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WINTER EDITORIAL

Some Reflections on the Nurse Practitioner Movement: Potential Danger, Exciting Possibilities

Plus ça change, plus c'est la même chose is the adage that springs to mind with the resurgence of the nurse practitioner movement in Canada. Across the country there is growing pressure by governments to establish nurse practitioner programs to train nurses to assume "simpler" medical acts previously performed by doctors. The impetus for this movement is economically motivated as governments look for solutions to contain health care costs. In times of financial constraints and spiraling deficits, the idea of training nurses to be "mini" doctors at a fraction of the cost appears to be a practical and logical solution. However, this solution is fraught with inherent dangers for nursing: It has the potential of undermining nursing's unique role in the health care system. At the same time, it presents possibilities for opening new vistas and creating new challenges.

For those of us who were around 25 years ago these unfolding events is a *déjà vu*. Canadian nursing leaders debated nursing's future direction in the then newly reformed health care system. Some advocated for a greater blurring of the functions between medicine and nursing and argued for an expansion of nursing's role into medicine. Others advocated for a clearer distinction and separation between the two professions and pushed for an independent but complemental role for nursing (Allen, 1977). The latter position won out and nursing continued on the exciting course that it had already embarked on some ten years earlier.

Nursing distinguished itself from medicine as it developed its own functions. It explored different philosophical world-views, formulated new theoretical foundations, entertained different research methodologies, and extended its boundaries through its scholarship and innovations in practice. Nursing articulated a broad vision of health; a vision that was revolutionary and that placed itself at the cutting edge of redefining health and transforming health care practices. Research findings expanded the vision and reinforced that nursing was on the "right" track. Nursing's potential seemed limitless; its confidence and self-respect soared and others began to take note. Nursing had at last found its own unique voice.

This voice is now in danger of being muted and stilled. The recent moves by several governments to remunerate nursing for practicing medicine rather than nursing sends a message to nurses and to the public that threatens to undermine nursing as an independent profession. By their actions govern-

ments are in effect conveying the message that nursing is valued as a profession worthy of compensation only when it provides a "cheaper" form of medical services. The threat to nursing is that any successes in health outcomes will be attributed to medical knowledge and skills rather than to nursing knowledge and skills. These actions also serve to reinforce old stereotypes of nursing as a second-rate, "simpler" form of medicine and further obfuscates nursing's true role.

Having identified a few of the dangers, these new developments also present exciting possibilities. Nursing, if it positions itself wisely and takes control over its destiny, can play a major role in transforming the health care system. As hospitals down-size, beds close, hospital-stays shorten, the knowledge and skills that nurses possess are urgently needed by patients and their families. Nursing can have a major impact on a nation's health when it is given greater control over its practice. This will only come about if nursing becomes a major player in negotiating its future. Nursing's future cannot be left to politicians or to other professions alone. It is essential that nursing defines and decides on the medical tasks that it wants to assume. These decisions must be taken in light of nursing's goals and mission, and be congruent with its theoretical and philosophical orientations. Anything less will be a betrayal of our past and a denial of the very essence of nursing; the progress made during the past 40 years will be for naught. The adage that everything changes yet everything remains the same will prove correct. Let us have the wisdom and courage to prove it otherwise.

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Laurie Gottlieb
Editor

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ÉDITORIAL DE L'HIVER

Quelques réflexions sur le mouvement des infirmières : le risque éventuel et les passionnantes possibilités

Plus ça change, plus c'est la même chose est l'adage qui vient à l'esprit lorsqu'on pense à la réapparition du mouvement des infirmières au Canada. Les gouvernements à travers le pays font de plus en plus de pressions pour que soient mis en place des programmes afin de former les infirmières à assurer les actes médicaux «simples» que pratiquaient auparavant les médecins. L'impulsion de ce mouvement a sa source dans l'économie; en effet, les gouvernements cherchent des solutions pour maîtriser les coûts des soins de santé. En période de contraintes financières et de spirale des déficits, l'idée de former les infirmières pour qu'elles deviennent des «mini» médecins à moindre frais semble une solution pratique et logique. Pourtant, cette solution est pleine de risques pour les sciences infirmières : elle peut éventuellement miner leur rôle unique dans le système de la santé. En même temps, elle offre la possibilité d'ouvrir de nouvelles perspectives et de créer de nouveaux défis.

Pour ceux et celles d'entre nous qui étions déjà dans la profession il y a un quart de siècle, nous avons, face aux événements actuels, un sentiment de déjà vu. Les responsables canadiens en sciences infirmières discutaient de la direction future de leur discipline au sein de ce qui était alors le système de santé nouvellement réformé. D'aucuns préconisaient que les fonctions en médecine et en sciences infirmières soient moins nettement départagées et que le rôle des sciences infirmières s'étende à la médecine. D'autres prônaient une distinction et une séparation plus claires entre les deux professions, et recommandaient un rôle indépendant mais complémentaire pour les sciences infirmières (Allen, 1977). Cette dernière position l'emporta et les sciences infirmières suivirent la route qu'elles avaient prise quelque dix ans plus tôt.

Tout en développant leurs fonctions propres, les sciences infirmières se distinguèrent de la médecine. Elles explorèrent divers points de vue philosophiques du monde, formulèrent de nouveaux fondements théoriques, considérèrent différentes méthodologies pour la recherche et poussèrent leurs frontières grâce à leurs bourses d'études et aux innovations dans leur pratique. Elles articulèrent une vision étendue de la santé, une vision révolutionnaire qui se plaçait à la limite de la redéfinition de la santé et de la transformation de la pratique des soins de santé. Les résultats de la recherche élargirent cette vision et confirmèrent que les sciences infirmières étaient sur la «bonne» voie. Leur potentiel paraissait ne connaître aucune limite; leur confiance et respect de soi montèrent en flèche et on commença à le remarquer. Les sciences infirmières avaient enfin trouvé leur propre voix.

Mais cette voix, on risque maintenant de la faire baisser et même taire. Les récentes actions de plusieurs gouvernements qui consistent à rémunérer les infirmières pour pratiquer la médecine plutôt que les sciences infirmières envoient un message au public et aux sciences infirmières qui menace de les miner en tant que profession indépendante. Par ces actes, les gouvernements transmettent en fait le message que les sciences infirmières sont considérées comme une profession digne de compensation seulement lorsqu'elles offrent des services médicaux «bon marché». Le risque pour les sciences infirmières est que tout succès dans le domaine de la santé soit attribué à la connaissance et aux compétences médicales plutôt qu'à la connaissance et aux compétences en sciences infirmières. Ces actes renforceront également les anciens stéréotypes sur les sciences infirmières, à savoir qu'elles sont une forme de médecine «plus simple», de deuxième ordre, et ils obscurciront le véritable rôle des sciences infirmières.

Quelques risques ayant été établis, cette évolution offre aussi de passionnantes possibilités. Si elles se positionnent judicieusement et prennent leur destin en main, les sciences infirmières peuvent jouer un rôle crucial dans la transformation du système de la santé. Tandis que les hôpitaux réduisent leur personnel, que l'on diminue le nombre de lits, que les séjours à l'hôpital raccourcissent, les malades et leurs familles ont un besoin urgent des connaissances et des compétences des infirmières. Les sciences infirmières peuvent avoir un effet important sur la santé d'une nation si elles obtiennent une plus grande maîtrise de leur pratique. Cela s'avérera seulement si les sciences infirmières sont un acteur majeur dans les négociations sur leur avenir. On ne peut laisser le futur des sciences infirmières seulement entre les mains des politiciens ou d'autres professions. Il est impératif que les sciences infirmières définissent les tâches médicales qu'elles veulent accomplir. Elles doivent prendre cette décision en fonction de leurs objectifs et de leur mission, et être en phase avec leurs orientations théoriques et philosophiques. Tout ce qui se situera au-dessous de cela sera la trahison de notre passé et le reniement de l'essence même des sciences infirmières; les progrès accomplis au cours des quarante dernières années auront été vains. L'adage *Plus ça change, plus c'est la même chose* se révélerait juste. Ayons la sagesse et le courage de le démentir.

Laurie Gottlieb
Rédactrice en chef

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Women's Health

I still have a key chain given to me by my son many years ago. The tag on the chain has an inscription: "Everybody has a right to my opinion." It was a surprisingly insightful gift from a ten year old! I am grateful for this opportunity to voice a few opinions on the important topic of women's health.

Perhaps this focus issue should have been titled "women's work" rather than "women's health." Because of the quality of the submissions rather than any pre-ordained plan, the four papers on women's health are all about women's paid and unpaid work as caregivers. Each paper views the issue through a different lens, and the result is a thought-provoking, often disturbing look at women's lives in general, nurses' lives in particular, and the nursing profession.

The links between one's work and one's health have been an important focus of study for some time. The landmark Whitehall Study in England was the first major study to find a relationship between health outcomes and the amount of power and control people had in their paid work (Marmot, Shipley, & Rose, 1984). Unfortunately in the current economic climate the majority of nurses are uncertain whether they will have jobs at all, much less control over their work.

More recently attention has been given to the importance of unpaid work – household and child care responsibilities – in determining health outcomes. This issue contains two studies about women as caregivers. One study (by Miriam Stewart and colleagues) poignantly portrays the stressors experienced by mothers of chronically ill children, and the other (by Margaret Ross and colleagues) describes the challenges and rewards nurses experience in their dual paid and unpaid caring roles.

I learn something new from Jan Angus' paper each time I read it. The "ideology of separate spheres" of home and work, the myth of the home as a restful haven from the outside world, and the transfer of economic responsibility for care to the family in the guise of "community-based care" – these interrelated themes can be viewed as the subtext in both the Stewart et al. and Ross et al. studies, and they set the stage for Patricia McKeever's persuasive argument in her "Discourse" paper.

Dr. McKeever raises an issue that the nurisng profession can no longer afford to ignore the overlaps in the spheres of nursing and unpaid caregiving. While Dr. McKeever's research has focused on family caregivers in the home, one of my doctoral students, Barbara Davies, has had to face the same question in a very different context: the care of labouring women in hospital. In our field, the number of doulas (lay women trained in labour support) is

growing rapidly, despite the fact that doulas are not permitted or are marginalized in many Canadian hospitals. A meta analysis of the 11 randomized controlled trials provides strong evidence of the benefits of continuous support by a nurse, midwife, or doula during labour (Hodnett, 1994). The Society of Obstetricians and Gynaecologists of Canada is about to publish a consensus statement recommending that all women in labour receive continuous one-to-one support from a specially trained caregiver. How are Canadian nurses going to react to this recommendation? Hopefully not with the short-sighted response, "we have no time."

It is one thing to mouth platitudes about nursing and caring. It is quite another to convince policy makers of the importance of nurses' caring activities in an ever-tightening economic climate. In the past a great deal of attention has been given to defining nursing by putting boundaries around it, to distinguish it from medicine, for example. Such territoriality is dangerous, leading to a "bunker mentality" that could well contribute to nursing's demise. On virtually all fronts – from community nursing to intensive care nursing – we have seen new kinds of health workers take over roles formerly performed by nurses. Dr. McKeever argues convincingly that we should acknowledge the overlaps between the work of nurses and non-professional caregivers, joining forces in a fight for social equity. Suppose we take her recommendation a step further, to suggest that nurses also unite with other health care workers, (e.g., midwives, occupational, physical, and speech therapists, health educators). Using the above example concerning nurses and intrapartum support, what if Canadian labour nurses were to work with doulas, midwives, and childbearing families, towards the common goal of ensuring that all women receive optimum, evidence-based care during childbirth?

Finally, since a) the topic is women's work, b) I am a woman whose work is mostly research, and c) this is Canada's national nursing research journal, I feel compelled to make a comment about an ongoing shift in the national research environment. I was an active participant at the local and national levels in the recent restructuring of the Medical Research Council, and I remain optimistic that Canada's largest health research granting agency will one day fulfil its legislated mandate. However, actions speak louder than words, and the results of first grant competition under the "new" MRC indicate it has a long way to go in its metamorphosis.

It was a pleasure to work on this issue. Special thanks go to Laurie Gottlieb, for offering me a wonderful opportunity to appreciate the complexities of journal editorship, and to Jill Martis, for her invaluable help in all phases of the editorial process.

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Ellen D. Hodnett
Guest Editor
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ÉDITORIAL INVITÉ

Les femmes et leur santé

J'ai encore un porte-clés que mon fils m'avait donné il y a bien longtemps. Sur la chaînette, on peut lire une inscription : «Tout le monde a droit à mon opinion.» C'était un cadeau d'un enfant de dix ans étonnamment perspicace. Je suis reconnaissante de l'occasion qui m'est donnée de faire connaître mon opinion sur un sujet aussi important que la santé des femmes.

Peut-être que cette question cruciale aurait dû être intitulée «le travail des femmes» plutôt que «la santé des femmes». Grâce à la qualité des articles soumis, et non à un quelconque projet préétabli, les quatre articles sur la santé des femmes concernent tous le travail rémunéré et le travail gratuit des femmes en tant que soignantes. Chaque article examine la question selon un angle différent et le résultat force la réflexion. Il s'agit souvent d'une observation dérangeante de la vie des femmes en général, de la vie des infirmières en particulier, et de la profession d'infirmière.

Depuis quelque temps, les liens entre le travail et la santé sont une question essentielle dans la recherche. L'étude de référence Whitehall en Angleterre était la première étude importante qui établit la relation entre les effets sur la santé et le niveau de pouvoir et de maîtrise que les gens avaient dans leur travail rémunéré (Marmot, Shipley et Rose, 1984). Malheureusement, dans la conjoncture actuelle, la majorité des infirmières ne sont pas certaines d'avoir un emploi, et que dire d'une maîtrise de leur travail!

Plus récemment, l'attention s'est portée sur l'importance du travail gratuit (les responsabilités concernant le foyer et les enfants) dans la détermination des effets sur la santé. Cette question occupe deux études sur les femmes en tant que soignantes. Une étude (par Miriam Stewart et ses collègues) décrit de façon poignante les facteurs stressants que connaissent les mères d'enfants atteints de maladie chronique. L'autre étude (par Margaret Ross et ses collègues) décrit les défis et les joies que rencontrent les infirmières dans leur double rôle de soignantes rémunérées et gratuites.

Chaque fois que je relis l'article de Jan Angus, je découvre quelque chose de nouveau. L'«idéologie des sphères séparées» de la maison et du travail, le mythe du foyer comme havre de paix face au monde extérieur, et le transfert de la responsabilité économique des soins à la famille sous la rubrique «soins communautaires» – on peut considérer ces thèmes étroitement liés comme le sujet sous-jacent des études de Stewart et al. et de Ross et al. Ils permettent l'argument convaincant de Patricia McKeever dans son article DISCOURS.

