bracket is a common time for both getting married (changing one's marital status), and having children. Tables 2 and 3 break down the percentages of external and internal employment status changes by number of children during career (that is, children born after completion of basic nursing training), and number of marital status changes (since completion of basic nursing training).

Table 2

Percent reporting external employment status changes by family status changes

Family status variables	Increase employment status	Decrease employment status	Increase or decrease
Overall percentage change (N = 1056)	38.6%	53.1%	60.9%
Number of children during career:			
No children (N = 295)	30.4%	34.5%	42.3%
One child (N = 134)	27.9	45.2	48.4
Two children (N = 377)	41.9	63.0	71.5
Three or more children (N = 251)	48.8	64.4	73.4
Chi square test of significance	27.60*	72.22*	85.54*
Number of marital status changes:			
No changes (N = 223)	27.9%	37.0%	44.2%
One change (N = 702)	39.3	55.5	64.4
Two or more changes (N = 131)	52.5	67.6	70.2
Chi square test of significance	21.64*	35.89*	34.60*
Interaction: Children x marital status, changes:			
No children, no marital status change (N = 156)	23.8%	32.0%	39.9%
No children, marital status change (N = 139)	37.9	37.3	45.1
Children, no marital status change (N = 66)	37.7	49.0	54.3
Children and marital status change (N = 695)	42.1	61.4	69.3
Chi square test of significance	18.14*	61.65*	65.63*

*p<.01

The mobility percentages shown in Table 2 reflect any external employment status changes and changes in family status from the time of completing basic nursing training to the time of the telephone survey interview in 1992. There are strong associations of number of children born during the employment career with each of the change indicators (increased status, decreased

status, and any status change). Generally, the greater the number of children born during an employment career, the higher the status mobility. However, the most dramatic changes were found for respondents who had two or more children. In the last column of Table 2 (reflecting any change in employment status over time), less than half of those respondents with one or no children reported status change (48.4% and 42.3%, respectively), compared to close to three-quarters of those nursing professionals who had two or more children (71.5% and 73.4%, respectively) over the course of their careers.

There were also strong statistically significant associations between the number of marital status changes and employment status changes: The greater the number of marital status changes, the higher the levels of change over time. A relatively small number of nurses had experienced two or more changes in marital status over the course of their careers. In most cases, they had been married and later lost a spouse or partner through separation, divorce, or death.

Changes in family status were much more strongly associated with decreasing employment status than increasing employment status. This is reasonable since in many cases getting married and having children involves greater family commitments, leaving less time available for outside employment.

Finally, there is an interaction effect between the combined family status variables and employment status change, especially decreases in employment status.[4] The simple two-fold interaction of family status indicators shown at the bottom of Table 2 demonstrates the joint effects of these two variables upon employment status change levels. Nursing professionals with no children or no marital status changes had the lowest mobility percentages of all (23.8% increase, 32% decrease, and 39.9% increase or decrease). Respondents reporting change on only one of the family status indicators had intermediate levels of employment status change. The highest levels of change were found for respondents who reported both having children and changing their marital status (42.1% increase, 61.4% decrease, and 69.3% increase or decrease). Table 3 provides the family status indicator breakdowns for the three measures of internal (within-job) employment status change. Only number of children was significantly associated with increase in employment status. However, the pattern is not a strong one and lacks the progressive increase in mobility percentages found in Table 2.

Stronger statistically significant associations ($p < .01$) were found between family status variables and decreased employment status or any employment status change (increase or decrease). As number of children increased, employment status decreased. However, there appears to be a critical

Table 3

Percent of respondents reporting internal employment status changes by family status changes

Family status variables	Increase employment status	Decrease employment status	Increase or decrease
Overall percentage change (N = 1056)	34.7%	33.3%	51.9%
Number of children during career:			
No children (N = 295)	31.7%	21.5%	41.5%
One child (N = 134)	26.7	27.9	42.0
Two children (N = 377)	40.1	39.4	61.4
Three or more children (N = 251)	34.2	41.0	55.3
Chi square test of significance	9.76*	33.38**	32.73**
Number of marital status changes:			
No changes (N = 223)	33.3%	24.6%	46.6%
One change (N = 702)	35.3	38.2	55.7
Two or more changes (N = 131)	33.9	22.2	40.6
Chi square test of significance	.35	22.45*	13.34*
Interaction: Children x marital status, changes:			
No children, no marital status change (N = 156)	30.4%	21.2%	40.3%
No children, marital status change (N = 139)	33.2	21.8	42.8
Children, no marital status change (N = 66)	39.9	32.7	61.7
Children and marital status change (N = 695)	35.4	38.4	55.4
Chi square test of significance	2.36	26.82**	19.07**

*p<.05 **p<.01

threshold: Survey respondents who had two or more children had markedly higher mobility percentages than those with one or no children (39.4% and 41% versus 27.9% and 21.5%, respectively).

Number of marital status changes was also strongly associated with decreasing employment status, although there was no progression in percentages in this relationship. Nursing professionals who reported making one change to their marital status over time (in most cases, moving from single to married) showed the highest percentage for decreasing employment status (38.2%); those reporting two or more changes to marital status showed the lowest percentage (22.2%).

Finally, there was evidence of a modest three-way interaction between the two family status variables and the percentage of nursing professionals decreasing their employment status. Those experiencing no family status changes exhibited the lowest change percentage (21.2%), while those experiencing change in both family status dimensions reported the highest level of mobility (38.4%). There is a joint effect of the two-family status variables, but it is much weaker than that observed for external decreases in employment status in Table 2.

In all cases, the strength of the associations found in Table 3 are much weaker than those for the external change indicators in Table 2. This is especially true for the increased employment status variable, where the only statistically significant relationship in Table 3 was found with number of children and this was much weaker than any of the relationships found in Table 2. It is clear from Tables 2 and 3 that changes in family status over the course of an employment career are more likely to be associated with changes in employment status between jobs rather than within jobs.

It is also useful to look at the effect internal status changes have upon the duration of jobs. For this exploration of transitions (durations between starting and leaving specific employment positions), the unit of analysis is the job rather than the nursing professional, and is restricted to terminated jobs for which precise employment durations can be determined.

Table 4

Employment duration for Ontario registered nurses by number of internal employment status changes

Number of internal employment status changes	Average duration (yrs)	Number of jobs*	Test of significance
No employment status change	2.21	4051	$F = 207.43$
One employment status change	4.62	342	
Two or more employment status changes	6.86	93	$p < .001$

*Only jobs which were terminated are included in this table.

Of the total of 4,486 terminated jobs reported by respondents, 90.3% involved no changes in employment status, 7.6% one change, and 2.1% two or more changes in employment status over the duration of employment. The greater the number of internal employment status changes, the longer the overall average job duration: with no employment status change, the average job duration was 2.21 years; with a single change, 4.62 years; and with two or more changes, 6.86 years.

Conclusion

The current data demonstrate the high magnitude of employment change among nursing professionals. On average, the mid-career registered nurse in this sample had held five different jobs over a 16-year employment career since completion of basic nursing training. This implies a mobile career path with job changes every few years. Evidence of high mobility is even stronger when specific employment dimensions such as employment status are examined. While external or between-job changes in employment status are much

more common, the frequency of internal or within-job changes is also considerable. Overall, more than three-quarters of this sample of respondents reported at least one change in employment status over the course of their career, with more than half reporting two or more changes.

These survey data reveal a general increase in the overall magnitude of part-time employment over time, which is consistent with patterns identified in the literature (Paddon, 1992; Paton & Lobin, 1992; White, 1992). However, despite this trend, there is no clear directional bias (increasing or decreasing) in reported employment status changes among surveyed nursing professionals. To illustrate this point, combining both internal and external changes, there were a total of 1,038 increases in employment status (45.2% of all reported changes), compared to 1,256 decreases in status (54.8% of the total), and both forms of employment status change were very common. Hence, while it is true that nursing as a traditional female career facilitates the transition to part-time employment status (as argued by Duffy and Pupo, 1992), the enhanced flexibility for those in the profession appears to work in both directions. Registered nurses are as able and likely to increase their employment status within and between jobs as they are to decrease their employment status. It is important to recognize the truly bi-directional nature of employment status changes in the nursing profession since these patterns suggest much greater flexibility on this dimension than commonly acknowledged.

Changes in kinship responsibilities over the duration of employment careers are important determinants of employment status changes over time. This is especially true in a predominantly female profession such as nursing. Of the current sample, 78.9% of survey respondents experienced at least one change to their marital status, and 72.1% had had at least one child during their employment careers. Changes in kinship responsibilities were found to be generally positively related to changes – both decreases and increases – in employment status. Once again, it is important to recognize that different forms of employment status change can be expected at different stages in the family cycle. Hence, while younger registered nurses who have recently been married or had a child may be more likely to decrease their employment status, older nursing professionals who have lost their marriage partner or whose children have grown up may be more likely to increase their employment status.