Dre McKeever soulève une question que la profession ne peut plus se permettre d'ignorer, les chevauchements dans les sphères des sciences infirmières et de la prestation de soins gratuits. Tandis que Dre McKeever

concentrait sa recherche sur les soignants de la famille dans le foyer, l'une de mes étudiantes de troisième cycle, Barbara Davies, était confrontée à la même question dans un contexte différent : les soins aux parturientes à l'hôpital. Dans notre domaine, le nombre de sages-femmes autodidactes (femmes non professionnelles formées pour le soutien aux parturientes) croît rapidement, même si elles ne sont pas autorisées ou sont marginalisées dans bien des hôpitaux canadiens. Une méta-analyse de onze essais aléatoires contrôlés démontre les avantages du soutien continu qu'apporte l'infirmière, la sage-femme diplômée ou autodidacte pendant le travail de la parturiente (Hodnett, 1994). La Société des obstétriciens et gynécologues du Canada va bientôt publier un accord général recommandant que toutes les parturientes bénéficient d'un soutien continu et individuel d'un soignant spécialement formé. Comment les infirmières canadiennes vont-elles réagir à cette recommandation? C'est à espérer que ce ne sera pas avec la réaction de gens qui ne pensent qu'è court terme : «nous n'avons pas le temps.»

C'est une chose de dire des platitudes sur les sciences infirmières et les soins. C'en est tout à fait une autre de convaincre les décideurs de l'importance des soins que donnent les infirmières dans une conjoncture qui se dégrade sans cesse. Par le passé, on a accordé une grande attention à la définition des sciences infirmières en y mettant des frontières, pour les distinguer de la médecine par exemple. Une telle territorialité est dangereuse car elle conduit à une «mentalité de blockhaus» qui pourrait bien contribuer à la fin des sciences infirmières. Sur pratiquement tous les fronts, des soins communautaires aux soins intensifs, on a vu de nouveaux types de travailleurs sanitaires jouant le rôle habituellement tenu par les infirmières. Dre McKeever indique de façon convaincante que l'on devrait reconnaître les chevauchements qui se font entre le travail des infirmières et celui des soignants non professionnels, et rassembler les forces dans une lutte pour l'équité sociale. Supposons que l'on élargisse sa recommandation et que l'on propose que les infirmières s'unissent également avec les autres travailleurs de la santé, par exemple, les sages-femmes, les ergothérapeutes, les physiothérapeutes, les orthophonistes et les hygiénistes. Si l'on utilise l'exemple susmentionné concernant les infirmières et le soutien au cours de la délivrance, et si les infirmières canadiennes spécialisées dans l'accouchement travaillaient avec les sages-femmes diplômées ou autodidactes et les familles qui attendent un enfant, vers un objectif commun qui consisterait à s'assurer que toutes les femmes, au cours de leur accouchement, reçoivent des soins optimaux fondés sur la recherche?

Finalement, étant donné que, premièrement, le sujet est le travail des femmes, deuxièmement, je suis une femme qui se consacre surtout à la recherche et, troisièmement, j'écris dans la *Revue canadienne de recherche en sciences infirmières*, je me sens obligée de faire remarquer que la recherche nationale connaît un continuel changement. J'ai participé activement au

niveau local et national à la récente restructuration du Conseil de la recherche médicale et je crois sincèrement que le plus grand organisme subventionnaire de la recherche sur la santé remplira un jour le mandat qui lui a été assigné. Cependant, les actes sont plus éloquents que les paroles et les effets de la première compétition pour les subventions sous l'égide du «nouveau» CRM montrent qu'il reste encore beaucoup de chemin à parcourir dans sa métamorphose.

J'ai eu beaucoup de plaisir à travailler pour ce numéro. Je souhaite remercier tout particulièrement Laurie Gottlieb qui m'a donné la merveilleuse occasion de découvrir la complexité de la rédaction d'une revue, et Jill Martis, pour son aide précieuse dans toutes les étapes du processus de rédaction.

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Discourse

Between Women:
Nurses and Family Caregivers

Patricia McKeever

Throughout Canada in recent years, contractionist policies have predominated in a labour market recession with high levels of unemployment. Government-funded healthcare has become overwhelmingly expensive, hence related policies and programmes have undergone rapid and profound transformations (Dominelli, 1991). Correspondingly, there have been major reallocations in healthcare work in both the public and private domains (Dowler, Jordan-Simpson, & Adams, 1992; Drover & Kerans, 1993). These changes have been especially dramatic in the burgeoning area of longterm care. "The family" is now held responsible for providing care to even the most severely disabled people, and the household has become the primary site for care delivery (Steel & Gezairy, 1994).

Although health care activities have always been within the realm of domestic responsibilities, the scope and extent of these activities have changed remarkably in the last two decades. These changes have been associated with widespread sentiment against institutional care, the closure of longterm care facilities (Switzky, Dudinski, Van Acker, & Gambro, 1988), and the increasing proportion of very old people in the population (Steel & Gezairy, 1994). In addition, advances in medicine, pharmacology and biotechnology have led to decreased mortality rates and increased rates of severe chronic illness and disability among people of all ages (DeJong & Lifchez, 1983). Consequently, more people now require care at home that is complex, labour-intensive, and very expensive (Plough, 1981).

My aim in this paper is not to discredit the indisputably humane goals of the homecare movement, but rather to identify some negative consequences that deserve serious consideration. First and foremost, I believe that women currently are bearing a disproportionate share of the costs that are associated with chronic illness and disability. Because the traditional division of domestic labour undergirds government policies as essentially as do class relations,

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redistributive health care practices have perpetuated gender inequalities (Fraser, 1987; Mayall, 1993; Wilson, 1982). Secondly, nurses and family caregivers are in ambiguous social positions and they have been pitted against one another in some untenable ways. Finally, nurses are losing wages and jobs, and family caregivers are forfeiting wages. Hence, both are losing employment benefits, pension entitlements and will have diminished lifetime earnings.

The current form of longterm care represents a "mixed economy" (Beecham, Knapp, & Fenyo, 1994). Families bear the major associated costs, unpaid women do most caregiving work, and nurses and cheaper health workers provide some relief and support. A chain of relationships links government and corporate interests to paid healthcare workers, unpaid family caregivers and people who have longterm care needs. At the bottom are family caregivers whose work has been appropriated from the domestic sphere and substituted for formerly paid nursing work. This transfer of work from paid to unpaid is a very unusual reversal of a longterm trend in capitalism (Glazer, 1988). It has been supported by the ideology of the market that proclaims competition and efficiency to be the major criteria by which to justify government expenditure and the ideologies of individualism, neoconservatism, and personal responsibility which justify the retrenchment of public services (Anderson, 1990; Simms, 1989; Sorochan & Beattie, 1994). In addition, because caregiving work is viewed as a low status activity (Rosenberg, 1987), the fact that many nursing skills can be performed competently by lay women in household settings may have diminished further the societal value of nursing work.

Estes and Alford (1990) argue that homecare can be seen as part of a larger process in which economic, sociocultural, and political problems are displaced into nonprofit services and the family in order to avert major fiscal crises. Without question, the deconstruction of the boundary between care given by nurses and that given by family caregivers in the home has led to fewer nursing positions and considerable public savings (Premier's Council on Health, Well-being and Social Justice, 1994). The fact that there also have been associated costs and some negative consequences now needs to be addressed.

The Relationship Between Nurses and Family Caregivers

Points of tension and conflict are inevitable between nurses and family caregivers because contemporary homecare occurs amidst ambiguity, very limited resources, and competing agendas. Both groups of women have few sources or past experiences to draw on as they try to meet ambiguous and conflicting expectations. The household as the site of caregiving is problematic and awkward because it is the setting that traditionally has been considered a

refuge from work and public interference (Graham, 1985; Rosenberg, 1987). In contrast to the institutional care milieu, family care is embedded in intimate, affective relationships that have histories and futures. Hence home care is delivered in a complex interactional context which is characterized by tension as well as solicitude and warmth (Atkin, 1994).

Nurses are urged to form "partnerships" with family caregivers (Jutras, 1988), to teach and supervise them, and to provide "family-centered care". Hence, they are required to view family caregivers simultaneously as colleagues, subordinates and people who themselves are in need of nursing care. Although the relationship between nurses and family caregivers has not been studied to date, it would appear that conflict and confusion are inevitable because these conceptualizations lead to mutually exclusive approaches. For example, there are usually clear disparities between the needs of family caregivers and those of care recipients that put at odds nurses' efforts to simultaneously maintain optimal patient care and ensure caregiver wellbeing (Twigg, 1992a).

Nurses and family caregivers must encroach on each other because their roles and relative status overlap and shift. For example, nurses give care based on their professional expertise whereas family caregivers rely on a skill repertoire that is specifically related to particular relatives' needs. Over time, most family caregivers develop a care regimen and a knowledge base so attuned to the care recipient's needs that their skill rarely can be matched by nurses (McKeever, 1992). On the other hand, nurses have more formal education, are invested with more authority and enjoy a higher social status than most family caregivers because only 35% of Canadian women have attained post secondary school education (Statistics Canada, 1990). In summary, unusually complex negotiations related to authority, accountability, values, and the use of household space must prevail between these two groups of women.

The Economic Consequences of Homecare

Many of the economic consequences of home care are related to the fact that nurses and family caregivers are in competition for scarce public resources. Nurses are vying for jobs and wages and family caregivers desperately need more support services. In addition, most of the ongoing costs associated with homecare are borne by families with a single wage earner. Consequently, most nurses and family caregivers work with few resources in contexts of financial distress (Glazer, 1988; McKeever, 1992; Scott, 1984). Although the occupational health conditions of homecare have not been documented, it seems fair to suggest that they are far from satisfactory.

Finally, most family caregivers make significant economic sacrifices by quitting their jobs, working part-time, or not seeking employment at all. The

majority do not have retirement or pension benefits and few participate in dental or medication prescription insurance plans (McKeever, 1992; Phillips & Phillips, 1993; Stone, 1994). Similarly, as more and more nursing work is performed by family caregivers and health aides, many nursing jobs have been lost or reduced to part-time positions. Currently there are many unemployed or underemployed nurses in Canada whose expected career paths, lifetime earning profiles, benefits and pension savings have been seriously affected (Premier's Council on Health, Well-being and Social Justice, 1994). Hence, it is beyond dispute that, when longterm care is delivered in the home, women suffer serious immediate and long term financial consequences.

Suggestions and Conclusions

The combined effects of the economic recession, technological innovations and unbalanced economic growth will increase the need for homecare for the foreseeable future. The structural position of nurses and family caregivers remains subordinate to that of those who control household resources and determine policies and practices (Mayall, 1993). The challenge therefore, is to alter the current arrangement so that responsibility and costs are distributed more equitably. I believe that nurses and family caregivers could contribute to meeting this challenge by working together to reconceptualize and repoliticize longterm care.

This task will not be easy because the medical model still dominates the healthcare system and absorbs most available resources. However, the enormous social value of female domestic work is finally being acknowledged (Theilheimer, 1994) and the concept of a clear division between the private and public domains is being discredited. Stacey and Davies (1983, In Mayall, 1993) argue that paid health work such as homecare nursing, actually occurs in an "intermediate domain". Situated between the private and the public domains, it complements, parallels, competes with, or replaces unpaid work in the private domain.

The concept of the intermediate domain can be used to facilitate recognition of the fact that the family and the state are indivisibly interconnected and that activities in one have significant implications for those taking place in the other. It also provides a framework that could be used to first understand and then ameliorate the tensions and adversarial relationships that develop between nurses and family caregivers. If nurses and family caregivers differentiated and clarified their respective roles, their mutual plight would become obvious. Together, they could lobby for their collective well-being. They could highlight the fact that they are performing an essential social service by supporting extraordinarily dependent people in the community. However, they are doing so with inadequate societal support and at great cost.

Davies (1983, pp. 39-41) argues that power, in its widest sense, is the ability to alter or influence the course of events, and to create possibilities where none existed before. As social individuals, caregiving women hold simultaneous memberships in various *systems* of power within the private, intermediate and public domains. By using these positions as a source of control, it is possible that gender could be upturned to provide a powerful avenue for bargaining and exchange. Although it is not considered "feminine" for women to act together in public political protest and women usually underestimate the value of the work that they do (Bielby & Bielby, 1988), there are few other options. Without positive public sentiment and acknowledgement, nurses and family caregivers will not fare well in the current policy environment.

Canadians espouse egalitarian values, therefore both groups of caregiving women should expose inequitable practices and structures which support gender disparities. The nonprofit service sector could be shown to legitimate the economically driven system by removing and treating "social problems" through policies that are consistent with the ideology of individualism (Estes & Alford, 1990). If women are to bear the major responsibility for homecare of the chronically ill, they must be able to discharge this responsibility in a context of societal support in which they have political power (Ruddick, 1989, p. 46).

Finally, most homecare research essentially continues to be driven by the *anti-institution* themes generated during the 1960s. The relationship between research findings and the rationalization of care suggests that investigators also have contributed to retrenchment practices (Simms, 1989). By reconceptualizing homecare and recognizing the price it is exacting in its present form, nurse researchers would no longer contribute to this process. As I write, governments are seeking ways to divest themselves of more and more health and welfare expenditures. In that this means enlarging the invisible welfare system of family caregivers and eliminating nursing jobs, this matter should command the immediate attention of researchers, clinicians and family caregivers.

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Women's Paid/Unpaid Work and Health: Exploring the Social Context of Everyday Life

Jan Angus

On a étudié la documentation de différentes disciplines pour obtenir une description de la vie active des Canadiennes. L'analyse allait dans le sens des recherches de Smith (1987, 1990), de féministes et d'autres théoriciens critiques qui soutenaient que la majeure partie du travail des femmes était invisible et sous-estimée. Les schémas de pensée normative ou l'idéologie peuvent masquer l'étendue et la valeur de la contribution des femmes. L'étude semble indiquer qu'une « idéologie des sphères séparées » opère dans la manière de désigner l'activité rémunérée dans la sphère publique (à savoir, le travail), tandis que les activités qui ont lieu dans la sphère privée (à savoir, chez soi) sont négligées. On indique également que l'immense participation des femmes dans des activités non rémunérées qui soutiennent autrui et renouvellent sa force de travail, en fait des citoyennes de seconde zone et les conditions préalables à leur propre santé sont souvent compromises. Souvent, le travail des femmes a lieu en dehors de l'économie formelle, dans une économie de l'ombre qui est celle de la subsistance (Illich, 1981) et qui est fondamentale au maintien de la bonne santé d'autrui.

Literature from various disciplines was reviewed to obtain a description of the working lives of Canadian women. This analysis drew on the work of Smith (1987, 1990) and other feminist and critical theorist authors who have argued that much of women's work remains invisible and undervalued. Patterns of normative thought or social ideology may obscure the extent and value of women's contributions. It is suggested here that an "ideology of separate spheres" operates in the designation of paid activity in the public sphere as work, whereas activities pursued in the private sphere of the home are overlooked. It is further argued that women's heavy involvement in unpaid activities that support and sustain others results in a state of lesser citizenship, and women's own prerequisites of health are often compromised. Women's work often takes place outside the formal economy, within a "shadow" or subsistence economy (Illich, 1981) which is essential for the continued health of others.

The activities individuals engage in that affect their health are by no means a simple matter of personal choice. They are facilitated and constrained by social and material conditions that form the context of human action and exert an impact on the prerequisites of health (Poland, 1992). Indeed, the Ottawa Charter for Health Promotion (1986) implicitly defines health as a product of social relations in the statement that health "is created and lived by people in the settings of their everyday life, where they learn, work, play, and love" (p. 427). Furthermore, the Charter acknowledges that "changing patterns of life, work, and leisure have a significant impact on health" (p. 427). Thus, any analysis of women's health must include some consideration of their work, as well as the social and material conditions under which it is performed. By definition, women's activities affect their own health and that

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of others by exerting an impact on prerequisites of health such, as time for personal growth and leisure, adequate income, and equity (Doyal & Gough, 1991; Ottawa Charter for Health Promotion, 1986; Pascall, 1993). This approach to women's work and health directs attention to the general coordination of activity in our society and the resultant effects on the prerequisites of health. Rather than focusing on outcomes such as stress, fatigue, or the presence or absence of disease, I will therefore analyze the organization of work according to gender in Canada.

West (1993) explains that gender is the product of social interactions that involve "the local management of conduct in relation to normative conceptions of attitudes and activities that are appropriate for particular sex categories" (1993, p. 59). The gendered division of labour in the home and the work place is part of a negotiated order that is accomplished within the social context of a prevailing set of normative conceptions, or ideologies, about what activities are appropriate for men and women. According to Drover and Kerans, "the contemporary family is still largely constituted by a gender division which defines certain kinds of work as domestic, female and unpaid, while other kinds of work are public, male and paid" (1993, p.18). Nurses can better understand the working lives of female clients, and indeed, the work of the nursing profession, if that work is reframed within a macro-analysis of the social ordering of women's activities. Concern is shifted from the problems of individual women clients to the common challenges shared by larger groups of women.

Entire aspects of women's everyday paid and unpaid work remained invisible until the concept of work was expanded by several authors to include women's activities in the privacy of the home (Pascall, 1986; Smith, 1987, 1993). The physical and ideological separation of home and place of employment as settings of everyday activity has had far-reaching consequences for women's health and well-being. Women's activities in the two settings have been considered separately, but their similar purposes and outcomes, as well as their combined impact on the prerequisites of women's health have only recently been recognized. Beginning with the work of selected critical and feminist theorists as an analytic framework, I will examine aspects of women's work to find the connections between the conditions that shape women's health and the "ideology of separate spheres" of work as defined by Drover and Kerans (1993). Next, I explore the extent of women's paid and unpaid work, drawing on literature from a variety of disciplines. Finally, I consider the value of women's work on a broader social scale, citing examples of how social policy affects women's working lives.

The Invisibility of Women's Work

As West's (1991) definition of gender suggests, one method of linking everyday experience with social context is through idiographic or cultural analysis, as first explicated by Denzin (1989). Working from the feminist perspective, Smith (1987, 1990) provides an analytic framework for this method. She argues that the everyday lives of women are situated within a network of social relations that extend outward to institutions such as the health care system, education, and the state. Women's activities, both in the home and in the labour force, are largely concerned with the concrete and particular details of the physical subsistence and well-being of others. As clerical workers, health care workers, and homemakers, for example, women perform the bulk of the mundane labour that facilitates more abstract, better-rewarded work. However, ideologies reflect the views and experiences of dominant groups in the social order and not necessarily those of women. Ultimately there exists a "line of fault" between popular discourse about women, and the actualities of women's experiences (Smith, 1990). If, for example, we think in terms of separate locations when considering women's work, we may fail to see the continuities in the purposes and outcomes of women's activities across all situations and misunderstand the total effects on prerequisites for women's health.

The recognition of women's contributions to societal well-being has been similarly impeded by the artificial splitting of the private sphere of the home from the public domain of productive, market-related activity; the result is the ideology of separate spheres (Armstrong & Armstrong, 1994; Drover & Kerans, 1993; Wilson, 1991). This rupture began during the Industrial Revolution, when wage labour became centralized in factories and other commercial sites. Existing gendered patterns of subsistence activity became exaggerated and solidified; the public sphere became the male dominated world of work, and the private home became a supportive environment created by women for the nurturance and socialization of children and for the restoration and relaxation of men as they returned from their daily labours (Johnson, 1974; Phillips & Phillips, 1993; Strong-Boag, 1988). Yet the ideology of separate spheres is based on the historical experiences of a more advantaged segment of society. It obscures the reality that women in some socioeconomic groups have always contributed to the economic circumstances of their families, either through paid employment or through informal means such as economizing on household expenditures (Phillips & Phillips, 1993). Finally, this distinction between sites of activity underlies the devaluation of women's health-oriented and caretaking work by locating them outside the cash nexus (Anderson, 1989).

Feminist and critical welfare theorists argue that social policy decisions are informed by these elements of the ideology of separate spheres, and reduce women to a state of lesser citizenship (Drover & Kerans, 1993; Eichler, 1988; Evans, 1991; Neysmith, 1991; Pascall, 1986, 1993). Doyal and Gough (1991) suggest that social arrangements ought to be judged according to their adequacy in meeting common human needs and observe that, in comparison to men, women's basic needs are poorly met in all societies. Pascall thus reasons that full citizenship for women would mean "the equal recognition of needs – for shelter and food, personal space and time, for social acceptance – and the construction of rights and obligations within such a framework of needs" (1993, p. 115). In Pascall's view, then, full citizenship would mean that the prerequisites for physical and mental health were satisfied. The following analysis of the current situation for Canadian women builds on this definition of citizenship by examining the structure of their everyday lives, as well as the social and material conditions that contribute to the creation of this structure.

The Working Lives of Canadian Women

West (1993) argues that if the concept "gender" becomes individuated as the property of a person, it is prematurely treated in research as an explanation rather than the starting point for a critical analysis of social experience. Thus, while it is clearly useful to study such concepts as stress and fatigue in women as the result of specific work situations, West urges us to also consider the broader social arrangements that render women's work in specific locations stressful or fatiguing. The purpose of this section is to describe the working lives of Canadian women by examining their unpaid work in the home, and their paid work in the labour force. The adequacy of these working arrangements to meet the prerequisites of women's health is also considered.

Women's Unpaid Work in the Home

In 1990, 71% of all couples with children under age 19 in the household were dual earners, while only 30% of similar couples were dual earners prior to 1970 (Marshall, 1993). Although polls show that men are gradually taking on more household chores, women continue to bear the brunt of the gender-negotiated division of work. The work that women do in the home is marked by frequent interruptions, contingent upon the changing developmental and physical needs of others, conducted in isolation, and seemingly never completed (Armstrong & Armstrong, 1994). Within the ideology of separate spheres there is an androcentric notion of the home as a restful haven from the world of commerce, further obscuring the restorative work that is endlessly pursued in that setting. For women, the home is not necessarily a site of leisure, and the work they do there has no temporal boundaries. The unpaid activities they pursue at home are multifaceted, including housework, repro-

duction and childcare, care of the elderly and disabled, and tension management (Armstrong & Armstrong, 1994). Many authors acknowledge an element of emotional labour that is embedded in most of the physical activities of homemaking (Hochschild, 1983; Hochschild & Machung, 1989; James, 1989; Wilson, 1991). All of these aspects of homemaking are essential to the health and well-being of family members, as well as to the continuity of production outside the home, yet the conditions under which they are enacted have an impact on the prerequisites of women's health.

The Division of Work in the Home

The population-based survey findings on the division of household labour reveal the differences in time spent on housework by men and women, but reveal little about the social processes behind these differences. The results of the 1992 General Social Survey show that Canadian women spent an average of 4.5 hours/day doing unpaid housework, in contrast to 2.6 hours/day spent by men (Devereaux, 1993). Several conditions appeared to contribute to this inequity. The presence of young children in a household expands the amount of work to be done (Chandler, 1994; Devereaux, 1993). Women who were employed full time and had children under age 6 did an average of 5.4 hours of unpaid work daily, while their partners did 3.4 hours (Devereaux, 1993). Of the hours allotted to unpaid work, these women devoted 2.2 hours solely to childcare, while men spent 1.2 hours in childcare.

In the dual income families where both spouses were employed full time, women were solely responsible for housework in 52% of the families, and mostly responsible in 28%, responsibility was equally shared in 10%, and the men were solely or mostly responsible in 10% (Marshall, 1993). The age of the couple appeared to be linked with the division of household work: 47% of women were solely responsible for housework in the under-35 age group, 53% between ages 35-44, and 69% between ages 45-64 (Marshall, 1993). The division of household tasks was also linked to income: sole responsibility for housework was held by 67% of women whose incomes were under $20,000, 53% of those with incomes over $40,000, 39% of those whose husbands' incomes were under $20,000, and 45% of those whose husbands had incomes over $40,000. However, Brayfield (1992) found that unemployed men did no more than 40% of the housework regardless of their spouses' employment status. Hessing (1993) found that female clerical workers frequently altered their own employment routines to attend to sick children or household errands in order to protect the schedules of their spouses, who had more lucrative jobs.

When housework *is* shared, women are often responsible for such daily routines as meal preparation and laundry, while men take on chores of a

more episodic nature, such as home and car maintenance (Armstrong & Armstrong, 1994; Devereaux, 1993; Hochschild & Machung, 1989; McKeever, 1994). Marshall (1993) observes that:

> because of the differences in the nature of the responsibilities, it is usually more difficult to manage the daily household chores in conjunction with full-time employment than to manage the more infrequent repairs, yard work and maintenance. Without a more equal division of responsibility for housework, women will have to continue to juggle employment, household chores, and family time. This, in turn, will leave them more limited time for professional or personal development (p. 14)

Thus, time is a critical resource for employed women as they seek a position of health for themselves amid the demands of home and career, but time studies and population surveys do not fully reveal the challenges women face while attempting this balance (Hernes, 1987; Hessing, 1993). Hochschild and Machung (1989) used findings from their qualitative study of dual career couples to illustrate a state of transition from a more traditional ideology about the gender division of household work to an ideology that emphasises equality and fairness. Where the traditional view prevailed, women retained primary responsibility for household work. The costs of this arrangement were seen in career sacrifices and diminished leisure time for the women, as well as in increased marital conflict and family discord. Only 20% of the couples equally shared household tasks, and, although both husbands and wives in these less traditional families grappled with resultant limitations to their leisure and career pursuits, they appeared more content with their marriages and family lives.

Neysmith (1991) observed that the notion of community based care that has become a prevalent feature of Ontario health policy in recent years merely transfers economic responsibility to the family. But historically, family responsibilities have been women's responsibilities, and this ethic is embedded within the ideology of separate spheres (Anderson & Elfert, 1989; Andrew, 1984; Neysmith, 1991; Ursel, 1992). Women's undervalued work as family caregivers bears a legacy of poverty as women limit their paid activities to attend to the needs of children, spouses, and ill family members (Evans, 1991). Anderson and Elfert (1989) found in a qualitative study that responsibility for managing the care of chronically ill children rested primarily with their mothers. McKeever (1994) found that in a sample of 62 biological and foster mothers of children with disabilities, 30% of the 48 married mothers reported that their spouses gave no assistance with child care, and another 25% that their spouses helped for less than on hour per day. The majority of the women were also solely responsible for household chores (85% for meal

preparation, 65% for meal clean-up, and 77% for cleaning and laundry). The incidence of some physical ailments, such as migraine headaches, was higher in this sample than that found in general population surveys.

It is difficult to calculate the value of women's unpaid work in terms of outcomes such as family health, but attempts have been made to attach monetary values to the work itself. Chandler (1994) estimated from 1992 General Social Survey data that the replacement value of household labour done by women, based solely on the cost of paying other individuals to do domestic work, care of household members, and shopping, ranged from $26,310/year for women with children under age 5 to $8,260 for those with no children. However, this estimate does not factor in the value of intangible activities such as emotional support, nor does it deal satisfactorily with the overlaps in tasks that mothers deal with in caring for young children while doing housework (Wilson, 1991). These figures are also based on the wages of workers whose activities in the marketplace are considered less skilled and low in status; those familiar with the issues of Pay Equity will recognize that these figures are based on undervalued wages (Armstrong & Armstrong, 1994; Cuneo, 1990; McDermott, 1992). Indeed, Chandler assigns a higher hourly rate to men's activities in the home than to women's because men tend to do heavier maintenance and repair work that requires more skill to perform, therefore the replacement cost of their contribution is higher. Whatever the estimated value of the work, it still remains that women who labour to sustain the health and well-being of family members do not receive any financial reward.

Emotional Work

Within the ideology of separate spheres, rationality is the province of the public world whereas emotionality is relegated to the private domain (James, 1989). The suppression of emotion during the hours of paid employment may be compatible with productivity, but its expression is merely postponed. Armstrong and Armstrong (1994) classify some aspects of women's house-hold work as tension management whereby women "sustain and orchestrate the private implosion of public tension" (p. 125). Some authors argue that this activity can only be understood subjectively and does not lend itself to empirical study (Graham, 1983). However, a small number of researchers have provided qualitative evidence that women consider tension management an important responsibility, and develop strategies for relaxing and soothing their spouses (Gaskell, 1991; Livingston & Luxton, 1991; Luxton, 1980). The theoretical and empirical literature in the areas of social support and caregiving provides additional clues about the emotional activities that sustain the well-being of families.

Although the ideological association of emotional work with women and the private sphere has enabled its dismissal as instinctive or natural, on closer examination emotional work is complex and demanding (James, 1989; Wilson, 1991). The needs of the other must be comprehended and interpreted in order to provide an appropriate and effective response. Within families, it is necessary to consider how the needs of each member will affect the functioning of the group. Finally, emotional labour is often intertwined with other activities and responsibilities, requiring some capacity to pace, organize, and prioritize tasks (James, 1989). Women's own emotional needs may be subordinated to those of other family members.

In recent times, much attention has been focused on social support as a determinant of health. Some authors have recognized the need to study the conditions that foster supportive relationships (Gottlieb, 1990; House, Umberson, & Landis, 1988; Pilisuk & Minkler, 1985), but there has been little recognition of the possibility that a socially structured and gendered division of labour may be one such determinant. House, Umberson, and Landis (1988) implicate recent upheavals around the structure of the family in the waning of supportive interactions, but argue that it is more than simply the end product of the double burden of paid and unpaid work. Pilisuk and Minkler (1985) reason that "if social support is essential to health, then our economic arrangements, our individualistic values, and our dispersed families place large numbers at risk, especially when local communities are unable to provide supplementary assistance" (p. 99).