The relationships between family status indicators and internal employment status change were relatively weak, suggesting that those who are faced with changes in family circumstances are more likely to cope by changing jobs. If nurses had the option of temporarily changing their employment status or taking temporary leave from their jobs as family circumstances dictated, a significant proportion would probably take such opportunities to stay with the same employer in the same setting over time.

Although the desire to change employment status is not frequently mentioned as a reason for leaving a job, status change between jobs commonly occurs. Unfortunately, the current data do not clarify whether such external changes in employment status are imposed, or truly voluntary (where nursing professionals pick and choose among jobs with different statuses). Both factors are likely to have some impact upon the level of external changes in employment status.

As noted by White (1992), high turnover rates are a serious problem in the nursing profession. The data on internal employment status changes revealed that increased opportunities to change employment status within a given job setting could have a strong positive impact on the tenure of employment by nursing professionals. In the current survey, where internal employment status changes occurred, the average job duration was markedly longer than where no changes in status occurred. Greater flexibility could serve to reduce the high costs associated with job turnover, and especially the costs of recruiting and training new nursing staff. It would not eliminate job turnover among nursing professionals; nurses would still leave their jobs for various other reasons. The strategy of increased flexibility would be especially feasible in large health care institutions or organizations that have large nursing staffs. Status changes are not necessarily permanent; one in five surveyed nurses in the current study reported two or more internal employment status changes over the course of their careers.

It is important to acknowledge the limitations of the current empirical study. Although age and family status indicators are clearly important determinants of employment status mobility, various other factors, including specific job-related problems and more personal circumstances, were not taken into account. Nor did this study address the implications of employment status mobility for such issues as quality of patient care or the degree of autonomy in the workplace. These are important issues which warrant investigation in future research.

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Footnotes

1 Detailed information was not collected for fourth or higher-order changes in employment status. However, of the total of 5,123 jobs reported by survey respondents, only 23 (.4%) involved four or more internal changes to employment status.

2 These data are based upon reported working hours and employment status at the time of starting a new employment position.

3 Nursing respondents were asked to provide up to three reasons for leaving each of their jobs held during their career.

4 The Pearson Chi Square statistics (and associated significance levels) are based upon three-way structural independence (that is, complete equi-probability or no relationships between any of the three variables included in the interaction).

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Supporting: Men's Experiences with the Event of their Partners' Miscarriage

Jennifer Miron and Jacqueline S. Chapman

L'objectif de cette étude était d'examiner le vécu des hommes lorsque leur partenaire fait une fausse couche. On a utilisé la méthodologie relative à la théorie à base empirique pour rassembler des données sur huit hommes. C'est grâce à des entrevues informelles et non-structurées qu'on a collecté ces données, desquelles émergent quatre phases séquentielles : (a) reconnaître le(s) signe(s), (b) confirmer la nouvelle, (c) la surmonter et (d) continuer à vivre sa vie. LE SOUTIEN est ressorti comme étant le processus social de base. Quatre concepts majeurs ressortirent à chacune des phases : (a) vivre les émotions, (b) attendre, (c) chercher de l'aide, et (d) accepter la situation. On examine les implications quant à la pratique et on présente des recommandations pour la recherche à venir.

The purpose of this study was to investigate men's experiences with the event of their partner's miscarriage. Grounded theory methodology was employed to gather data from eight men whose partners had experienced a total of 10 miscarriages. Data were collected through informal, unstructured interviews. Four sequential phases emerged from the data: (a) recognizing sign(s), (b)confirming the news, (c) working through it, and (d) getting on with life. Supporting was the basic social process that emerged, and four major concepts arose: (a) living the feelings, (b) waiting, (c) seeking help, and (d) accepting. The implications for practice are examined and recommendations for future research are presented.

Miscarriage remains the most common form of reproductive loss (Wall-Haas, 1985; Whittaker, Taylor & Lind, 1983). Decreased rates of fertility (Blenner, 1990) along with the fact that women are choosing to delay childbearing until they are older may influence the personal significance of both pregnancy and reproductive loss (Campbell, 1988). The developmental stages for a woman's attainment of the maternal role (Mercer, 1986; Rubin, 1967; Stainton, 1985) and the woman's psychological processes throughout a normal pregnancy (Ballou, 1978; Leifer, 1977; Rubin, 1984) have been well documented.

Most writings devoted to the event of miscarriage pertain only to women's experiences (Corney & Horton, 1974; Friedman & Cohen, 1982; Seibel & Graves, 1980; Swanson-Kaufmann, 1986; Wall-Haas, 1985). Swanson-Kaufmann's (1986) work, using grounded theory, has provided the most knowledge on women's perspectives of miscarriage. This author identified six phases associated with women's (N=20) experiences of miscarriage: coming to know, losing and gaining, going public, sharing the loss, getting through it, and trying again. However, these phases reflect women's specific feelings and concerns, and may not include men's perspectives.

Jennifer Miron, R.N., M.Sc., is a Clinical Nurse Specialist at The Hugh MacMillan Rehabilitation Centre in Toronto, Ontario. Jacqueline S. Chapman, M.S.N., Ph.D., is Professor in the Faculty of Nursing at the University of Toronto.

Limited research has looked at couples' experiences with miscarriage (Campbell, 1988; Harris, Sandelowski & Holditch-Davis, 1991; Leppert & Pahlka, 1984; Stinson, Lasker, Lohmann & Toedter, 1992). Stinson, Lasker, Lohmann and Toedter (1992) examined couples' (N=56) grief reactions after a pregnancy loss on a Perinatal Grief Scale. Women reported responses that were more intense than those of their male counterparts. The researchers concluded that men denied their grief and internalized feelings of loss. Campbell (1988) conducted interviews with 30 families and found that men were often protective and supportive of their partners at the time of miscarriage; the women in this study described men as being "strong." Campbell also reported that men suppressed their emotions in their efforts to offer support. Men's experiences may not be accurately reflected in these study findings as the men and women were not always interviewed independently. Moreover, in some instances concurrent professional counselling may have influenced the study findings.

The existing literature indicates that men attach at some time during pregnancy to the fetus (Cranley, 1981; May, 1982), and that they experience perinatal loss differently than do their female partners (Williams & Nikolaisen, 1982). The male version of Cranley's (1981) maternal attachment tool was administered to men (N=100) and found to have a Cronbach's alpha of .80. Cranley reported that these men, who were enrolled in childbirth education classes (times of fetuses' gestations unspecified), demonstrated attachment to their fetuses. In a grounded theory study of 20 couples May (1982) found that men's attachment to their fetuses – the focusing phase – coincided with women's noticeable physical changes at the start of the third trimester. Since the majority of miscarriages occur in the first and early second trimester when the fathers have not yet focused on the fetus, they may experience such losses differently than do their partners. In their retrospective survey Williams and Nikolaisen reported that mother's (N=37) experiences differed significantly from those of fathers (N=17): In response to the sudden death of their infants, they described more of the typical emotional responses found in the literature. However, the number of men who chose to respond to the survey was small. Earlier anecdotal reports (Smialek, 1978; Stitt, 1971) had suggested that mothers perceived fathers to be uncaring because they had a tendency to busy themselves with outside activities.

Men's individual experiences with miscarriage have not been studied. In addition, little research exists on men's experiences with the loss of either a fetus or infant (Hughes & Page-Lieberman, 1989). Health personnel can only provide optimal support and care to couples coping with a miscarriage when they are aware of what the experience means for both men and women.

Research Question

The following research question guided the study: What is the experience of men whose partners have had a miscarriage?

Method

A retrospective qualitative research approach was taken. Grounded theory (Glaser, 1978; Strauss, 1987) was the qualitative method used to generate explanatory theory about the event of miscarriage from men's perspectives.

Sample

All men included in the current study had partners who had experienced a miscarriage; were able to speak, understand, and read English; and consented to participate. One of the men approached chose not to participate. Five participants were found through an urban teaching hospital and three through snowball sampling (Wilson, 1985) when one subject's partner suggested other subjects. Theoretical sampling for saturation of the emerging categories was used after the second subject. The investigator aimed to do as heterogenous a sampling as possible by looking for variation in men's experiences of miscarriage.

Procedure

Permission to conduct the study was received from appropriate university and hospital ethical committees. Interviews were limited to 45 minutes to avoid subject and investigator fatigue. With the subjects' permission, all interviews were tape recorded. To open the first interview each subject was asked, "Could you tell me about your experience when _____ miscarried?" The unstructured nature of the interviews allowed the men to relate their experiences through their own stories.

Second interviews took place 5 days to 3 weeks after the initial interview. One subject declined a second interview for unknown reasons. The researchers reviewed all transcripts from the first interview, then clarified their impressions with the subjects and sometimes asked them to comment on other subjects' responses. Follow-up phone calls were made 1 to 2 weeks after the second interviews to provide the subjects with an opportunity for additional discussion. Data were collected between July and October 1991.

Data Collection, Analysis, and Interpretation

The investigators used the constant comparative method to develop a grounded theory of men's experiences with the event of miscarriage (Strauss, 1987, Strauss & Corbin, 1990). The data were simultaneously analyzed and coded line by line; data from the second interview were continuously compared to phases and categories that had emerged the first interview (Glaser,

1978). Throughout analyses a coding paradigm (Strauss, 1987) was used to identify recurring patterns from which key concepts and theoretical codes were ultimately derived. The latter helped the investigator to (a) conceptualize how the key concepts related to each other, and (b) integrate them into a theory relating to men's experiences with the event of miscarriage.

Credibility of the Generated Theory

Robinson and Thorne (1988) and Rosenbaum (1988) contend that qualitative research should include documentation of the rigour of the method and its credibility. Several authors (Cook & Campbell, 1979; Lincoln & Guba, 1985) consider truth value to be one required criterion. Truth value was enhanced in the current study by: (a) holding multiple private interviews with each subject, (b) sharing researchers' emerging interpretations with all subjects for verification, and (c) using a specific paradigm to identify recurring patterns and themes (Leininger, 1985). A second criterion of credibility was achieved in this study, where researchers are the instrument (Dobbert, 1982) by (a) limiting the length of interviews to avoid investigator fatigue, and (b) having two researchers independently code the data to check for consistency (Sandelowski, 1986).

A third criterion of credibility, potential for applicability (Lincoln & Guba, 1985), fittingness (Kirk & Miller, 1986), or transferability (LeCompte & Goetz, 1982) of the derived theory in other settings and samples was less well attained in this one setting study of employed men. However, the findings of the current study are derived from rich, detailed, "thick" (Lincoln & Guba, 1985) descriptions of the subjects' experiences.

Findings and Discussion

Description of Sample

Seven of the subjects' partners had had one miscarriage and one subject's partner had had three; therefore l0 experiences with miscarriage are considered in this report. One man and his partner had experienced a stillbirth after a miscarriage.

At the initial interviews the time elapsed since the miscarriage ranged from 2 months to 2 years. Gestation of the miscarried fetuses ranged from 4-16 weeks. Differences in the number of miscarriages, gestational age of the fetus at the time of miscarriage, and time post-miscarriage at the initial interview did not influence the pattern of concepts that arose from the data. All men were Caucasian, married or living common law with their partners, and held occupations ranging from executives to labourers. Two of the men had emigrated from Portugal and one from Ireland. All subjects' partners had undergone dilation and curettage (D&C) post-miscarriage.

The Substantive Theory: Supporting

The core category identified by the men in this study was supporting. As men did not physically experience the miscarriage, they described their primary role as one of supporting their female partners: "I had to be strong...be there for her." "She needed me...so I needed to keep it together for her." Support was manifested in both tangible ways (e.g., "...getting her the painkillers, helping her wash, [and] she was really tired afterward so I had to help her"), and non-tangible forms (e.g., "...just giving her some time...listening to her... letting her feel sad").

Men talked about supporting their partners throughout the miscarriage event, and four successive phases of supporting were identified: (a) recognizing signs, (b) confirming the news, (c) working through it, and (d) getting on with life. During each of the phases four concepts emerged from the data and indicated how these men went about supporting their partners: (a) living the feelings, (b) waiting, (c) seeking help, and (d) accepting.

The Phases

Recognizing Sign(s). In the first phase some men suspected problems with their partners' pregnancies because of biological warning signs. Seven men recognized a sign as a threat to their partner's pregnancies and lived feelings of worry: "But you know when someone starts bleeding the pregnancy is probably not normal." "She felt pains and I got scared...it's scary." Men described more worry if their partners experienced a lot of physical distress. One man did not describe living feelings of worry until his partner returned from abroad. Some men denied the biological sign in an effort to support and comfort their worried partners. "I told her it [the spotting] was probably nothing...'don't worry.' "

Men also sought support for their partners to deal with the sign(s) of miscarriage from such sources as reading materials, family members, friends or workmates. "We asked her mother – she had one (miscarriage) before – 'Is this O.K?'...'No!' " Men realized the significance of the signs to the outcome of the pregnancies ("We realized...that the bleeding was serious.") and became resigned. Once they had accepted the signs of the impending miscarriage, men began supporting their partners. "I knew what lay ahead...and I sat with her...holding her hand and saying ...'no matter what we'll be all right'. She was crying."

Men described how difficult it was for them to wait during this phase because the outcome of the warning signs was uncertain. "I mean...I didn't know what to expect...what it all meant...what was going to happen next." Men sometimes found themselves waiting to seek help for their partners from

professionals in emergency rooms or doctors' offices. They also sought professional assistance to validate or dispel their worries about the signs. Help was sought in either a rushed, panicky manner ("She was bleeding a lot ...my thoughts were... let's get to the hospital now.") or a deliberate manner ("For a week or so we had been suspecting a problem so we went to the doctor...cause she'd been spotting.").

Confirming the News. In the second phase men learned of their partners' miscarriage or impending miscarriage. Upon having the news confirmed they lived the feelings of worry concerning their partners' physical and emotional well-being and continued to support their partners. "When we found out, I just had to be strong...so that she doesn't have some kind of breakdown." Some described feelings of acceptance; they had grown to expect the miscarriage because of their partners' signs. "I knew it wasn't good...you know it isn't O.K. to be feeling like that. So when the doctor told us we already know ...and I held her when he told us." Other men felt surprised even though their partners had experienced signs. "It (the miscarriage) caught me off guard ...even after all the bleeding...But she needed me now more than ever."

Men waited anxiously for the news to be confirmed. "I was going crazy ...waiting." Supporting occurred as men waited with their partners in doctors' offices and hospitals. "I remember waiting in emergency...talking to her, trying to keep her calm." Other men waited apart from their partners. "She phoned me and told me she wasn't feeling well and she was gonna go to the doctor. I told her I can leave work and meet you there but she said 'No.' I said 'Are you sure?...I'd like to be there.' She said she would call me." Men found the volume of professionals they encountered while waiting overwhelming. "Go here, wait there, people from ultrasound, the emergency department, the doctor's office...Oh man! So many people (Sigh)." Men also found waiting difficult if they were left with little or no information about their partners' condition. "All these people and no one saying anything...It's just hard waiting". Once the news was confirmed men waited facing the unknown, while their partners underwent a D&C. "I was pretty concerned you know...I'd get home and get a call that something's gone wrong with the operation and I'd have nothing." Men lived the feeling of uncertainty as they waited to learn the cause and the implications of the miscarriage. "I didn't know why...what happened...what happens next...I didn't know."

Men sought help from professionals to confirm the news about the miscarriage or impending miscarriage and supported their partners. "In the back of my mind I already know the signs weren't good, but still tried to keep it up for her. Never know it wasn't for sure until the visit from the doctor...it was for sure." Men described being treated by professionals as either outsiders or insiders. Outsiders described feeling unable to support their partners. "They

didn't tell me anything...shoved me in a corner. It made me mad...I felt like a child. I didn't know how to help her." Insiders described feeling included by professionals during the event and had more positive experiences with their supporting efforts. " I felt...like it was important for me to be there with her and for her...and they (the professionals) made me feel like I mattered." One respondent, whose partner had had three miscarriages, consistently described insider experiences. "The people were very good...they laid out all the options it could be. I sat with her and we talked about it. We were sad but...that's life." Insiders, unlike outsiders, did not express feelings of helplessness around the seeking help experience.

After vacillating between hopefulness and hopelessness about the fate of the fetus, men accepted the event once the news was confirmed. They continued to support their partners. "The news was the worst and I knew how she felt, so I stayed with her and just listened." Once men realized the inevitability of the event they expressed feelings about the lost fetus. "It was too bad. I felt bad...I really wanted this kid and I hoped they could save it but there was nothing we could have done...[but] no time for me...she needed me."

Working Through It. The third phase was devoted to men negotiating with their feelings post-miscarriage. Men described living through immediate feelings like anger, sadness, loss, disappointment, and helplessness as they attempted to work through their experiences. The one man who was geographically separated from his partner at the time of her miscarriage expressed immediate feelings of being disconnected. "I didn't feel sad or...I mean I just wasn't connected." One subject expressed feeling relieved and explained that he had not felt ready to deal with a baby yet.

Men attempted to support their partners by sparing them from their own feelings. Instead, they sought help from such sources as friends, workmates, or family members. "If you were dragging a golf cart...sort of could talk about how I felt miserable...But it had to be worse for her. And if I talk to her about it then she's gonng to be more upset." This finding holds significant relevance for couple counselling since previous anecdotal reports (Smialek, 1978; Stitt, 1971) indicated that women whose partners busied themselves outside the home felt that the men did not care about the loss.