House and Kahn (1985) note there is some evidence that "relationships with women may be more supportive and health promoting than relationships with men" (p. 83). They also review evidence that marriage is more beneficial to the mental health of men than of women; women more commonly turn to same-sex relationships with friends and relatives for support and companionship. The working mother has less respite from demands for attention and nurturance than her partner does, and the time consuming nature of housework leaves little time for leisure and self-renewal (Belle, 1982; Wilson, 1991). However, some authors have found that the relationships women form during employment hours also serve to bolster and sustain them. Indeed, the satisfaction of successfully providing support to others is a powerful intrinsic reward for women (Wharton, 1993; White, 1993; Wilson, 1991).

Unlike the activities of social support which take place within relationships of mutuality, those of caregiving imply a greater immediacy of need or dependency in the case of one participant with less likelihood of reciprocation in kind (Baines, Evans, & Neysmith, 1991). In either case, there is a dimension of affective attachment, or *caring about,* that encompasses the emotional,

informational, and appraisal support functions; and one of *caring for* that includes the instrumental or tangible aspects of support. This entanglement of emotion and labour, together with normative expectations of women, may lead to feelings of guilt on the part of those who are unable to perform caring work for family or who find the work unpleasant and frustrating (Aronson, 1991; Wilson, 1991). Women who care for children with disabilities deal with a contradictory complex of worry, frustration, attachment, and emotional rewards (McKeever, 1994). Mothers with chronic illness struggle to find a balance between their own health needs as "good patients" and their obligations as "good mothers" (Thorne, 1990).

Turner and Avison (1989) found that in a sample of 947 married adults with physically disabling chronic illnesses, the women recalled significantly more negative events than did men. When asked to enumerate stressful events transpiring within the previous 12 months, the women reported far more negative events that involved significant others instead of simply reporting incidents more central to themselves. The authors speculated that:

> the role of married women includes the experience of responsibility for the well-being of family members. Because control over the happiness of others or over events that impinge on such happiness is clearly limited, the adequacy of personal coping skill may be irrelevant to the impact of such events on mental health (p. 453).

Marshall, Barnett, Baruch, and Pleck (1990) describe *contagion stress* as a product of exposure to the problems of others and explain that it is manifested as "worrying about other people's problems, feeling unable to help important others, or blaming oneself for others' difficulties" (p. 269). They found that in a sample of 367 American women who were employed as nurses or social workers, those with higher levels of contagion stress, burden from social network caring, or costs of caregiving at work had significantly poorer mental and physical health than did the other women. Women who had high scores in more than one of the three dimensions of emotional involvement exhibited the poorest mental and physical health.

Thus, although the physical and emotional work of women may sustain the health of others, the conditions under which they labour may exert an influence on their own well-being. Although the domestic workload of women is undervalued, time consuming, and tediously cyclic in nature, a powerful emotional dimension simultaneously obligates and rewards them. The nature of the work that women perform in employment reveals some continuities in the gendered division of labour in the home and in the labour force.

Women's Waged Work in the Labour Force

In 1991, 45% of all members of the labour force were women and 60% of women over 15 years of age were employed or actively seeking employment (Armstrong & Armstrong, 1994). Over 60% of all married women participate in the workforce (Phillips & Phillips, 1993). Although the dramatic increase in women's employment has been attributed to the influence of the women's movement since the early 1960s, some authors are quick to point out that most women work out of economic necessity rather than choice (Connelly & MacDonald, 1990; National Council of Welfare, 1990). The Keynesian model of full employment featured the notion that *men's* wages ought to be adequate to meet the living requirements of their families. Since the end of the post-war economic boom in the early 1970s, there has been a continuing erosion of the "family wage" for men, as well as marked increases in unemployment; during this period, the contribution of women to family well-being has been extended to include wage earning (Armstrong & Armstrong, 1994; Pascall, 1986, 1993). Other authors have noted that eligibility for social benefits such as the Canada Pension Plan and employer sponsored dental and drug plans serve as an additional incentive for women to participate in the labour force, accepting the extra burden of work as the short-term payment for long-term financial security (Phillips & Phillips, 1993; Wilson, 1991).

Some critics of the feminist perspective blame men's unemployment on women's increased labour force participation, but the Canadian labour force is characterized by marked horizontal (occupational) and vertical (hierarchical) gender divisions. Horizontally, women entering the workforce have predominantly concentrated in a narrow range of service industries where the demand for inexpensive, flexible labour power has increased dramatically (Armstrong & Armstrong, 1994; Phillips & Phillips, 1993). Approximately 80% of female workers are employed in labour-intensive service occupations, and are particularly concentrated in the public sector where the "fiscal crisis of the state" has recently generated cutbacks in services, wage freezes, and loss of jobs (Marchak, 1987; Phillips & Phillips, 1993). Work intensification is another solution to fiscal shortfalls that further erodes the prerequisites of women's occupational health. Finally the clerical, service, sales, teaching, and health care positions that women occupy in the labour force emphasize the needs of others and have been gender-typed as women's occupations (Armstrong & Armstrong, 1994; Belle, 1982; Hochschild, 1983; Wilson, 1991). Physical and emotional care are as predominant in women's paid employment as they are in the home. Smith (1990) explains that, in the labour force and in the home, women deal with the concrete and particular details that form the foundations for the more highly rewarded and abstract work of others. For example, nurses do the vital work of physical and emotional care that enables physicians to pursue their own better paid activities.

In many industries, work is vertically divided according to gender: Male dominated occupational groups within job hierarchies are better rewarded than female dominated ones, and technical skill is better recognized than interpersonal skill (Armstrong, Choiniere, & Day, 1993; Butter, 1985; Cuneo, 1990). Furthermore, women who work within male dominated occupations and professions such as medicine earn less than their male counterparts (Armstrong & Armstrong, 1992). Although this is often partially attributed to the conflict between the burden of women's larger share of family responsibilities and the demanding nature of many areas of professional practice and education (Armstrong & Armstrong, 1992; Butter, 1985; Wilson, 1991), it is also suggested that women may be marginalized by an incomplete indoctrination into the political subtleties of an occupational subculture (Atkinson & Delamont, 1990). Furthermore, the time constraints introduced by the double burden of employment and family responsibilities make it difficult for women to participate in the activities of unions or professional organizations. Therefore their perspectives are often missing from negotiations with employers (Armstrong, 1984; Gannage, 1986).

The incompatibility between the structure of employment and the responsibility for family well-being is a pervasive issue for women. In 1991, Canadian women were no more likely than men to be absent from work due to illness, but lost an average of 17.5 days of work because of personal responsibilities in comparison to 3.9 days lost by men for similar reasons. Women were more likely than men to quit work to attend to personal responsibilities (Phillips & Phillips, 1993). Only 29% of the mothers of children with disabilities in McKeever's (1994) sample had some form of paid employment, and those who were not employed were reluctant to add a job to their already heavy family responsibilities. Not only is part-time work often preferred by women who seek to balance career and family demands, employers in many fields have found that the flexibility of part-time workers as well as their lower salary and benefit costs are an advantage in a climate of economic uncertainty. While part-time work may be a boon for the women who choose it, others are forced to accept it because nothing else is available (Phillips & Phillips, 1993).

In 1991, women's full-time earnings approached 70% of those of men (Canadian Social Trends, 1993). Pay Equity legislation has been introduced in recent years, but implementation has proven problematic in the Ontario experience and has been marked by expensive legal struggles between women and their employers (Cuneo, 1990; McDermott, 1992). Restraint programs in the public sector such as wage freezes, contract rollbacks, and unpaid leave have diluted progress towards fair remuneration. Anderson, Blue, Holbrook, and Ng (1993) showed that female immigrants who belong to ethnic or racial minorities must often settle for poorly paid, less flexible forms of employment

that conflict with their personal health needs. Women of colour, and those who are not fluent in English or French are among the lowest paid workers in Canada (National Council of Welfare, 1990). When these women belong to unions, they are often prevented from fully contributing their views by language barriers or culturally-embedded attitudes regarding femininity (Gannage, 1986).

Older women and female heads of lone-parent families are also at particular risk in this climate of wage inequity. Approximately one-third of all Canadian marriages are destined to end in divorce or separation, and including unmarried and widowed women, 84% of all women can expect to spend a significant portion of their lives without a partner (Phillips & Phillips, 1993). Although the wages and labour force participation of younger, better educated women have improved in recent years, older women who have returned to waged work after years of absence remain concentrated in less skilled and poorly paid occupations (Phillips & Phillips, 1993). Because the accumulation of pension entitlements is linked with years of labour force participation and the amount of wages earned, these older women are penalized for their years of unpaid work as homemakers and caregivers (Evans, 1991; Wilson, 1991). Single mothers, too, are at risk of poverty; in 1986, 44.1% of all single mothers had incomes below the poverty level in contrast to 9% for all couple families (Phillips & Phillips, 1993). For those single mothers who were employed on a full-time basis, the incidence of poverty was 25.7%, while poverty rates for those engaged in part-time employment and those dependent on welfare benefits were 75% and over 90%, respectively (Phillips & Phillips, 1993).

In summary, the above description of the everyday working lives of Canadian women leads us to question the adequacy of these arrangements in meeting the prerequisites for women's health. As Pascall (1993) points out, women are not as free as men to avoid unpaid labour, with the result that they have less time available for personal and career development. Women are bound to unpaid work by emotional and ideological obligation, and may seek to protect the financial welfare of the family by facilitating the more highly valued and better rewarded market activities of their spouses. Thus, the health prerequisite of time for personal growth and leisure is in short supply for women, particularly those who balance paid employment and family responsibilities. Because of their lower wages, most women are less able than men to afford the necessities of life, and many authors have observed that marriage remains an important economic boon to women in the current economic context (National Council of Welfare, 1990; Pascall, 1993). Women who belong to ethnic and racial minorities, single mothers, and retired or widowed women face financial hardship with the present structure of remuneration and social benefits. An adequate income is therefore another prerequisite of health that is less accessible to many women than it is to men.

Equity, or recognition of the value of women's contributions in the home and in the labour force, is another prerequisite of health that is not adequately met. Although some women's professions such as nursing and teaching have recently achieved greater recognition, largely through the efforts of their female dominated unions and professional organizations, others are afforded poor social status and acceptance because they are viewed as "unskilled" work. The complexity of skill and knowledge gained through experience and everyday activity remains largely unrecognized within the current discourse of science, therefore the paid and unpaid work that women pursue is poorly understood (Smith, 1990). Using Pascall's (1993) framework of citizenship requirements as a yardstick, many Canadian women are lesser citizens; their basic human needs or prerequisites of health are often poorly dealt with.

In the final section of this paper, I will examine examples of how Canadian social policy reinforces women's state of lesser citizenship, and consider the position held by women's activities within the economic structuring of our social order.

Contextualizing Women's Work Within Canadian Social Policy

The continuity between women's paid and unpaid labour is intensified when this work is reframed within the context of the welfare state. Here, discussion of welfare policy goes beyond the notion of social benefits, to all aspects of state policy that affect social welfare, including such elements as health care, labour issues, education, and day care. Feminist and critical welfare theorists have argued that women are powerfully affected by policies in this area by virtue of their involvement as employees in the public sector areas of health care, education, and social work; as clients receiving social benefits; and as consumers of public services (Borchorst & Siim, 1987; Drover & Kerans, 1993; Eichler, 1988;). Historically, women have also been active in shaping Canadian public policy (Andrew, 1984; Ursel, 1992). This intricate set of relationships is summarized by Hernes:

> To the extent that the welfare state's "crisis" is regarded as *financial*, women will be affected more than men by attempts to solve the crisis through budget cuts. To the extent that the "crisis" is regarded as a crisis of *legitimacy*, it is women who, through their demands and their support, can maintain belief in the state as opposed to the market as problem solver. If one regards the "crisis" as mainly a problem of governmental *overload*, women will be affected if one solves the problem by transferring services back to the family and to the market, a process which would affect women as employees and clients (1987, p. 80).

The state is caught between the contradictory tasks of maintaining its legitimacy as "the ultimate guarantor of societal promises" in the estimation of the electorate (Drover & Kerans, 1993, p. 20), and safeguarding the accumulation of capital in the market realm (Drover & Kerans, 1993; Ursel, 1992). For example, Pay Equity legislation served as a mechanism to legitimize the state in the view of women voters, yet the difficult wording of the legislation placed the onus on women to expend considerable time, money, and energy in the pursuit of its implementation (Cuneo, 1990; McDermott, 1992). As Drover and Kerans (1993) point out, the claims of dominant groups are rarely challenged because the basis of these claims are already aligned with prevalent attitudes and norms. On the other hand, the claims of subordinate groups challenge this established order by demanding a new system of social identity. In struggling for fair implementation of Pay Equity, groups such as the Ontario Nurses' Association were forced to deal with the embodiment in legislation of the socially embedded, androcentric definitions of such terms as *work, skill,* and *knowledge*. These biased definitions permeated the very measurement scales used to compare and assign value to the work done by men and by women (Butter, 1985).

Within the current discourse of scarcity, Evans (1990) notes that cost containment efforts within the Canadian health care system generate struggles between groups that seek to increase their profits and raise costs, and those that attempt to resist increases or transfer costs to others. The path of least resistance is an attractive one, he argues: "Transferring the burden of costs to some other individual or group is equivalent to reducing it...and may be a great deal less stressful managerially and politically" (p. 102). The deinstitutionalization of care for the chronically ill and elderly, as well as the transfer of some aspects of acute care from the hospital to the community has been accomplished in alignment with the ideology of separate spheres. Normative conceptions about the home as a site of restful relaxation and the family as the locus of mutual help and caring inform the notion of family care and encourage its acceptance (Anderson & Elfert, 1989; Drover & Kerans, 1993; Neysmith, 1991). Yet this same ideology subtly prompts women to accept the burden of family care, while the isolation and intensity of this work discourages the organization of similar women into interest groups to resist the transfer of care.

The women who shoulder the burden of cost containment in health care or who interrupt their careers to raise children face a legacy of poverty or lost income, as well as immediate restrictions to personal time and space (Evans, 1991; McKeever, 1994). Women are not paid for these services, and unemployment and retirement benefits are indexed only according to participation in the paid labour force under the implicit assumption that paid employment is the only valid form of "work". The adverse effects of poverty on health have

been documented (Black, Morris, Smith, & Townsend, 1980; Lundberg, 1993). Recently it has been found that there may be a positive relationship between economic status in adult life and health (Lynch, Kaplan, Cohen, Kauhanen, Wilson, Smith, & Salonen, 1994). That women experience an excess of physical morbidity and affective disorders in comparison to men has been documented, but a satisfying empirical explanation has not been found (Popay, Bartley, & Owen, 1993; Verbrugge, 1989). The ideology of separate spheres may mask the long-term costs in poverty and chronic poor health that women incur as they absorb the burden of costs transferred from social institutions that operate within the formal economy.