In an effort to support their partners some men held back their own immediate feelings because they worried that their partners' reactions would be intensified. This finding suggests men are aware that their partner's grief is more intense than their own, as Stinson et al.(1992) reported. It also corroborates a classic literature review by a social scientist (Veevers, 1973) which concluded that since motherhood is more important to women than fatherhood is to men, "the relationship between childlessness and psychological

maladjustment is expected to be more pronounced for wives than husbands" (p. 303).

All of the men worked through their feelings and then waited for their partners to do the same; they rationalized why it took their partners longer to process their feelings. "It wasn't as deep for me as it was for my wife...because for me it was something that was still off in never-never land." Although men understood the reasons why women took longer, they found supporting difficult if they were expected to continue indefinitely, and expressed some negative feelings if they had to wait too long. "You wonder if it should take so long. What is normal? Sometimes you just want to forget it...and get on with it." "After awhile enough is enough [motions with hands as though he is fed up]...Get on with life...but you know you got to be patient."

Men accepted the miscarriage and supported their partners in accepting the event by trying to find a reason for its occurrence. It was disarming for men if they were told by professionals that the miscarriage could be attributed to no specific cause. "I needed a reason to make sense of it...to help her put it in perspective." Men who were given a cause seemed more willing to accept the miscarriage. "He [the doctor] said that there was something wrong with the baby and that's why the miscarriage happened. We felt a little better... accepting the miscarriage". These findings are consistent with the results of an earlier study (Williams & Nikolaisen, 1982) which showed that men and women accepted the death of their child more readily when the death could be attributed to a diagnosis such as Sudden Infant Death Syndrome.

Other men accepted the miscarriage by realizing that they are common events; this awareness was often gained through their informal networks. "I mean it was learning [from others]: 'Yeh I had one'. It was pretty common, so we didn't feel so bad." Men were able to continue their supporting efforts through sharing such knowledge with their partners. "Now that I knew we weren't freaks – I mean it just happens – I could sort of help her to realize it. We hadn't done anything wrong and it wasn't her fault...because I think she thought that."

Getting on with Life. The final phase found men getting on with their lives after the miscarriage. All the men reported living the feeling of worry about future pregnancies. Those whose wives had conceived again described their worrisome experiences with joyless pregnancies throughout gestation or for short intervals. "The three-month period is sort of the magic date when everything is gone by. Prior to that there were periods of waiting for something to happen." Their naivety had changed to vigilance. "You're conscious [that] it can happen to me. Be on the lookout. It's an ongoing worry."

Seeking help was important for men and their partners when they contemplated having a subsequent pregnancy. Men supported their partners by finding answers to the couple's questions and concerns about miscarriage from professional and informal sources. Information from informal sources sometimes became overwhelming for men so that they turned to professionals for clarification of information. "Oh my God! How am I going to get through this? People telling us we may have two or three miscarriages...so it is back to the doctor. What are the probabilities?". Once they had accepted the miscarriage, men were ready to move on with their lives and were hopeful about the possibility of future pregnancies. "We're still trying to start a family and I'm optimistic. She seems late...maybe we struck gold again [laughs]. Everything's working out fine." "When she gets down I stay up. So we keep trying and I know we can do it. So she feels better."

Men identified their primary roles during the miscarriage experience as supporters to their partners. The concept of support has been studied in various populations. In a longitudinal study Mercer and Ferketich (1988) found that high-risk obstetrical women and their partners reported greater anxiety and depression than did low-risk pregnant women and their mates. Perceived greater support, in these same subjects, was a predictor of less anxiety. Repetti (1989) reported that spousal support moderated the association between air traffic controllers' (N=33) workload and marital behaviours (<.05). Repetti proposed that a spouse's (N=27) emotional support was a necessary condition in the process of recovery from overload. Norris, Stephens, and Kinney (1990) studied subjectively reported interactions with family members that facilitated or impeded the recovery of geriatric stroke patients (N=48). Problematic supportive interactions with the primary caregiver/spouse were described as unsupportive by patients. Negative supportive relationships were associated with slower recovery times for stroke patients.

Implications for Practice

The findings from this study identify a number of implications for health care workers. Men defined their primary role as being supporters to their partners. Couple-centred care during the initial event and couple-centred counselling after the event could help men to maintain this supportive role throughout the miscarriage experience.

After the miscarriage was confirmed, men initially experienced a flood of feelings. Feelings such as helplessness, anger, failure, disappointment, fear, sadness, and loss were intensified if men felt they were being shut out by the professionals from whom they sought help. Also, fear of their partners' mortality during the miscarriage process threatened men's supporting role.

Attending staff need to create a climate for dialogue that addresses men's worries concerning their partners' miscarriages. Some of men's imagined fears may be alleviated by allowing them to stay with their partners throughout the event if their partners so wish. Some of men's negative feelings may be alleviated by including them in all decision-making and information-sharing during and after the event.

As Campbell (1988) had found for women who miscarried, the men in the current study also realized how busy professional staff were, but still felt that they and their partners should have been better cared for. Spending additional time with couples may be difficult for busy professionals, but it is important that all interactions with them be considerate and compassionate. Men were also troubled by the large number of professionals they met throughout their experiences with miscarriage. The various health care providers might explain their respective roles to the couple.

Men identified that they needed follow-up and support and sometimes sought help to answer their questions long after the miscarriage. Follow-up phone calls in the working through it and getting on with life phases might be done by a designated professional to ensure consistency with the couples. Campbell (1988) also found that discussing probable causes and the chances of a repeat miscarriage are very important to couples, but rarely addressed by professionals. If follow-up care is provided by the same professional, consistent and comprehensive information can be provided.

It is important to assess each couple's informal resources; the current study revealed that such resources were not always helpful. In such cases, the professional might enable couples to access appropriate community resources such as support groups or bereavement counselling.

Recommendations for Future Research

Future research could investigate a more diverse group of men than did the current study. A multicentred approach to data collection could better test the credibility of the present theory, and increased size and diversity of the sample would allow the assessment of applicability across settings. In addition, an examination of men's experiences with other kinds of pregnancy loss such as genetic termination might prove useful in determining the transferability of the theory of supporting.

Few studies have examined differences in how men and women experience miscarriage. A retrospective quantitative/qualitative study combining questionnaires with unstructured interviews might help professionals to gain insight into the couples' experiences with miscarriage. Enough information

has been derived from the existing data for the development of an initial questionnaire for men. Further research is needed to define the conditions under which a woman finds her partner to be supportive. This would be very important in both decreasing her anxiety (Mercer & Ferketich, 1988) and shortening her recovery process (Norris, Stephens & Kinney, 1990).

Conclusion

Miscarriage remains the most common form of reproductive loss. In the current study men described themselves first and foremost as supporters to their female partners. Health care professionals would benefit from an understanding of the meaning of miscarriage for men in order to facilitate their supportive roles.

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A Reactionist Professional Association: The Provisional Council of University Schools and Departments of Nursing, 1942-1948

Sharon Richardson

Depuis ses débuts en 1942, l'Association canadienne des écoles universitaires de nursing (ACEUN) s'est fait le porte-parole national de ses trente écoles-membres et l'organisme accrédité pour les programmes universitaires en sciences infirmières. L'objectif de cette recherche était d'analyser la création en 1942 du *Provisional Council of University Schools and Departments of Nursing*, précurseur de l'ACEUN.

La recherche se veut historique. Des données primaires et secondaires ont été collectées et analysées par méthode inductive. Les données primaires consistaient en documents d'archives se trouvant à l'université Queen à Kingston en Ontario et à l'association des infirmières et infirmiers du Canada (AIIC) à Ottawa en Ontario. Les données secondaires ont affiné et corroboré l'analyse des données primaires; elles incluaient les histoires publiées de l'ACEUN et de l'AIIC ainsi que des livres et des articles sur le développement de la formation universitaire en sciences infirmières au Canada.

L'élan des débuts en 1942 du *Provisional Council* prit sa source dans l'AIIC. Le Provisional Council n'atteint aucun des objectifs qu'il s'était fixés. Au lieu de cela, il mit l'accent sur sa relation avec l'AIIC et débattit de la nécessité de continuer à exister. Le *Provisional Council* était une association réactionnaire qui reflétait l'absence de coordination de la formation universitaire en sciences infirmières et l'incapacité des professeurs en sciences infirmières à mettre de côté leurs querelles de clocher.

From its inception in 1942, the Canadian Association of University Schools of Nursing (CAUSN) has developed into the accrediting agency for university nursing programs and the national voice for its 30 member schools. The current research examines the creation in 1942 of the Provisional Council of University Schools and Departments of Nursing, the forerunner of the CAUSN. The research is historical in design. Primary and secondary data were collected and analyzed inductively. Primary data consisted of archival documents located in the Queen's University Archives, Kingston, Ontario and the Canadian Nurses Association (CNA) Archives, Ottawa, Ontario. Secondary data augmented and corroborated analysis of primary data and included published histories of the CAUSN and the CNA, as well as books and articles about the development of university nursing education in Canada.