Smith's (1990) observation that the bulk of women's paid or unpaid activities enable others to pursue more highly valued and abstract work is particularly powerful when combined with Illich's (1981) analysis of "shadow work." Illich argues that an informal, parallel economy supports the formal, market-based economy; this shadow economy is based on activities and social relations that sustain and reproduce the labour force so that productivity is maintained. No estimate of Gross Domestic Product incorporates the value of shadow work, but the vitality of the shadow economy is crucial to the success of the formal market economy. Smith (1993) also argues that current ideas in welfare theory and policy fail to recognize the networks of social relations organized around human subsistence. From the earlier-mentioned analysis, it is clear that women are key actors in these networks of shadow work. Their work in the home sustains the health of the labour force and contributes to the socialization of a new generation of workers. Women actively ensure that men are free to participate fully in their better rewarded jobs. Women serve as an inexpensive pool of labour whose need for flexible employment arrangements often compliments fluctuations in market requirements. Current wage inequities for women favour capital accumulation, or at least cost containment. Finally, women buffer the formal economy from increasing health and social welfare costs by absorbing these costs into the shadow economy.

Conclusions

The above analysis of women's working lives has many implications for nursing research and practice. First, several target groups of women have been identified as at risk for poor health because the prerequisites of health are compromised among them. Yet no reader will be surprised by the identities of these groups, not only because we have considered their needs frequently in our capacities as health care workers and researchers, but because the majority of nurses are women who have experienced similar conditions. Many nurses are, or can expect to be, members of dual income families, single mothers, retired women, women who belong to racial or ethnic minorities, women who are providing informal care for family members of all ages, or

women who are employed in labour intensive occupations where cost containment has produced additional burdens and frustrations. Indeed, many nurses hold more than one of these identities and can expect to hold others as their life circumstances change. Therefore, most will understand the need to consider in our research and practice the cumulative effect of multiple working identities on the prerequisites of women's health and well-being, as well as women's needs in relation to specific identities or situations.

Secondly, as implied by West's (1993) ethnomethodologic definition of gender, research is needed to examine how activities are coordinated around specific events or problems, such as care of a chronically ill family member. Consideration of the social conditions (normative conceptions about appropriate activities for either gender, for example) and material conditions (such as available financial resources) would be part of the analysis of how work is negotiated among members of social groups. Such studies would describe the actual work involved, as well as the way in which the division of labour is negotiated among those involved in the process. By describing the extent and nature of women's work in specific instances, a clearer understanding of the knowledge and skill that is embedded in everyday activities would be achieved. This description would also shed light on the many ways that women's work can affect their own prerequisites of health and those of others. An analysis of the division of labour around specific events or problems would necessarily include all of the actors involved in the process, from women and their families to others such as health care workers. Because everyday activities that affect health are often enacted in contact with the health care system and associated professionals (Smith, 1987, 1990), analysis of the influence of these contacts on women's activities and health will assist nurses in expanding and refining approaches to care.

Finally, as Borchorst and Siim (1987) point out, workers in female dominated occupations within the public sector are in a unique position to advocate for their female clients. As nurses, our understanding of the health implications of women's work, our strong professional organizations and unions, and our links with the research and policy communities situate us between the realities of women's experiences and the social institutions that exert a powerful influence on the prerequisites of women's health. The increasing politicization of nursing is a positive trend that has introduced a new perspective to health policy. Within a climate of cost containment through shifts to alternate models of health care, it is essential to the well-being of women that we urge attention not only to short-term cost containment, but to the long-term personal and health costs of reorganization. These efforts will be strengthened by research documenting the activities and circumstances of women as they attend to their own health needs and those of others.

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Acknowledgements

Nurses' Work:
Balancing Personal and Professional
Caregiving Careers

Margaret M. Ross, Elizabeth Rideout and Mary Carson

Quarante infirmières travaillant à plein temps et donnant également des soins chez elles se sont portées volontaires pour une étude qualitative sur les professions oeuvrant dans la prestation de soins combinés. Chaque répondante nota quotidiennement ses activités de soignante pendant deux périodes représentatives de 24 heures. Les infirmières furent interrogées avant et après avoir pris leurs notes. La plupart d'entre elles subissaient de fortes tensions liées aux soins, aussi bien dans leur vie professionnelle que dans leur vie privée. Elles étaient en général relativement satisfaites de leur vie (aussi bien privée que professionnelle) et trouvaient qu'elles maîtrisaient un peu mieux leur vie au travail que leur vie à leur domicile. Pour ce qui concerne les tensions ou les conflits auxquels elles ont fait allusion, les thèmes suivants sont revenus le plus fréquemment : des attentes élevées, le sentiment d'être déchirées entre deux mondes, de travailler isolément, et de mettre les bouchées doubles. Les avantages comprenaient la rémunération, la reconnaissance et l'estime de soi, les opportunités de croissance personnelle et de croissance familiale.

Forty full-time nurses who were also responsible for providing care to individuals in their private lives volunteered for a qualitative study of combined caregiving careers. Each respondent kept a diary of caregiving activities during two representative 24-hour periods, and was interviewed prior to, and after diary-recording. Most nurses experienced high levels of stress associated with caregiving in both their professional and private lives. In general, they were relatively satisfied with their lives in both spheres, and felt a slightly greater sense of control in their work lives than in their home lives. Regarding the tensions/conflicts they alluded to, the following themes emerged: an ethic of high expectation, feeling torn between two worlds, a sense of working in isolation, and working in overdrive. The rewards/benefits included remuneration, recognition and self-esteem, opportunities for personal growth, and opportunities for family growth.

The quality of nurses' work lives within a climate of health care reform characterized by down-sizing and fiscal restraint continues to be an issue of concern because of its ultimate effect on patient care. While traditionally research has focused on work as separate and distinct from family, there is increasing recognition of spillover effects, both positive and negative, in balancing personal and professional careers. The current study derived from concerns about the quality of nurses' lives in light of severe constraints that have resulted in a work environment that increasingly embraces an ideology of productivity, efficiency, and cost effectiveness. Such an ideology is not easily married with an ethic and ideal of care that permeates not only the

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professional, but also the personal lives of nurses. The vast majority of nurses, who are married and have children and other family responsibilities, begin their days in the informal sector by providing care to husbands and children, move into the formal sector where they render care to non-family members, and then return home to resume domestic obligations. The worlds of work and family interface in ways that are yet to be fully understood. Consequently, the purpose of this research was to more fully understand the experience of nurses whose personal and professional lives both centre on the provision of care to others. More specifically, the objectives were to investigate the subjective dimensions of the care that nurses provide at home and at work, the challenges and opportunities associated with such care, and the outcomes of balancing two careers that centre on the provision of care.

Literature Review

The literature addressing the process and outcomes of balancing personal and professional careers is rudimentary and derives primarily from studies designed to investigate work and well-being, the provision of formal and informal care, and role characteristics. In large measure, these studies are situated within the context of feminist and social science scholarship. Feminist scholarship points to the centrality of care in women's lives; the invisible nature of much of women's work; the relationship of this work to poverty, vulnerability, and disadvantage; and gender inequalities associated with the provision of care. Social science scholarship takes a role theory and stress and adaptation approach to analysis that focuses on role stresses and strains, role and inter-role conflict and role accumulation. Both bodies of literature point to the difficulties that women have in juggling multiple roles (Marshall, Barnett, Baruch & Pleck, 1990). Despite Parsonian distinctions between instrumental tasks and affective relations (Abel & Nelson, 1990), the provision of care is seen to involve love and labour, caring *for* while caring *about* (Graham, 1983; Ungerson, 1987; Waerness, 1984).

The Centrality of Caring

The literature is replete with evidence of the centrality of caring in women's lives. Gilligan (1982) noted that women's identity is defined in a context of relationship and judged by a standard of responsibility and caring. Through a process of socialization, girls and women assimilate the expectations and norms that surround the provision of care in our society. As a consequence, the provision of care not only shapes their private lives as daughters, wives, and mothers, but also their public lives as care providers and service users (Baines, Evans & Neysmith, 1991). Nursing has its roots in a maternal ethic of care that emphasizes service, dedication, and self-sacrifice – attributes that comprise the traditional attributes of women (Baumgart & Larsen, 1992).

Consequently, the provision of care assumes a heightened importance in the lives of nurses who are mandated to care both within the context of their families and their professions.

The Invisible Nature of Providing Care

It has been widely reported that the work of providing care is, in large measure, invisible (Baines, Evans & Neysmith, 1991; Finch & Groves, 1983). Distinctions are made between caring *for* and caring *about* (Dalley, 1988). The former refers to the instrumental and tangible tasks involved in providing care; the latter, to its expressive and affective dimensions. Despite these distinctions, there is evidence that the provision of care involves both caring *for* and caring *about* (Bowers, 1987, 1988). The lack of validation of the affective dimension of care obscures the work involved and reinforces the idea that it is natural for women to provide care. In a society that values paid work in the public sphere, women's care in the private sphere is so taken for granted that it has not been viewed as work, and has received little research attention. The provision of care in the public sphere, as in nursing, tends to remain invisible and undervalued, and the status of nurses who are responsible for such care is only marginally enhanced. Aspects of this invisible work include intuitive and holistic ways of knowing, cue sensitivity, discretionary judgment, and identification with and relatedness to patients (Fox, 1989). Daniels (1987) argued for a heightened visibility for the care that women provide as homemakers, mothers, and volunteers, not only for its economic value but for its contribution to a caring community.

Relationship of Caring to Disadvantage

Much of women's work, which is central to the maintenance of families and by extension society, remains unpaid. This undervaluing is also seen within the formal health care system. Nurses are seeing their jobs eliminated, expanded or moved from one work site to another (Glazer, 1988). Baumgart and Larsen (1992) have argued that, as with other women's work, the provision of care in nursing has been constrained by understaffing and the higher priority given to the more technical aspects of care. Despite a trend to view nurses as co-workers with physicians and team members, research demonstrates that nursing is subordinate to medical care (Edginton, 1989). This subordination is most vividly demonstrated by a salary differential that places physicians in a position of relative advantage. In addition, when compared with physicians and other health care workers nurses are in a subordinate position with respect to issues of autonomy and control over their practice (Fox, 1989).

Gender Inequalities

According to the literature, women clearly provide most of the needed care. A division of labour has evolved whereby women assume major responsibility for care and men take on the role of economic providers (Baines, Evans & Neysmith, 1991; Marshall, 1993). Although some men assume responsibility for the provision of care, their identities and opportunities are not structured and shaped by the same behavioral norms regarding care. The assumptions that men do and should have primary responsibility for providing care is not likely to be reflected in their own expectations, the expectations of those around them, or in policies and services. Within the health field, especially institutional-based health care delivery, nurses have little autonomy and decision-making power around issues related to health care, particularly at the administrative and policy level. Changing structures and the dominance of physicians and health care administrators render the position of nursing and the importance of nursing care even more invisible (Fox, 1989).

Role Stresses and Strains

Much of the literature centres around two theories that support different predictions about the effects of the work-family interaction for women (Valdez & Guter, 1987). On the one hand, role conflict proposes that competing demands and expectations by role senders exist for many working women as a consequence of the demanding and pervasive nature of women's home and family responsibilities. On the other hand, the conflict and overload arising from a multiplicity of roles can be overshadowed by the rewards of role accumulation. The nursing literature, in large measure, takes an approach that emphasizes the theoretical underpinnings of recruitment and retention. This body of literature focuses on situational and occupational variables such as education and training (Bartz & Maloney, 1986; Keane, Ducette, & Adler, 1985; Price & Mueller, 1981), professionalism and proletarianism (Coburn, 1988), job satisfaction (Attridge & Callahan, 1989; Dear, Wiseman, Minader, & Chase, 1982), stress, (Lobb & Reid, 1987; McCranie, Lambert, & Lambert, 1987), management styles (Taunton, Krampitz, & Woods, 1989; Duxbury & Armstrong, 1982), and age (Hansen, 1988). With few exceptions (McBride, 1988), little research has been devoted to examining how dimensions of nurses' lives at work spill over into their lives at home and vice versa.

Theoretical Perspectives

The current study was informed by the interpretive perspective in sociology and Hughes' (1971) concept of career, which distinguished between objective and subjective career. The interpretive perspective "emphasizes the human capacity to construct and share meaning and the human tendency to attempt to control, through symbolic interaction, situations in keeping with biograph-

ically meaningful intentions" (Marshall, 1979, p. 35). Hughes (1971, p. 137) defined objective career as "a series of statuses and clearly defined offices held throughout the life course, in which there are sequences of position, achievement and responsibility." Responsibilities for care in this study comprised objective dimensions of nurses' personal and professional careers. Hughes (1971, p. 137) defined subjective career as "the moving attributes in which people see their lives as whole and interpret the meaning of various attributes, actions and things that happen to them." Subjective career was conceptualized as feelings of satisfaction, stress, and control over the care they provided. The concept of career is useful because of its focus on objective and subjective reality as used in sociological analysis. In addition, the concept is congruent with the hypothesis that becoming a caregiver involves a status acquisition similar to other social statuses that are precipitated by socially recognized events, such as marriage, motherhood, and becoming a professional (Suiter & Pillemer, 1990).

Method

Study Purpose and Design

The overall objective of this study was to examine the experience of nurses whose personal and professional careers both center on the provision of care to others. Of particular interest were the feelings associated with providing care to others, and the perceived tensions and benefits that result from these combined roles. Personal interviews and diaries provided the data for analysis. Nurses were recruited to the study through notices posted in a central location at the two study sites: a 211-bed community general hospital, and a community nursing organization. Diversity of practice settings was sought to elicit a broad based understanding of professional care. Volunteers were screened to ensure they were employed in nursing on a full-time basis, and responsible for the direct provision of care to patients and to members of their own families. The response was enthusiastic: the quota of respondents was recruited to the study within five days of posting the notices.

Participants

Twenty nurses based in the community and 20 hospital-based nurses volunteered to participate in the study. The majority (*n*=32) were married and lived with their spouses. five nurses were separated or divorced and living with children for whom they were the primary caregivers. The three remaining nurses were single or widowed but living with elderly parents for whom they provided care on a daily basis. Their ages ranged from 25–64 with a median age of 40. Of the 37 respondents who had children, 26 had one or two, nine had three, and only two had four or more children. Eleven of these 37 nurses also

reported being responsible for the care of older parents or relatives. The amount of time per day reported in the provision of care at home ranged from 15 minutes to 9.2 hours, with a mean of 3.02 hours ($SD = 2.04$ hours). Such care was in addition to the hours of care provided at work. Respondents were experienced nurses who were in relatively stable professional positions: 32 had been in practice for more than 10 years; 28 had been in their current position for more than 4 years, and 10 of these nurses for more than 10 years. Nineteen respondents reported a combined family income of more than $70,000.00. Seven reported incomes ranging from $51,000.00 to $70,000.00 and 13 reported incomes from $31,000.00 to $50,000.00. Only one nurse reported an income less than $31,000.00.

Data Collection

Respondents kept a diary of the care they provided in their personal and professional lives. The researchers did not attempt to impose a standardized method of recording (for a fuller description of the use of diaries in the current study see Ross, Rideout & Carson, 1994). In recognition of the commitment associated with diary keeping and the potential for respondent fatigue, data collection was restricted to two 24-hour periods. Respondents selected their own method of diary keeping. They also decided on which days to record their diaries, with the proviso that these be as close to typical days as could be predicted in which both family and patient care occurred.

The diary was modelled on that used by Dressel (1990), employed a semi-structured format, contained six questions, and included one page for each hour of the day for a total of 48 pages. The first question asked respondents to describe the care they had provided in the previous hour. Such an approach allowed respondents to use their own definitions of the specific activities that were involved in caregiving rather than searching through a list of potentially irrelevant predetermined activities. This approach was congruent with the exploratory and descriptive nature of the study (Carr & Kemmis, 1986) and allowed for an understanding of care as perceived by the respondents and revealed through their responses. The second question asked about the purpose of providing the care, eliciting the cognitive processes surrounding caregiving or the thoughts respondents used to define and explain the situations they described. The third question asked respondents to describe the feelings they had about providing care, exploring the affective dimensions of caregiving. Questions 4 and 5 probed for other activities that respondents were doing along with the care they were providing, and any other activities they felt should be receiving their attention. These questions were designed to illustrate the context within which caregiving took place and the level of attention accorded to the act of caregiving. The final question provided respondents with the opportunity to evaluate the time period as stressful or

tension-producing, rewarding or pleasureable, neither or both. This question sought further elaboration of the context and an understanding of the consequences of caregiving that may not have been evident from the desciption of the situation itself.

Respondents also participated in face-to-face interviews immediately prior to and after diary keeping. During the initial interview, demographic data were gathered and the purpose and process of diary completion were explained. During the terminal interview, respondents reviewed any problems they had experienced with diary keeping and described how they decided what to include in their diaries. They also responded to single-item fixed-choice questions on a scale of 1 *(very little)* to 5 *(a great deal).* The questions asked were: "what is your level of satisfaction with your home life," "what is your level of satisfaction with your work life," "how much control do you have over your caregiving responsibilities at home," "how much control do you have over your caregiving responsibilities at work," "how much stress is associated with your caregiving responsibilities at home," and "how much stress is associated with your caregiving responsibilities at work." Single-item indicators asking for global ratings of a particular concept are congruent with the emphasis in nursing on wholism and individualism, and are known to provide acceptable psychometric properties (Youngblut & Casper, 1993). Respondents were also provided with the opportunity to comment more fully on their responses to these questions. finally, they responded to two open-ended questions: "What are the tensions and conflicts created for you as a result of balancing two caregiving careers" and "what are the rewards and benefits of combining two caregiving careers." Interview data were transcribed and entered into microcomputer files for analysis. Upon completion of the terminal interview, respondents received an honorarium in recognition of their substantial contribution to the study. This approach is typical of that used in other studies employing diaries.

Analysis

The diaries provided a detailed record of personal and professional care provided by 40 nurses over a period of two diary days, and generated a total of 1920 hours of information about the process of providing care (forthcoming in another paper) and the outcomes of balancing personal and professional careers that both center on an ideology of care.

The work of Berg (1989) provided direction for content analysis of verbatim data. The goal of analysis was that emergent categories and themes should reflect the meaning of messages provided by respondents and retain, as much as possible, the exact wording used in their comments. Data reduction involved coding and clustering of data. Data reconstruction and synthesis

involved identification and verification of patterns and themes. The unit of analysis included words, phrases, and sentences that respondents used to describe their experience. Initial coding involved a careful and minute reading of verbatim responses, which had been entered into the Ethnograph software package (Seidel, Kjolseth & Seymour, 1988), to determine tentative abstractions reflecting the data. Categories were formulated both deductively (for the six single-item questions) and inductively (for the two open-ended questions) by sorting abstractions into clusters that were judged as grouping together. Tally sheets were created to ensure the relevancy of the categories to particular questions and to a significant proportion of respondents. Two coders reviewed the data to ensure consistency of analysis and when disagreement occurred, a third coder was consulted. Although this process is considered by some reseachers to violate the process of induction (Morse, 1994), in the current study, discussion continued until consensus was achieved regarding the analysis. As coding became repetitious, level of specificity changed and patterns and themes were identified from the coding categories. Respondents' own words were used to generate patterns and themes. After patterns and themes were identified, the data were once again read to confirm or verify that each pattern and theme reflected the experience of respondents. Illustrative comments reflecting each theme were then extracted from the data for reporting purposes. It was important to ensure that comments selected were illustrative of respondents' experience. Consequently, once again, two coders reviewed the comments to determine that they reflected the pattern or theme, and when disagreement occurred a third was consulted to achieve concensus.

Findings

Subjective Dimensions of Nurses' Lives

The subjective dimensions of nurses' lives were reflected in the six single-item interview questions inquiring about the level of satisfaction, stress, and control they experienced providing care at home and at work. The results were pooled according to the subjective ratings of these variables as *low* (1 or 2) or *high* (4 or 5) and respondents were assigned to either a high or low group. Additional data were derived from respondents' verbatim comments explaining more fully their responses to these six questions.

Level of satisfaction at work. Twenty-five respondents reported a high level of satisfaction with their work lives. They felt confident and competent with respect to the provision of care, and derived pleasure from patients and the challenges and rewards of their work, as reflected in the following comments: I feel comfortable and know what I need to know to carry out the job well." "Each of my days is different and a challenge." " When people are very appreciative of the care I provide, I feel as if I have made an important contribution." Respondents reporting a low level of satisfaction (*n*=5) re-

ported interpersonal conflicts with supervisors, uncertainty with respect to their jobs in the current economic climate, and dissatisfaction with the organizational dimensions of their work lives. Comments reflecting these views included: "Changes in administration at work are creating difficulties for me." "Things are much more demanding now than before...my patients are much heavier... supervisors are not helpful." "I'm working more weekends and shifts."

Level of stress at work. Respondents reporting a high level of stress at work (*n*=21) spoke of the conditions of their work as stressful, including dealing with crises, death and dying, and constant change. They also spoke of bureaucratic constraints, inflexible organizational policies, impending budget cutbacks, resultant layoffs, and changing organizational configurations, as stressful. Also reported as contributing to a higher level of stress were relationships of conflict with supervisors, pressure to increase productivity, and the need to negotiate care with others, including home care personnel and physicians. Respondents who reported a low level of stress (*n*=8) described feeling confident in their knowledge of patients and related clinical situations, and trusting in their ability to make correct decisions vis-à-vis the provision of care.

Level of control at work. Eighteen respondents evaluated their level of control at work as high. These nurses spoke of the importance of being flexible and able to adapt to the unexpected. Additionally, they referred to the importance of pacing themselves, developing more confidence in their decision-making abilities with increasing experience, and having others (peers and colleagues) as backups and resources. One community-based nurse spoke of having to learn to trust other nurses so that she could feel confident in turning over patients to their care. She stated: "This trust helps me feel in control." Others spoke of trying to help patients assume responsibility for their own care as a method of being in control. Only two nurses reported that they experienced a low level of control at work. They spoke of the pressures associated with increasing expectations around productivity, for example, increasing caseloads on the part of a hospital-based nurse, and decreasing amount of time for direct patient care on the part of a community-based nurse.

Level of satisfaction at home. Respondents reporting a high level of satisfaction with their home lives (*n*=13) referred to their husbands as very supportive, understanding, and helpful. Additionally, they spoke of the contribution made by other members of their families including parents, parents-in-law, and children. Descriptions of their family situations created the impression of people who worked together, almost spontaneously, without requiring a great deal of direction or organizing on the part of respondents. For example, one nurse stated: "I come from a closely knit family that

provides lots of support... everybody does something...is responsible for their share at home." Those who reported only a low level of satisfaction with their home lives ($n=8$) described a state of disorganization within their families. This disorganization stemmed, in some instances, from difficult events such as a death in the family, financial reverses, or unemployment on the part of husbands; in other instances, from problematic relationships with husbands and difficulties with children. The following comments provide a sense of the complexity of one nurse's life: "I am working on my bachelor's degree, we are renovating the house, both of my parents-in-law have recently died, my husband lost his job six months ago and only recently was hired by a company that requires that he travel a great deal. I am currently on my own and finding it difficult." Although this account can in no way be viewed as typical, it sheds light on the level of complexity involved, for some, in combining work and family lives.

Level of stress at home. Respondents reporting a high level of stress in their home lives ($n=26$) spoke of problematic relationships with husbands and children, situational crises such as illness and/or death in the family, financial constraints, and the heavy care required by young children and older and disabled parents. Those reporting only a low level of stress at home ($n=8$) spoke of the benefits of support from, and clear and frequent communication with, husbands and children, and good health within families. Additionally, these respondents were able to lower their standards with respect to the up-keep of their homes. One nurse's comment exemplified this finding: "The house doesn't bother me any more...I don't feel guilty that it isn't sparkling clean all the time...it has become everybody's responsibility." Another nurse commented: "I've learned that I can't do everything and I don't try any more."

Level of control at home. Respondents reporting a high level of control at home ($n=14$) described "letting go" of high expectations related to house-work, and were able to set priorities, make choices, and be flexible with respect to household routines. A large component of control apparently related to housekeeping activities and household routines. One respondent who reported a high level of control at home stated: "I can say no...the world doesn't revolve around me...everyone can manage." Another suggested: "Do things as they come up...and hope they get done...if not, they'll get done tomorrow." Still another said: "...the dirt gets left behind...but it doesn't bother me...I can walk out and leave it and it doesn't worry me." In contrast, those reporting only a low level of control at home ($n=9$) spoke of high expectations and a perceived feeling of lack of support with respect to house-hold management. One such nurse commented: "I'm a very meticulous person and like things done a certain way...my expectations are too high." Another remarked "...if I don't do the chores, they don't get done...my husband takes no initiative whatsoever...we also have different standards of

housekeeping." The presence of young children and babies in the home also contributed to the sense of a low level control.

Balancing Careers: Tensions and Conflicts

To further explore nurses' experiences of caregiving, data from the two open-ended questions inquiring about the balancing of personal and professional caregiving careers were combined and analyzed. Regarding tensions and conflicts, the emergent themes included an ethic of high expectation, feeling torn between two worlds, a sense of working in isolation, and working in overdrive.

Ethic of high expectation. Respondents described trying to do both jobs well, perceived that their expectations were at times unrealistic, and felt guilty about aspects of care they were unable to carry out. Increasing acuity of patients' situations and budget cutbacks and layoffs in their own and their families' work lives caused intensification of nurses' work. Conflict arose with respect to the expectations of husbands and supervisors, and respondents needed husbands and children to be more sensitive to their responsibilities both in and out of the home. Respondents also felt burdened by having so many people depend on them, and recognized that they needed to decide priorities, yet spoke of finding it difficult to do so. As one respondent stated, "I can't do it all perfectly."

Feeling torn between two worlds. The great number and variety of responsibilities associated with conducting of two careers caused respondents to feel torn between two worlds. Respondents felt obligated to provide care to both their families and patients. They felt particularly conflicted when they had to make alternative care arrangements for their sick children. Furthermore, they assumed responsibility for the care of extended family members, friends, neighbours, and colleagues. Additionally, many also had responsibilities related to the pursuit of a university degree and participation in community, church, and cultural activities. Respondents were very busy individuals. The provision of care, while a central feature of their lives, was only one of the many dimensions of their lives. The following comments exemplify the notion of feeling torn between two worlds: "There are many times when I want to be in two places at once." "I feel pulled in so many directions." There is not enough of me to go around."

A sense of working in isolation. Respondents described situations that suggested they had a sense of working in isolation. This feeling was intensified by the fact that nurses had few opportunities to interact and develop collegial relationships with each other (discussing issues related to patient care as well as issues of a more personal nature) and by the fact that the hierarchy impeded communication with those responsible for policy development and imple-

mentation. Husbands and children were seldom mentioned as active partici-
pants in the care provided at home. Rather, the major impression was that
family members were receivers of, rather than participants in, care. Even
when families played a more active role, such involvement had to be orches-
trated by delegating, organizing, and supervising – activities that felt very
much like "more work" for respondents.

Working in overdrive. This theme was exemplified by comments such as
"there is not enough time...I am always on the run," "I need more time...there
is always more to do," and "I often wonder how things will all get done."
Nurses spoke of bringing their work home and always trying to catch up.
Working evenings, and nights, and weekends interfered with regular activities
at home. Nurses reported feeling preoccupied, in the centre of things with
everyone expecting them to solve problems, and not having any time for
themselves. Nurses who worked in overdrive also experienced conflict
between their desires to carry out the more affective dimensions of care and
the requirements to work more efficiently and cost effectively. Although they
valued being with, listening to, and supporting patients and families (invisible
aspects of care), such dimensions of care were often neglected because time
available for carrying them out was limited. Working in overdrive resulted in
spillover between personal and professional lives.

Balancing Careers: Rewards and Benefits

The rewards and benefits of combining two caregiving careers were both
monetary and non-monetary, including recognition and self-esteem, oppor-
tunities for personal growth, and opportunities for family growth. Financial
rewards were reported by the majority of respondents. For these nurses,
combining two careers was not optional; they needed to work outside the
home. One nurse stated: "I am a single mother who looks after her mother as
well...I have no option...I need the money." Nevertheless, some respondents
received satisfaction from being in control of their own financial resources, or
being able to provide extras for their families. This sense of control contrib-
uted to feelings of esteem and self-worth. For example, one respondent stated:
"I like being a breadwinner...having my own money and making decisions
about how I spend it adds to my sense of competence." Another said that
having her own money gave her a sense of freedom and self-sufficiency.

Feelings of recognition and self-esteem also came from respondents' real-
ization that they were making a valuable contribution to society. One stated
that combining two careers made her feel like "a functioning and valuable
member of society." Respondents also described how combining careers
provided their lives with a focus, increased their level of independence, and
contributed to their self-confidence. One commented that the care she

provided as a nurse made her feel effective and increased her self-respect. Another stated: "I know that I can function by myself if something were to happen to my husband." Respondents also spoke of the positive responses of patients and, to a lesser extent their own families to their work. One said: "It makes me feel good to know that patients value the care I have to offer." Another reported that her family was proud of the fact that she was a nurse.

Opportunities for personal growth were also viewed as benefits of balancing personal and professional careers. Respondents spoke of learning from the experiences of their patients, finding self-fulfilment, developing a broader perspective, and the contribution that their careers made to their relationships with spouses and others. For example, one nurse stated "I have more to bring to my relationship with my husband...it [combining careers] makes me a more interesting person." There were also comments that demonstrated the effects of one career on the other, such as: "Community nursing makes your life broader and helps you in your own personal life." Another respondent said: "I now have a better understanding of older people, which helps me with the emotional issues within my own family."