The impetus for the inception in 1942 of the Provisional Council of University Schools and Departments of Nursing originated with the CNA. The Provisional Council subsequently achieved none of its stated goals. Instead, it focused on its relationship with the CNA and contested the need for its own existance. The Provisional Council was a reactionist association that reflected the uncoordinated nature of university nursing education and the inability of university nursing educators to set aside parochial differences.

The professionalization of nursing in Canada was inexorably linked to the development of university nursing education and national nursing associations. One such association is the Canadian Association of University Schools

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Sharon Richardson, R.N., Ph.D., is Associate Professor in the Faculty of Nursing at the University of Alberta in Edmonton, Alberta.

of Nursing (CAUSN) which currently represents 30 of the 33 university schools. Established in 1942 to support the development of standards for university nursing education, the CAUSN evolved slowly during the subsequent half-century. A singular achievement was its national voluntary program of accreditation, implemented in 1987.

The establishment of the Provisional Council of University Schools and Departments of Nursing in 1942 and its existence as an association of university nurse educators distinct from the Canadian Nurses Association (CNA), had considerable impact on the subsequent development of the organization known today as the Canadian Association of University Schools of Nursing. The Provisional Council was a reactionist professional association significantly influenced by the nature of university nursing education prior to the Second World War.

University Nursing Education Before 1940

University nursing education was slow to take root in Canada and slower still to grow and expand. As a female-dominated occupation, nursing was plagued by the constraints imposed on all women seeking higher education in Canada. Nursing was further penalized by having adopted what Davis termed "the Nightingale compromise", whereby student nurses staffed the hospitals and provided patient care[1]. This apprenticeship form of education reinforced societal perceptions that nurse training served primarily to refine the inherent ability to care, which all women possessed[2]. As an academic discipline, nursing was viewed with skepticism and suspicion in universities staffed almost entirely by men. Universities were reluctant to admit nursing, and demonstrated their reticence by failing to provide the financial support necessary for educationally sound programs. The terms under which the first Canadian university department of nursing was established in 1919 at the University of British Columbia was a classic illustration of the current attitude. The Board of Governors of the university approved a department of nursing solely on the understanding that no expense would be accrued by the university[3]. The Director of the University's Department of Nursing was also to be the Director of the Vancouver General Hospital, and the latter agreed to pay her full salary. Thus, the costs of opening the first department of nursing in a Canadian university were borne entirely by a hospital.

The curriculum model of this first degree program reflected prevailing American models of the time[4], and was decidedly cost-containing. Students took one year of university arts and science courses, followed by three years as a trainee of the Vancouver General Hospital and a concluding year of university nursing courses. During the first and fifth years, students paid regular university tuition, and for the three years at the hospital, they paid for their

training in service to the hospital. This prototype for university nursing degree programs became known in Canada as the non-integrated model. Although politically expedient and inexpensive for universities to implement, it failed to promote integration of nursing content throughout its five years and precluded university control of the nursing content provided by the hospital.

Three other non-integrated five-year degree programs in nursing began at the University of Western Ontario, the University of Alberta, and the Institut Marguerite d'Youville (University of Montreal) in 1924, 1925, and 1926, respectively. There were no additional degree programs until shortly before the Second World War. In 1938, both the University of Saskatchewan and the University of Ottawa initiated degree programs, and in 1939 St. Francis Xavier University in Nova Scotia admitted its first degree students[5]. These programs were small, with limited student enrollments and few nurse teaching staff.

Far more common and much more in demand than the degree programs were the certificate courses offered by university departments of nursing to graduates of hospital diploma programs. The first of these certificate courses was financed by the Canadian Red Cross in the early 1920s and was for post-graduate instruction in public health[6]. It cost the universities very little; the Red Cross provided funds directly to the universities of Toronto, McGill, British Columbia, Alberta, and Dalhousie to pay for these courses and financed students who wanted to attend[7]. Certificate courses proliferated much more than did degree programs, and came to include supervision and teaching, as well as public health. They had the additional advantage of being suitable for offering during the fifth year of the non-integrated degree programs.

The Depression seriously impeded the growth of university nursing education throughout Canada and almost led to the demise of programming at McGill University, a private institution which received minuscule funds from the Quebec government. In 1932, the McGill School of Nursing faced closure unless it could raise an endowment of $40,000[8]. Miraculously, nursing alumnae and other supporters across the country donated about $20,000 which, when coupled with extreme internal cost cutting, enabled the School to survive. However, these stringent economies meant that fewer courses were taught, a planned two-year diploma program was replaced by a one-year certificate program, and plans for a degree program were cancelled.[9]

Precarious funding seriously limited expansion and innovation in university nursing education. Nevertheless, the University of Toronto School of Nursing was able to introduce a unique 39-month program in 1933, funded by the Rockefeller Foundation. This program was innovative in two ways: the faculty of the school assumed total responsibility for the education of students, and the school became an autonomous unit within the University able

to participate fully in University governance[10]. Unlike the situation in the United States, where private philanthropy stimulated the growth of collegiate education in nursing[11], Canadian departments of nursing relied on public funding channelled through university processes upon which they had little influence.[12]

Prior to the Second World War, university nurse educators were few and geographically isolated from one another. Frequently, there were only two or three full-time faculty in each nursing department. At the University of Saskatchewan in 1940, the only nurse faculty member was the director of the degree program[13]. Most of these individuals held a baccalaureate degree as their highest earned credential, although some also possessed specialty diplomas or certificates in public health, supervision, and teaching. Few engaged in research, which is not surprising given their extensive course planning and teaching workloads.

Communication between university departments of nursing and between individual nurse educators in the geographically dispersed universities was tedious at best, especially in the four western provinces. Most communication was by letter. Travel, which was primarily by train, was time consuming and relatively expensive, thereby limiting face-to-face interaction. The trip from Vancouver to Montreal required four or five days. As Kirkwood and Bouchard confirmed:

> University schools of nursing tended to develop in isolation, each faculty dealing with its own issues and problems on an individual basis. ...These factors hindered them from developing an understanding of each other's unique situation and a shared vision of university nursing education.[14]

Conception of the Provisional Council

The impetus for the creation in 1942 of the Provisional Council of University Schools and Departments of Nursing, the forerunner of the CAUSN, originated with the CNA. Selected representatives from both university schools of nursing and provincial professional associations were invited to meet with the Executive Committee of the CNA in the fall of 1941 to discuss problems in nursing service and education – problems which had been intensified by the Second World War.[15] It seems unlikely that the CNA envisaged establishment of a separate association at that time.

This meeting was triggered by a written query in July 1941 from the Manitoba Association of Registered Nurses (MARN) to the CNA regarding "a Vassar plan or something similar [to] guarantee us a temporary increase in numbers [of practising nurses] in the form of women well qualified to assume

professional responsibility and leadership."[16] The MARN also asked that the opinions be solicited of nurse educators Lindeburgh, Russell, Ellis, and Gray of the Universities of McGill, Toronto, Saskatchewan, and British Columbia, respectively, on the "advisability or practicability of such a plan."[17] The CNA president, Grace Fairley, complied.

All four nurse educators responded in writing, but their responses were equivocal. After an initially enthusiastic letter in which she asked that a meeting of the CNA Executive be arranged with representatives from university schools of nursing to "make some long wished for progress in connection with our nursing schools,"[18] Kathleen Russell adopted a neutral stance. Marion Lindeburgh observed that the existing shortage of qualified nursing teachers and supervisors, as well as the low salaries and lack of professional recognition accorded general duty nurses, were ongoing problems that contributed to low enrollments in the university schools.[19] She recommended further study and analysis before undertaking "whatever plan might seem sound," without overtly endorsing the proposed meeting.[20] Mabel Gray cautioned that the "whole situation is very involved...I do not think that hasty action should be taken."[21] She recommended instead that the CNA establish liberal scholarships to assist exemplary senior students, thus ensuring their retention and graduation. Kathleen Ellis thought that "such a meeting might be of more value after further investigations had been made regarding the several plans mentioned and the likelihood of a grant being obtained from the Federal Government."[22] She counselled delay.[23]

Nonetheless, Grace Fairley convened a special CNA Executive Committee meeting 15 August 1941 in Vancouver, where it was agreed that a study was urgently needed to meet the shortage of nurses and develop leaders.[24] A subsequent meeting with representatives from the provincial associations and university schools of nursing was planned "for the purpose of discussing fully the present or future shortage of nurses."[25] To facilitate attendance, the CNA paid expenses of university nurse representatives; however, provincial nursing associations paid expenses of their delegates.[26]

The time allowed for organizing and scheduling the meeting was inadequate, resulting in confusion as to its purpose and overt antagonism from some participants. Letters confirming dates, location, and format were not sent until one week before the meeting.[27] The decision to convene in Montreal rather than Winnipeg was unexpected and resulted in overt expressions of dismay from the University of British Columbia[28], the Alberta Association of Registered Nurses (AARN),[29] the University of Alberta,[30] and the Saskatchewan Registered Nurses Association.[31] The AARN President Rae Chittick asserted that "Our impression here is that the arrangements were too hurried

and not well considered from the standpoint of the provinces, and that the emergency is not serious enough to warrant this haste."[32] Chittick also objected strongly to the CNA's choice of the University of Alberta's representative.[33]

On 29 September 1941 representatives of seven university schools of nursing – Toronto, Western Ontario, Ottawa, Montreal, McGill, Laval, and Saskatchewan – met with the President, the treasurer, and the executive secretary of the CNA; the editor of *The Canadian Nurse* journal; and a "guest" of unspecified affiliation. Grace Fairley chaired the meeting and represented the University of British Columbia. The absence of representatives from the University of Alberta and St. Francis Xavier University was noted with regret.[34] Guided discussion of problems affecting hospital schools, public health, and general duty nursing led to recommendations that the numbers and quality of students enrolling in university programs be increased. The issue of the university nurse educators organizing as a separate group within the CNA also surfaced.

The university educators met separately the next morning, 30 September, to prepare recommendations regarding undergraduate education, postgraduate courses, in-service education, recall of nurses to active duty, and publicity for the CNA Executive.[35] Kathleen Russell, Director of the University of Toronto School of Nursing, acted as chairperson. On 1 October 1941 she presented a reworked version of these recommendations, including detailed plans for their implementation, to the reconvened group of CNA Executive and university educators.[36] She prefaced her presentation by emphasizing "the urgency of the moment and the pressing need for immediate action."[37] With the exception of the proposal that schools of nursing admit only one class per year, all recommendations were approved.

Two additional resolutions were subsequently passed by the CNA Executive, clearly indicating that they felt a mandate toward promoting standards of university nursing education. Firstly, they appointed a committee comprised of the CNA president, two vice-presidents, and Kathleen Russell to select a nurse who would take charge of implementing recommendations from the joint meeting of CNA Executive and university nurse educators.[38] This led in 1941 to the appointment of Kathleen Ellis as Emergency Nursing Advisor to the CNA.[39] Secondly, they appointed a committee, comprised of the CNA president and vice-presidents, to approach the federal government for funds to carry out the recommendations of the university nurse educators.[40] This committee was successful; the federal government provided $115,000 in 1942 and $250,000 in each of 1943 and 1944 for nursing education through the CNA.[41] Throughout the three days of meetings, the CNA had maintained control and directed the deliberations of the university nurse educators, largely through the chairmanship of Kathleen Russell. All recommendations

emanating from these meetings in 1941 were later endorsed at separate meetings of the CNA Executive Committee.[42]

Although the university nurse educators who were present debated organizing under the auspices of the CNA or establishing independently, they made no decision at the time. The CNA Executive clearly favoured formation of a committee of university educators within CNA and even passed a motion that this be done;[43] however, because several university representatives were gone before this resolution was passed, plans for organizing them within the CNA were postponed to the June 1942 CNA General Meeting.[44] When directors of university schools were invited to discuss formal organization of university nurse educators at the time of the June CNA Annual Meeting,[45] eight of nine directors accepted.[46] Kathleen Russell somewhat reluctantly agreed to chair this meeting held on 20 June 1942 in Montreal; the agenda included organization of the group and deciding its relationship to the CNA.[47]

Birth of the Provisional Council

In 1942, it quickly became evident that opinion diverged about both the need for a formal association of university nurse educators and the advisability of accepting CNA sponsorship.[48] Agreement could not be reached and a committee consisting of Kathleen Russell, Sister Godefroy, and Kathleen Ellis was appointed to develop policy, functions, and bylaws for the proposed organization. These would be considered at a second meeting, to be held three days later.[49]

On 23 June 1942 the university representatives formally declined to organize under the auspices of the CNA, and chose instead to create the autonomous Provisional Council of University Schools and Departments of Nursing (PCUSDN).[50] The wording of the motion made by Marion Lindeburgh and seconded by Kathleen Ellis emphasized the temporary nature of the Provisional Council: "For the next two year period, in order to give further time for wise decision as to the form that the *permanent* organization shall take" [emphasis added].[51]

Arguably, their motion was a way of circumventing overt antagonism toward the CNA without discouraging university educators who were interested in forming an independent association. Supporters of the CNA hoped that the Provisional Council would not be seen as a permanently autonomous association. The CNA report on the formation of the Council in the October and November 1942 issues of their official journal, *The Canadian Nurse*, reinforced the perception of its temporary nature and CNA control.[52]

It can only be speculated why the university nurse educators declined sponsorship by the CNA. The minutes of the 23 June 1942 meeting present

only the motions that were carried. It is impossible to discern who was in favour of and who was opposed to CNA sponsorship, or the substance of the debate. However, reaction to Kathleen Russell's role may have been a contributing factor. Russell had been a key player in attempts to maintain the group of university nurse educators under the auspices of the CNA. She believed that there were too few leaders and resources in Canada to support two national nursing organizations. Her perspective was reflected in the following correspondence with Council President Evelyn Mallory:

> I think you know that I regret the decision to retain this Council as an independent body, but I have decided for the present that I should maintain membership. My thought is that it will be utterly impossible to separate these matters of university schools from the work of the Education Policy Committee of the CNA.[53]

Later, she also wrote:

> We [nurse educators, University of Toronto] feel very strongly that the work being done by this organization belongs to the CNA and that there can only be adequate resources if the work is consolidated with all of the educational work of the CNA. It seems to me that, in attempting to separate this Council from the Education Committee of the CNA we have an exact parallel to the confusion that now obtains between the Education Committee of the ICN and the FNIF branch of the ICN. I fear that the present Council will remain an exceedingly weak group until it has all the power and resources of the CNA behind it. And certainly it is not possible for the Education Committee of the CNA to disallow responsibility for nursing education at the University level.[54]

Russell was especially active in the CNA during the latter part of her career and significantly influenced CNA policies and activities in the 1940s as chairperson and later member of the CNA Committee on Nursing Education. She held strong views on most subjects, but especially on nursing. In discussing the impact of Russell's leadership, her biographer, Helen Carpenter, observed:

> Miss Russell received a mixed response. The objectives she held for nursing education were supported by some and opposed by others. The determination with which she pursued her goals was both respected and criticized. Miss Russell was often frustrated and impatient with those who clung to values of the past, and her frustration and impatience were apparent in her voice, manner, and facial expression at meetings, and also in her writing.[55]

Carpenter added that "Some who were associated with Miss Russell in the pursuit of her goals found her determination, drive, and unwillingness to

compromise difficult."[56] Some who might have had difficulty were other university nurse educators.

Having failed in the attempt to create a committee of university nurse educators within the CNA, members of the CNA Executive Committee and the Committee on Education sought to ensure a close working relationship between the two organizations. In order to accomplish this, they agreed that the President of the Provisional Council should be a member of the CNA Committee on Nursing Education, and the Convenor (chairperson) of the Committee on Nursing Education should be a member of the Provisional Council.[57]

The Council of University Schools and Departments of Nursing

At its founding meeting on 23 June 1942, it was agreed that the goals or objectives of the fledgling PCUSDN would be to: determine standards for university schools of nursing, strengthen the standards of existing schools, support the development of future schools, and strengthen the relationship between university schools in Canada and other countries.[58] Membership in the PCUSDN was open to directors and individual faculty of university schools who were nurses and paid an annual membership fee of two dollars. An executive committee was identified, and comprised of the president, vice president, and secretary/treasurer plus the chairpersons of the two standing committees on policies and studies. One general meeting of the PCUSDN was to be held annually, and additional meetings at the discretion of the president. Elected to office for an initial two-year period were: President Kathleen Ellis, CNA Emergency Nursing Advisor on leave from the University of Saskatchewan; Vice-president Reverend Mother Allaire, Institut Marguerite d'Youville, Montreal; and Secretary/Treasurer Mary Mathewson, McGill University, Montreal. These officers were empowered to name the chairpersons of the two standing committees; however, this was not accomplished at the inaugural meeting. The first business of the newly constituted Council was to agree to "send a resolution to the Canadian Nurses Association asking that a Clearing House for Studies be set up by the Canadian Nurses Association."[59] In the lexicon of the day, "studies" meant research. Not only did the structure of the PCUSDN reflect that of the CNA, but in asking the CNA to set up a repository for nursing research, they were requesting them to assume a role that the PCUSDN appropriately might have undertaken.