Opportunities for family growth were also viewed as outcomes of combining personal and professional careers. Many comments in the data indicated that the combining of two careers encouraged the development of independence in children. For example: "It's healthier for the children...they become more adaptable," and "Children become more socially independent and able to fend for themselves." Respondents felt that they were helping their children to assume some responsibility at home, and setting a good example for their children by allowing them to see that mothers were working and contributing to society.

Discussion

Caregiving has been identified as a central and common feature of the personal and professional lives of many women. While much is known about the instrumental and affective dimensions of such care, less is known about the experience of balancing personal and professional careers that both centre on an ideology of care. The current paper explored this phenomenon among full-time nurses who were also caregivers in their homes.

Although respondents were relatively satisfied with both their private and professional lives, more women reported higher levels of satisfaction with their work lives than with their home lives. Their verbatim comments suggest that feelings of control are important to feelings of satisfaction at home and at work. Confidence and competence, involvement in decision-making, and a

sense of flexibility in workplace all contributed to a positive work experience. Bureaucratic constraints, inflexible policies, feelings of uncertainty regarding the future, and interpersonal conflict were all reported by nurses experiencing higher stress, and lower satisfaction and control in the workplace. Husbands and children who were supportive and helpful made home life more positive for respondents. Open and frequent communication among family members, setting realistic expectations, and having good health were all identified as specific components of a satisfactory home life. Difficulties such as unemployment of the spouse, death in the family, and financial constraints all contributed to low satisfaction with life both at home and at work. Unattainable expectations for self, spouse, and other family members contributed to more negative feelings. Professional caregiving is also associated with remuneration and periodic performance appraisals, which may in themselves be sources of satisfaction.

Limitations

In the current study the small sample size and non-random nature of attaining respondents precludes generalization of findings to a larger population of nurses. Nevertheless, findings should be regarded as transferable, in the sense that it is likely that other nurses who combine personal and professional caregiving careers will also identify similar experiences and response to these experiences. Furthermore, the richness of this type of data yields fruitful insights into the complexity of having two careers that centre on the provision of care.

Implications

The general impressions derived from the current study are that women who provide care in both their personal and professional lives do cope, and in many cases, manage well. However, ways to enhance the quality of nurses' lives, both at home and at work, were identified.

Nurses need to find ways of having both private and professional lives without exploiting themselves and others. In large measure, they have internalized an ethic of high expectation which, at times, serves to their disadvantage. By letting go of unrealistic expectations for care at home and at work, nurses may come to accept the notion that they can't do it all perfectly. It seems crucial that they find time for themselves in the form of recreation, leisure, and cultural activities at home , and lunch and leisure breaks at work. Accepting the assistance offered by husbands and families, and asking for help if it is not offered might reduce the demands of household and family maintenance. Furthermore, where economically feasible, nurses might consider increasing the use of paid help within their homes rather than feeling that they must do all the work themselves.

Husbands and children need to play a bigger role in family and household management. Help from husbands in particular, and children, where appropriate, to take the initiative to do what requires doing around the home would be viewed positively. In this way, nurses might feel less responsible for orchestrating their participation, an endeavour, that to them feels very much like more work. Husbands and children, particularly older children, need to be more knowledgeable about and more sensitive to the work requirements of nurses. There are times when nurses need to talk and have the nature of their work outside the home more fully understood and appreciated by their families.

An improvement in the quality of nurses' work lives will have a spillover effect on their home lives. Employers need to facilitate the combining of personal and professional careers that both centre on the provision of care to others. For example, health care organizations might benefit from developing employee assistance programs that meet the needs of employees with heavy and/or unexpected caregiving responsibilities at home. Employers of nurses also need to recognize and value interpersonal expertise as going hand in hand with technical expertise. Nurses value spending time with patients, listening to them, and talking with them. However, they are often unable to carry out these more cognitive and affective (invisible) dimensions of nursing, resulting in frustration about the quality of care they provide. Collaboration should help to reduce nurses' sense of working in isolation, and physical space and time for nurses to meet with each other are crucial. finally, nurses need to feel confident about their level of nursing knowledge and skill. Continuing education and in-service programs offered at the organizational level were suggested as ways to maintain their competence in a health care system where change is the only constant.

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Acknowledgements

Mothers of Children with Chronic Conditions: Supportive and Stressful Interactions with Partners and Professionals Regarding Caregiving Burdens

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Quatre-vingt-dix mères ont évalué les différentes sources et types de soutien social qui les ont aidées par rapport aux diverses exigences de soins pour un enfant atteint d'une maladie chronique. Les données qualitatives ont été collectées au cours d'entrevues à domicile de mères qui ont des enfants souffrant de diabète, de spina-bifida ou de fibrose cystique. Pratiquement toutes les mères ont décrit les exigences de soins primaires comme étant directement liées à la maladie de l'enfant, à savoir les soins physiques, les soins de santé liés à la maladie, et le développement psychologique et social de l'enfant. De nombreuses mères ont également indiqué qu'elles n'avaient pas assez de temps pour satisfaire à leurs propres besoins secondaires, pour remplir leur rôle dans la famille et au sein de leurs relations, et pour leurs activités de mère en dehors du foyer. Les mères ont fait état de lacunes dans le soutien offert pour le fardeau de soins particuliers. Elles ont rencontré des interactions stressantes avec leurs partenaires et surtout avec les professionnels de la santé.

Ninety mothers appraised the specific sources and types of social support they received in relation to specific types of demands of caring for a child with a chronic condition. Qualitative data were collected during home interviews with the mothers of children with diabetes, spina bifida, or cystic fibrosis. Virtually all of the mothers described primary caregiver demands that were directly related to the child's condition, such as physical care, health care in illness situations, and the child's psychological and social development. Many mothers also reported secondary demands related to their own needs, family roles and relationships, and the mother's activities outside the home. Mothers experienced gaps in the support provided for specific caregiving burdens and encountered stressful interactions with their partners and health professionals in particular.

An estimated 31% of children are affected by chronic conditions (Newachuk & Taylor, 1992). Increasingly, their families have become the primary caregivers, even for children who require very complex care (Desquin, Holt & McCarthy, 1994). Although both parents share the emotional impact of the child's condition, most caregiving is provided by mothers (Anderson & Elfert, 1989; Kazak & Marvin, 1984). Such mothers report the physical and psycho-

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logical strain of caring for their children at home (Havermans & Eiser, 1991; Patterson, Leonard & Titus, 1992), and are at increased risk for health problems such as depression, anxiety, loneliness, and role strain (Florian & Krulik, 1991; Kronenberger & Thompson, 1992; Miller, Gordon, Daniele & Diller, 1992; Quittner, DeGirolamo, Michel & Eigen, 1992; Thompson, Gustafson, Hamlett & Spock, 1992; Vandagriff, Marrero, Ingersoll & Fineberg, 1992). Psychological and social variables such as social support influence women's mental and physical health (Maguire, 1991; Rodin & Ickovics, 1990; Sorensen & Verbrugge, 1987). Social support has an impact on health status, health behaviour, and health services use (Bloom, 1990; House, Umberson, & Landis, 1988). Although support is a key determinant of health and mechanism of health promotion (Rootman & Raeburn, 1994), very little work has been done to identify the nature of social support that mothers experience with respect to particular caregiving burdens. Therefore, the purpose of the current study was to describe the sources, types, and appraisal of social support that mothers received in relation to specific types of demands of having a child with a chronic condition.

Conceptual Framework

The study was based on a conceptualization of social support as a coping resource or source of assistance in coping with stressful situations (Folkman, Chesney, McKusick, Ironson, Johnson & Coates, 1991; Thoits, 1986) and, in particular, the burden associated with the care of children with chronic conditions. Social support, like other coping resources, can lessen the impact of chronically stressful conditions and acute stressors on the health of the caregiver. It can have direct, indirect, and interactive effects on physical and mental health (Bloom, 1990; Dunkel-Schetter & Bennett, 1990; Eckenrode & Gore, 1990; House et al., 1988) For the purposes of this study, social support was defined as a dynamic social process between people in relationships, and consisted of emotional, affirmational, instrumental, and informational assistance provided by family, friends, neighbours, co-workers, indigenous lay helpers, volunteers, self-help mutual aid groups, and health professionals (House et al., 1988).

It is important to distinguish the psychological sense of support from the actual expression and exchange of support (Gottlieb & Selby, 1989): The former may be perceived as potentially available from the social network; the latter, actually delivered and received. Perceived support influences how supportive transactions are interpreted and remembered (Heller, Swindle & Dusenbury, 1986; Lakey & Cassady, 1990). Received support is the recipients' view of support that comes from others (Sarason, Sarason & Pierce, 1990).

Interactions with others can be appraised as stressful or supportive (Coyne & Downey, 1991; Coyne, Wortman & Lehman 1988; Gottlieb & Selby, 1989). Most social relationships have both elements because of conflict and obligations for reciprocity (Buunk & Hoorens, 1992; Rook, 1990). It could be useful to construe negative interactions as interpersonal stress (Coyne & Bulger, 1990; Shinn, Lehmann & Wong, 1984). Conflicted support differs from a negative social relationship in that providers offer at least one positive form of support (Barrera & Bacash, 1990). Even successful intimate relationships involve some conflict between partners, including lapses or miscarried support efforts (Coyne et al., 1988; Sarason, et al., 1990), and failed support modes or functions (Eckenrode & Gore, 1990). Reports of low support may often signify the presence of a negative conflictive relationship (Coyne & Downey, 1991). In the current study, the terms conflicted support, absent support, and miscarried support were used to classify problems experienced with support.

Literature Review

Women are more likely than men to be caregivers of relatives (e.g., Lee, 1992; Stoller, 1992; Walker, 1992). A prospective, longitudinal study of women following childbirth revealed that they assume the majority of household responsibilities and child care despite employment, yet receive little emotional support from spouses and others (Gjerdingen & Chaloner, 1994). Tiedje and Darling-Fisher (1993) report that fathers are more likely than mothers to engage in play activities with children.

Mothers' needs for support in caring for ill children have not been studied in depth, despite research that has concluded that social support contributes significantly to such outcomes as the child's behaviour (Hamlett, Pellegrini & Katz, 1992), management of the child's illness (Gibson, 1986), maternal satisfaction (Fagan & Schor, 1993), and ability to manage other family responsibilities (Miller & Diao, 1987). Mothers of disabled children ranked social support as the most important need in managing their child's care (Bailey, Blasco & Simeonsson, 1992). While there are a number of reports suggesting that mothers of children with chronic conditions are at risk for poor mental or physical health (Fagan & Schor, 1993; Florian & Krulik, 1991; Kronenberger, Thompson, 1992; Stein & Jessop, 1984; Thompson, Gustafson, Hamlett & Spock, 1992), little is known about the role of social support in facilitating the mother's adjustment (Eiser, 1990).

Some coping strategies that mothers have reported are dependent on their interactions with family members, friends, health professionals, and other associates. These include seeking information, confiding in others, and seeking guidance (Damrosh & Perry, 1989; Gibson, 1986; Ray, 1988). Several researchers have reported that the major types of support needed or received

by mothers of children with chronic conditions are informational and emotional support (Bailey, Blasco & Simeonsson, 1992; Barbarin, Hughes & Chesler, 1985; Brenner, Norwell & Limacher, 1989; Damrosh & Perry, 1989; Gibson, 1986; Havermans & Eiser, 1991; Malone, 1988; Ray & Ritchie, 1993). Parents have also identified the importance of and variation in the quality of the support that they received from spouses and health professionals (Bailey, Blasco & Simeonsson, 1992; Elliott, 1991; Fagan & Schor, 1993; Havermans & Eiser, 1991; Ray, 1988), and sought support primarily from their spouses (Konstantareas & Homatadis, 1989; Van Cleve, 1989). Marital quality has been linked to reduced maternal depression (Kronenberger & Thompson, 1992; Quittner, et al., 1992). A study by Johnson, Hobfoll and Zalcberg-Linetzy (1993) indicated that satisfaction with social support behaviour by a spouse is mediated by intimacy and indirectly generated by the spouses' knowledge about social support behaviour. However, some studies revealed that parents had conflicting ways of coping that prevented them from gaining mutual support (Gottlieb & Wagner, 1991), perceived decreased spousal support as the child's hospitalizations increased (Barbarin, Hughes & Chesler, 1985), and experienced high role strain related to their spouses' absence and unhelpfulness with care (Quittner, DiGirolamo, Michel & Eigen, 1992). Furthermore, parents have reported inadequate support from health professionals (Chesler, 1991).

Woods, Yates, and Primono (1989) reviewed the support of families of the chronically ill and revealed that little attention has been given to appropriate sources of support, the potential negative effects of support, and the possibility of conflict and indebtedness. Studies have typically neglected pertinent factors such as the appropriateness of support for caregiving burdens and supportive and unsupportive interactions involving lay persons and professionals. The current study therefore included an intensive examination of the types of support received from specific sources pertinent to specific burdens, and the mothers' appraisal of that support, with particular attention to interactions with partners and professionals.

Research Questions

The following research questions guided the study: What are the sources and types of support that mothers of children with chronic conditions receive in relation to specific types of caregiving burden, and how appropriate are they? What are the stressful and supportive interactions that mothers of children with chronic conditions experience with their partners and health professionals?

Method

Sample

Approval for the current study was obtained from the university and hospital ethical review boards. Qualitative data were collected during home interviews with 90 mothers of children who had spina bifida (n=30), diabetes (n=30), or cystic fibrosis (n=30). These conditions entail different degrees of visibility, mobility, and cognitive ability for the child, and different types and extents of caregiving burden for the mother. A sample size of 90 is sufficient to permit comparisons across illness groups, to reflect different ages of children, to capture the diversity of types of burdens and types, sources, and appraisals of support, and to describe the relationship between specific types of burdens and specific types and sources of support. The mothers were randomly selected from the population of children who were being seen for assessment and treatment of their chronic conditions at a tertiary level children's hospital. Within Nova Scotia, among children less than 17 years old who are seen at the hospital clinics, there are 265 children with diabetes, 90 children with cystic fibrosis, and 160 children with spina bifida.

All mothers who participated were English speaking; their children were less than 17 years old and cared for at home with only periodic hospitalizations for treatment or investigations; and all families lived within a two-hour radius of the city. Ten mothers refused to participate and gave their reasons for refusal as family stress, time constraint or disinterest.

The ages of the mothers ranged from 23 to 53 years ($M = 35.3$ years); those whose children had diabetes were significantly older ($M = 38.8$ years) than the other mothers. Eighty-one percent of participants were married, 8% divorced, 4% single, 2% separated, and 4% cohabitating. Sixty-seven percent were employed at least part-time outside the home. With the exception of the mothers of children with diabetes, the majority had no post-secondary education. Seventy-one percent of mothers had more than one child. Nearly one-quarter (23.3%) were also dealing with the health problems of other family members. Eighty-four percent of the fathers were employed, and 66% had some post-secondary education.