As the fledgling Provincial Council fluttered through the next six years, it was focused inwardly; issues of relationship with the CNA, goals, and even the need for their continued existence as an autonomous association, dominated each general meeting. There is no indication in the meeting minutes that they discussed the contribution that university schools of nursing might make to the war effort or how they might take advantage of postwar opportunities.[60]

In 1943, a survey found that seven Council members were in favour of maintaining the PCUSDN as an autonomous association, seven favoured organizing as a standing committee of the CNA, and the remaining six wanted to become a subcommittee of the CNAs standing Committee on Nursing Education.[61] At the 26 June 1944 general meeting, the 12 Council members present agreed that *"In view of the fact that sufficient progress has not yet been made to justify a final decision as to the permanent form which the Council should take,* [emphasis added] ...the organization should be continued as a Provisional Council for the next two year period."[62] Neither Council President Ellis nor Secretary/Treasurer Mathewson were present at this meeting; it was chaired by Vice-President Reverend Mother Allaire of Institut Marguerite d'Youville. On 29 March 1946, the available Council members decided to hold a 1 July 1946 general meeting. Ellis (University of Saskatchewan), Russell (University of Toronto), Fidler (University of Toronto), Lindeburgh (McGill University), Sister Lefebvre (Institute Marguerite d'Youville), Sister Lacroix (Institut Marguerite d'Youville), and Mathewson (McGill University) requested members to come prepared with definite opinions about whether the Council should become a special committee of the CNA, a sub-committee of the CNA Education Committee or remain an independent organization.[63]

In a letter to Kathleen Russell, Council Vice-President Reverend Mother Allaire conveyed her regret at being unable to attend the meeting, but asserted her belief that it was preferable to maintain an independent organization of university nurse educators:

> Our schools would have a stronger tendency to raise their standards if our Council is under the guidance of a strong educational body such as universities, while if it is under the CNA...our schools will lack this guidance which I should like them to have in favour of the profession.[64]

Sister Denise Lefebvre of the Institut Marguerite d'Youville conveyed the same opinion to Council President Kathleen Ellis, appending a copy of Sister Allaire's letter to Russell.[65] This was the first recorded instance of the French Catholic sisters' antipathy to CNA control, and it may have been a significant factor in the continued existence of the Provisional Council.

There was considerable discussion at the July 1946 general meeting about the goals of the Council, whether or not the time was ripe for an association of university schools, and the form such an association should take.[66] Several members spoke of the need for a medium through which those teaching in university schools could discuss common problems and urged that some form of organization should be continued, if for that purpose alone. Subsequently, a motion was passed to continue the Provisional Council "under the present plan...for another two year period, and that an effort be made to find

out how the organization may be most useful and what form it should take."[67] In addition, it was agreed that the goal for the next two-year period was "to discover common problems of the University Schools of Nursing in Canada."[68] Once again, the existence of the Council as an organization of university nurse educators separate from the CNA had been affirmed despite a lack of concrete accomplishments in the four years since its inception.

The future of the Provisional Council came to a crisis point at the June/July 1948 general meeting in Sackville, New Brunswick. The relationship of the Council to the CNA was again discussed and the following resolution was debated:

> That WHEREAS there is a felt need for a sub-Committee of the Educational Policy Committee which is prepared to speak with authority for University Schools and Departments of Nursing, therefore, be it resolved that the Executive Committee of the Canadian Nurses' Association approve establishment of such a Sub-Committee.[69]

In response, a motion made by Sister Denise Lefebvre of the Institut Marguerite d'Youville, and seconded by Evelyn Mallory of the University of British Columbia, confirmed the Council's autonomy: "That the Provisional Council of University Schools and Departments of Nursing remain for the present an independent organization and that every effort be made to work closely with the Education Policy Committee [of the CNA]."[70] A second motion sponsored by the same two members that the word "provisional" be deleted from the name of the organization was also passed.[71]

The success of these motions may reflect voting by a number of non-university Catholic sisters purportedly acting as spokespersons for absent Council members. The attendance record of the June/July 1948 Council meeting indicates that the universities of British Columbia, Alberta, Saskatchewan, Toronto, Ottawa, Montreal, McGill, Queen's, and Laval, and the CNA Education Policy Committee were represented, but does not identify the individuals present. Secretary/Treasurer Helen Penhale defended her reluctance to identify individuals in the record, thus:

> For this time I would rather not include the names of the people who attended because there were so many sisters there who said they were representing members of the Council. As an example, Sister Keegan from Edmonton General Hospital was there. She is in no way connected with a university. How can she speak for another person?[72]

Resolution of the issue of who comprised the membership of the Council and therefore were eligible to vote was deferred by a motion by Sister Lefebvre, seconded by Evelyn Mallory "That a decision...be tabled pending the

report of the study on Faculty being prepared by McGill University and the reply to enquiry regarding the requirements for membership in the National Conference of Canadian Universities."[73] Maintaining the Council as an entity separate from the CNA subsequently proved meaningless because from 1949 to 1953, the Council was relatively inactive.[74] There were no general membership meetings during the two-year period of 1 July 1950 to 30 May 1952,[75] and membership declined from 29 in 1948 to 16 in 1952.[76] Not until 1957 did the Council finally achieve one of its stated goals when the document *Desirable Standards For Canadian University Schools of Nursing* was approved.[77]

Conclusions

The Provisional Council of University Schools and Departments of Nursing was a reactionist association that reflected the uncoordinated nature of university nursing education and the inability of nurse academics to put aside parochial differences and act in concert to influence public policy. The turmoil and demands of the Second World War intensified pressure on university nursing programs and their academic staff. Some university schools were hard pressed to maintain educational programming as nurse academics answered the call to military service.[78] Others struggled to become established. New degree programs in nursing began at Queen's University and McMaster University in 1941, the University of Manitoba in 1943, Mount St. Vincent University in 1947, and Dalhousie University in 1949.[79] Existing programming at the University of Toronto and McGill University was expanded.[80] A significant redirection of university nursing education began in 1942 with the University of Toronto's innovative integrated degree program.[81]

Expansion in university nursing education during and immediately after the Second World War was stimulated by federal funds distributed through the CNA and by scholarships, bursaries, and loans to students offered by the W.K. Kellogg Foundation, the Victorian Order of Nurses, and the Canadian Red Cross.[82] For example, in 1943, university schools of nursing received $30,000 in direct funds and $40,000 in bursaries from the federal government.[83] The W.K. Kellogg Foundation also offered fellowships to Canadian nurses to obtain master's degrees in nursing in the United States. During and immediately following the Second World War, many Canadian nurse academics took this opportunity to upgrade their qualifications.[84] Their absence intensified the shortage of university teachers occasioned by university program expansion. Some also chose to remain in the United States, further limiting the available pool of qualified nurse academics.[85]

Perhaps Kathleen Russell was right after all: There simply weren't enough resources available in Canada to support both the work of the Education Committee of the CNA and a separate association of university nurse educators.

Several prominent university nurse educators contributed significantly to the work of the CNA while participating minimally, or not at all, in the Provisional Council and its successor, the Conference of University Schools of Nursing. Among these were Marion Lindeburgh and Rae Chittick of McGill University, Kathleen Russell and Helen Carpenter of the University of Toronto, and Katherine MacLaggan of the University of New Brunswick. Others, including Kathleen Ellis, University of Saskatchewan; Mary Mathewson, McGill University; Evelyn Mallory, University of British Columbia; and Electa MacLennan, Dalhousie University; managed to participate in and contribute to both organizations, although rarely simultaneously.[86] It is intriguing to contemplate the impact these resourceful academics might have had on the development of Canadian university nursing education if they had concentrated their considerable talents under the auspices of a single professional association and acted more in concert with one another.

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10. Helen Carpenter, *A Divine Discontent Edith Kathleen Russell: Reforming Educator* (Toronto: University of Toronto Press, 1982), 17-26.

11. See Susan Reverby, *Ordered to Care*,159-179 and Celia Davis, "A Constant Casualty: Nurse Education in Britain and the USA to 1939", 102-122.

12. The detailed discussion of the financing of the University of Toronto's School of Nursing presented by Helen Carpenter, *A Divine Discontent,* 18-32, gives evidence of these financial constraints. See also Janet Kerr, *Financing University Nursing Education in Canada, 1919-1976* (Ph.D. diss., University of Michigan, 1979).

13. Lucy Willis, *Fifty Years: Just the Beginning* (Saskatoon: University of Saskatchewan, 1988), 4-5.

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16. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from Gertrude M. Hall to Grace M. Fairley, 7 July 1941.

17. Ibid.

18. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from E. Kathleen Russell to Grace M. Fairley, 22 July 1941.

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21. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from Mabel Gray to Grace Fairley, 15 August 1941.

22. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from K.W.Ellis to Grace Fairley, 3 September 1941.

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27. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from Jean S. Wilson to Grace Fairley, 15 September 1941 and from Jean S. Wilson to Directors of University Schools of Nursing, 22 September 1941.

28. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from Margaret Duffield to Jean Wilson, 25 September 1941.

29. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from A.E. Vango to Jean Wilson, 25 September 1941 and from Rae Chittick to Grace Fairley, 27 September 1941.

30. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from John James Ower to Jean Wilson, 27 September 1941.

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32. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from Rae Chittick to Jean Wilson, 25 September 1941.

33. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from Rae Chittick to Grace Fairley, 27 September 1941.

34. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, "Report of a Joint Conference of Representatives of University Schools of Nursing and of the Executive Committee, Canadian Nurses Association, September 29-October 1, 1941."

35. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, "Report of the University Representatives Prepared For Presentation to the Executive Committee of the Canadian Nurses Association in Meeting, September 30th, 1941."

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37. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, "Report of a Joint Conference of Representatives of University Schools of Nursing and of the Executive Committee, Canadian Nurses Association, September 29-October 1, 1941," p. 6.

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46. Ottawa, CNAA, CCUSDN Collection, ARC WY18.C453, letter from Jean Wilson to Marion Lindeburgh, 1 June 1942.

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79. Janet Kerr, "A Historical Approach," 257.

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82. Ibid., 256-257. For a comprehensive discussion of Canadian university nursing education funding, see also Janet Kerr, *Financing University Nursing Education In Canada, 1919-1976* (Ph.D. diss., University of Michigan, 1979).

83. Kirkwood and Bouchard, *Take Counsel With One Another,* 12.

84. Janet Kerr, "An Historical Approach," 256.

85. Kirkwood and Bouchard, *Take Counsel With One Another,* 14.

86. This interpretation is derived from review of elected and appointed positions held by these university nurse educators in the CNA, the Provisional Council and its successor, the Canadian Conference of University Schools of Nursing(CCUSN), from 1942 to 1967. Lindeburgh, Chittick, Carpenter, MacLennan and MacLaggan were Presidents of the CNA. Kathleen Ellis was President of the Provisional Council from 1942 to 1948 and Emergency Nursing Advisor for the CNA during the Second World War. Mary Mathewson was Secretary/Treasurer of the Provisional Council from 1942 to 1946 and chairperson of the CNA History Committee. Evelyn Mallory was President of the Provisional Council from 1948 to 1952 and a member of the CNA Education Committee. Electa MacLennan was President of the CCUSN from 1954 to 1956 and President of the CNA from 1962 to 1964.

Happenings

Institute for Philosophical Nursing Research

June Kikuchi

The nursing profession, today, is faced with far-reaching practical problems – problems such as the lack of clarity of practice boundaries among the health professions, inappropriate use of nursing manpower in the health care system, and inadequate recognition of the extent of its contribution to the health of society. These problems have not yielded to scientific and pragmatic attempts to solve them. Their solution (and that of similar problems) rests, in large part, in the attainment of philosophical nursing knowledge that underlies the sound advancement of the practice of nursing. For the purpose of identifying the aim, scope, and nature of nursing practice, the University of Alberta Faculty of Nursing established the Institute for Philosophical Nursing Research in 1988. It was established on the assumption that research infrastructures of this kind are indispensable in any sustained effort to advance thought in a particular area of inquiry.

Aim

The aim of the Institute is to provide leadership in the pursuit of philosophical nursing knowledge which underlies the advancement of the practice of nursing – the philosophical nursing knowledge required to guide and unite nurse practitioners, educators, administrators, and researchers in the development and use of nursing knowledge for the benefit of those who receive and depend on nursing care.

Objectives

The objectives of the Institute are six-fold:

- to undertake sustained study of philosophical nursing questions
- to promote the development of philosophical nursing knowledge
- to provide opportunities for nurse scholars to participate in philosophical nursing research
- to promote dialogue in philosophical nursing matters

Dr. June Kikuchi is Professor in the Faculty of Nursing at the University of Alberta and co-founder and Director of the Institute for Philosophical Nursing Research.

- to collaborate with other disciplines on philosophical nursing questions of an interdisciplinary nature
- to disseminate the results of philosophical nursing research/scholarly endeavours

Activities

The Institute has engaged in several major undertakings which have brought it wide recognition and acclaim:

- development and organization of three invitational philosophical biennial nursing research conferences (a fourth conference is to be held in May 1995)
- publication of two books entitled Philosophic Inquiry in Nursing and Developing a Philosophy of Nursing containing papers presented at the Institute's conferences
- submission of research/conference/operating grant proposals
- presentation of philosophical nursing research/scholarly papers at local, national, and international conferences
- establishment of an annual open philosophical nursing lecture series
- initiation of an informal postdoctoral philosophical nursing study program.

Administration

The Institute is being developed as a non-profit research unit within the Faculty of Nursing, under the direction of its co-founders: Dr. June Kikuchi (Professor, Faculty of Nursing) and Dr. Helen Simmons (Associate Professor, Faculty of Nursing; and formerly Special Projects Consultant, Nursing Division, Edmonton Board of Health) who serve as its Director and Associate Director, respectively. It is dependent on grants and donations for its operation. Its development and operation to date have been made possible through the generosity of the University of Alberta Master of Nursing Trust Fund, the Winspear Foundation, the Alberta Foundation for Nursing Research, the University of Alberta Conference Fund, and individual citizen donations.

Future Direction

To spearhead innovative developments in what is essentially virgin territory, infrastructures such as the Institute are necessary. However, sustained adequate funding is also required to realize the full potential of any infrastructure. Such funding, as we know, is difficult to come by, especially when it is sought for endeavors of a philosophical nature that will not result in "quick fixes" or powerful new technologies. The Institute continues to seek the funding required to more fully realize its potential. Adequately funded, it stands to make

a difference in the development of nursing practice and the nursing profession. With this in mind, the Institute has concentrated on activities which hold promise for putting it on a firmer footing, in its fund-seeking endeavors.

Planned activities, as funding and other resources permit, include: the conduct, on a sustained basis, of nursing and collaborative philosophical nursing research projects; the provision of philosophical nursing research associateships and assistantships; the offering of philosophical nursing research colloquia, workshops, and summer institutes; and the establishment of a visiting nurse-philosopher program, a formal postdoctoral philosophical nursing study program, and a philosophical nursing research journal library.

Letters

Authorship Patterns in CJNR: 1970 to 1991

Recent studies in several disciplines reveal that journal authorship patterns have changed considerably in the last 20 years. Evidence suggests that the pattern has gone from predominantly single authorships to a combination of co- and multiple authorships. To date, there have been no systematic studies in nursing per se, although there have been studies in related disciplines such as medicine and life sciences. I decided, therefore, to launch an investigation in nursing. I chose *The Canadian Journal of Nursing Research* as my target journal because it is the oldest national refereed journal in nursing that is devoted almost exclusively to research in the field.

I examined all major articles from 1970 to 1991. Excluded were abstracts, book reviews, briefs submitted to commissions, critiques, and rebuttals, editorials, letters to the editor, reports of conference proceedings, special columns such as "Query and Theory" or "Viewpoint," tributes, and works with an unspecified number of authors. The data were grouped into one seven-year interval and three five-year intervals as follows: 1970-1976, 1977-1981, 1982-1986, and 1987-1991. Each interval contained 20 issues. A record sheet for each of the intervals was compiled. The number of authors, that is, single, double, and multiple for each of the years and for the total period was calculated. Then the number of authors was converted to percentages for each year and for the total period.

I found that nursing was not unlike other disciplines, that it too has experienced changes in authorship patterns. Specifically, single authorships accounted for nearly 82% of all publications during the 1970-1981 period. However, the pattern shifted in 1982. In particular, co- and multiple authorships combined accounted for about 43% of all publications between 1982 and 1986. This number further increased to approximately 66% between 1987 and 1991. This means, in essence, that there has been a dramatic reversal in authorship patterns in the CJNR in the last 10 years.

Reasons for this increase in collaborative publication are speculative, but as a rule, are attributed to three factors. First, is the ever-increasing pressure on nursing faculty to "publish or perish." Second, is the ever-increasing complexity of nursing research itself, and third, is the increase in the mentorship of graduate students.

Robin P. Norris B.Sc. N., M.Ed.
Ryerson School of Nursing

This letter was first published in Volume 25, No.3, and will be indexed in Volume 26, No.4.

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☐ Veuillez trouver ci-joint un chèque de $_____libellé au nom de l'Université McGill

☐ Visa # _____ Date d'exp._____

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NOUVEL ABONNEMENT ☐ RENOUVELLEMENT ☐

	Un an (quatre numéros)	**Deux ans (huit numéros)**
☐ personnel	40$	☐ 77$
☐ institution	85$	☐ 165$
☐ étudiant	36$	☐ 72$

Les abonnements provenant de l'étranger font l'objet d'un supplément de 8,00 $ par année.
Les abonnés canadiens, veuillez ajouter 7% T.P.S.