The ages of the children ranged from 1 to 17 with a mean of 9 years. Fifty-one percent of the children were male and 49% were female. The average time elapsed since diagnosis was 6.4 years. The diabetic group was significantly older ($M = 12$ years) and had been diagnosed more recently ($M = 5$ years).

Data Collection

During the interview each mother was asked to describe her current caregiving experience on a typical day and during a recent acute illness of the child, and to describe the impact of her child's care and functional capacity on her own activities and those of the family. Interviewers asked the mother to identify who provided support, what support was provided, and whether this was helpful in managing each situation she described. Thus, this study focused on received support. For example, the questions about a recent illness invited the mother to:

> Tell me about the last time your child was ill/in the hospital. How did the episode go? How did the episode affect your family? How did you feel during the episode? Who provided support? What did they do? Was anyone particularly helpful or did any one make you feel better? Was anyone involved too much? Was anyone not involved enough? Did anyone leave you feeling upset or make matters worse?

The semi-structured interview guide also included probes for the mothers' appraisal of positive and negative interactions with their spouses/partners and health professionals. In the final question, mothers were invited to comment on "other kinds of support that might be helpful to mothers who are caring for a child with a chronic condition" (i.e., support needs).

The average length of the audiotaped interviews was one hour. The tapes were transcribed verbatim and the transcripts subjected to content analysis. The unit of analysis was any response from the mother that related to her current experience in caring for her child and that was beyond the usual care required for a healthy child. The unit changed when the content of the discussion changed. Each unit was coded for content related to primary burden (physical care or condition, illness or health care situation, psychological or social development), secondary burden (maternal psychosocial needs, maternal external roles, family relationships and activities, etc.), source of support (spouse, family, friend, etc.), type of support (emotional, informational, instrumental, affirmational, and the specific types of each), and appraisal of support (helpful, reciprocal, absent, miscarried, conflicted). Only manifest content was coded. The category system was based on previously reported types of burdens and supports, and the conceptual framework of social support used for the current study. In addition, the data were scrutinized to assure that the category system was both exhaustive and mutually exclusive of all the interview data pertaining to current demands. The system was assessed for content validity by the research team and an external expert on social support. The content analysis was completed by a research assistant and the project coordinator, in collaboration with and following training by the principal investigators.

To assure that the coding was as free from bias as possible, and that it could be replicated by other researchers (Berg, 1989; Holsti, 1968; Wilson, 1985), the reliability of unitizing the transcripts and coding the units was assessed by checking inter-rater and intra-rater agreement of the independent coders. Analysis commenced only after 80% agreement between the coders was achieved. Reliability was re-assessed twice during the analysis period to assure that agreement was maintained at 80%. To assure that no respondent's experience could skew the results, each reference to any burden category or support category in relation to that burden was counted only once per interview. Once coded, the data were analyzed using Ethnograph (Seidl, 1988). Frequencies of mothers' discussions of burdens and sources and types of support were compiled and then a detailed analysis examined the sources, types, and appraisal of support in relation to each burden.

Findings

The data from the three illness groups were analyzed separately and compared. The only significant differences between the illness groups were in the demographic characteristics (i.e., age of diabetic children and mothers, and educational level of diabetic mothers); there were very minimal differences in reports of either burden or support. For these reasons, and as a non-categorical approach to the study of responses to chronic illness has recently been recommended (Perrin et al., 1993), the data were pooled.

Burden and Related Support

The mothers' stories clearly illustrated the pervasive impact of the child's condition on the mothers' and families' lives, and showed that the mothers experienced little social support in relation to those demands. The mothers used the terms "burden" and "demand" interchangeably. Virtually all of the mothers described primary caregiver demands such as physical care (100%), health care in illness situations (92%), and fostering the child's psychological (89%) and social (82%) development.

Many mothers described the rigorous, time consuming, and unrelenting daily regime of treatments and management of symptoms. The mother of a child with cystic fibrosis described the demands: "Continuous, everyday, doing two aerosols every day. I stop and think how it must be nice to feed your child and then you don't have to worry no more until snack time and go to bed." For some, however, this care had become routine. Although some of the older children were involved in their own care, this did not appear to lessen the mothers' ongoing vigilance or ultimate sense of responsibility. During their child's most recent episode of illness, they assured that information from health professionals was correct, dealt with the system, advocated

for the child's health care, or arranged appointments. One mother described her experience as advocate for her child's care:

> The doctor came down and said "I hear you kicked up a stink down here today." And I said, "yes I did," And he said "well, you did right because... you know her more than they do." And after that everything was fine. Then, I think it took that, they respected me.

Ninety-four percent of mothers found that they lacked time to meet their own needs; they described fatigue, and the need for "me time," respite, or time to maintain their own health. Eighty-nine percent of mothers also described the impact of the child's care on family roles and relationships and the mother's own activities outside the home including employment, volunteer work, friendships, and social functions. Half of the mothers referred to the impact on homemaking (51%) and the relationship with their partners (50%). One mother of a diabetic child described her wish to "sleep in for just one day. You don't realize how much of a pain it is and how much it gets on your nerves to have to get up every morning and fight with a child to take needles and eat her breakfast." Other mothers experienced social isolation and needed to have someone listen to them. Many respondents described the pervasive nature of the child's condition; everything that the family did revolved around the child's needs. Trust in other caregivers was a major issue. As one mother of a diabetic child indicated, "If my husband was to go back to sea, it means that I would have to quit my job...I would not trust him [my child] to anybody else." Many described the considerable effort that it took to arrange an opportunity to get out of the house.

Although many types and sources of support were identified, mothers experienced considerable isolation in the management of their childrens' illnesses. They also perceived gaps in the availability of peer and health professional support, and revealed that their spouses differed in their abilities to cope and provide support. Almost all respondents referred to their partners (98.9%), immediate family members (94.4%), and health professionals (94.4%) as the key members of their support networks. Many women also discussed support from friends (85%) and illness peer groups (76.7%). All mothers received some form of emotional, informational, instrumental/practical, and affirmational support. However, the latter two were discussed less frequently than the first types of support. The most commonly mentioned forms of support functions were listening (96.7%), understanding (83.3%) (emotional), child care (97.8%) (instrumental/practical), oral explanations (73.3%) (informational), and feedback regarding the child's condition (64.4%) (affirmational).

The types and sources of support were somewhat different depending on the nature of the demand, but specific sources and types of support were lacking for all types of demands. Although partners were the most frequently cited source of support, they typically provided only emotional (e.g., listening) and instrumental support (e.g., caring for the chronically ill child). Health professionals offered support in relation to only physical care and health care demands. At least 20% of the mothers discussed sources and types of support for five burdens (physical care, health care encounters, psychological/cognitive development, personal needs, outside activities). In several cases, these interactions were appraised as stressful.

Support Related to Physical Care (Primary Burden). The support received from family (58.9%), partners (55.6%), and friends (24.4%) was almost exclusively instrumental, in the form of helping with the physical care of the affected child. Twenty-eight percent of the mothers who referred to instrumental support from their partners reported that it was stressful because of absence or conflict. The bulk of support from health professionals was informational (31%) and affirmational (21%); no mothers described receiving any emotional or instrumental support with respect to the child's physical care. Only two types of informational support were provided by health professionals: oral explanations about the child's condition, treatment, risks and care management, and suggestions of alternate ways of doing things. Some mothers talked about affirmational support in the form of feedback about the mother's caregiving. One new mother of a child with spina bifida recalled that the public health nurse would call to reassure her that "I was doing a good job ...just for support and just to make sure things are going well." Less than 40% of the mothers discussed support from health professionals and only 56% received help from their partners with respect to this predominant burden.

Support Related to Health Care (Primary Burden). Although the major health care demands faced by these mothers, (e.g., dealing with the health care system and advocating for their children) could require informational and emotional support, these types of support were seldom reported. They were received from only two sources: health professionals and partners. Health professionals provided some aspect of all four types of support: practical/ instrumental (34.4%), emotional (25%), informational (23.3%), and affirmational (10%). Nevertheless, a significant proportion of the mothers appraised informational (14%), instrumental (13%), and affirmational (12%) support from health professionals as stressful, either because it was absent or inappropriate. One mother of a child hospitalized with cystic fibrosis said:

> The parents need to be told what is going on. If you are not there to ask you just don't get the information and that's really too bad... before I got to speak to a [health professional] it was 7 or 9 days...so the communication needs to be worked on.

When the children were ill or hospitalized, partners provided only one type of support: care of the chronically ill child. The mother of a child with spina bifida described her husband's support during the child's hospitalization: "He came to the hospital and he'd tell me to go and do anything. He would take [child] for walks and, you know, be with him." Only 27% of the mothers reported receiving practical support; it was appraised by 4% as stressful, and was not mentioned by 69% of the mothers.

Support Related to Child's Psychological/Cognitive Development (Primary Burden). Mothers reported that teachers (31%) and partners (13.3%) provided support related to the child's psychological and cognitive demands. The only type of support identified was instrumental (care of the chronically ill child), and less than one-third of the mothers reported receiving it from any source. Further, many other types and sources of support needed to help mothers deal with their child's behaviour and psychological development were lacking.

Support Related to Mothers' Personal Needs (Secondary Burden). Several mothers reported that their personal needs were supported by their partner (41%), friends (30%), and immediate family (24%). These individuals provided support primarily by expressing understanding and listening. For the most part, mothers perceived that these types of emotional support were helpful. However, their sources of support were limited. Only 16% of the mothers reported that they received practical support from their husbands, through care of the chronically ill child. Mothers also reported limited sources of emotional support. Furthermore, other types of emotional support, such as the opportunity to share with others, to have a companion, and to be comforted, were not mentioned. Many mothers described a persistent sense of isolation.

Support Related to Maternal Activities Outside the Home (Secondary Burden). Some mothers reported that when they participated in activities outside the home care for the ill child was provided by husbands (24%), immediate family (30%), friends (23%), and sitters (15%). Child care was the only type of support that mothers discussed in relation to this demand. Although nearly 68% were employed outside the home, many received little assistance with housekeeping activities or any other relief.

Details of the specific sources, types, and appraisal of support related to physical care of the child, health care of the child, psychological/cognitive development of the child (primary burdens), personal needs of the mother, and the mothers' roles outside the home (secondary burdens) are being published elsewhere (Ritchie, Stewart, McGrath, Thompson & Bruce, in preparation).

Stressful and Supportive Interactions with Partners and Professionals

Supportive Interactions. Supportive interactions were reported predominantly with partners and health professionals. Mothers described the understanding they received from partners. One mother noted "He [spouse] lives the same battle that I do. So he pretty well understands everything." Another recalled that when her child was in hospital "sometimes he [husband] would come and tell me to go home and he would get [the child] ready for bed and stuff like that. So I would leave early and he would stay there." Some mothers described receiving emotional support from health professionals, who expressed respect for the parents' feelings and the significance of their role. They also recalled positive experiences with informational support from health professionals. As one mother indicated, "Everything was explained to us ... it just wasn't taken for granted that I was a nurse and that I knew ... I really appreciated that ... Because basically I was a mother first." Mothers generally valued affirmational support from health professionals. For example, one mother said, "She [nurse] tells me that I'm wonderful, that I'm doing a great job, that I'm a great mother. You know, all those things that you want to hear." Another mother of a child with diabetes reported that "On a few occasions when we've been having problems keeping [my child's] blood sugar in control, I can phone down there [hospital]. [The nurse] will call me back every other day, or so. And we'll try different things. You know, they're very, very helpful and cooperative and always very pleasant." Although many mothers perceived support as being helpful, there were many gaps in the types and sources of support related to specific burdens and many stressful interactions.

Stressful Interactions. Mothers of children with chronic conditions seemed more concerned about absent support (83%) and miscarried helping (74%) than about conflicted support (28%). Health professionals and partners were most frequently named as the sources of all types of stressful interactions. For example, health professionals either gave insufficient or inappropriate information. Stressful interactions with respect to physical care demands were experienced with partners, family members, health professionals, and baby-sitters. Typically, this was in the form of absent support; support that was anticipated but did not materialize. One mother explained, "But he [husband] doesn't participate as much as I would like. And I know if I asked him, he would. But I don't feel like I should ask him. I feel like he should volunteer." Another mother reported that:

> He [husband] can understand to a certain extent, but they can't really understand exactly what you are going through. If you feel stressed, or you feel exhausted, they can say, "Oh, you're tired. Sit down for awhile." But they don't understand the depth of it sometimes.

Miscarried helping, or support that was not perceived as helpful despite positive intentions, came from a variety of sources. One mother of a child with cystic fibrosis recalled her distress when residents and interns said, "She doesn't look sick." Although the comment might have been intended to reassure the mother about her child, it made her feel less confident in her knowledge of the child's condition. Some people minimized the illness in an attempt to make the mother look at the positive side. Suggestions of other ways to do things were not always perceived as helpful. Occasionally help from family members actually created more work for the mother. One mother reported that when her husband cared for their child, it was often more stressful for her because he worried about his own knowledge and competence to recognize problems. Several mothers described how their partners failed to enforce care regimens, letting the children indulge in poor health behaviours. One mother explained, "he [partner] doesn't keep a very good routine going. Like he gets him (the child) to bed a lot later than he should go." Other mothers described insufficient support from their spouses. As a mother of a child with diabetes described, "I just automatically do it ... for him [husband] to go in and try and get the meals ... I mean he could do it. There's no way he couldn't do it, it's just that I can do it a lot easier."

Conflicted support, that involved critical or condescending interactions, was encountered predominantly with health professionals, but also with family and friends. Mothers experienced stress when information about the child's condition was discussed inappropriately in front of the child, or information about the child's condition or reason for admission was withheld. They perceived that health professionals sometimes communicated in ways that were critical or demeaning of the mothers' caregiving or knowledge of the child's condition. One mother of a child with spina bifida described what a physician said to a resident in her presence. "He said, 'This is what happens when you try to educate the parent.' I just left there so humiliated. He told me there was nothing and it was all in my head." Another mother described a nurse's patronizing behaviour:

> Then I had a nurse come in and sit down and say to me that we will take you up to the clinic so you can be re-educated so this won't happen again. If I hadn't been so exhausted, I probably would have ripped her face off.

A health professional left one mother feeling that she had been censured rather than supported: "Instead I came out of there reprimanded for not dealing with it or something." Another mother, who had been terrified during an illness episode, described how a health professional trivialized her experience by saying: "Don't overreact. This is no big thing." Other health professionals communicated information in a seemingly heartless or cruel fashion. One

doctor said to a mother of a child with spina bifida: "The best you can hope for ... Your son is a basket case. In terms of intelligence, you can look for nothing but at the best to be below average." Some husbands or partners found fault with the children's disability. For example, one mother reported that "He complained about her smell, and he complained about this...He is just this weak rat that never could accept the fact that he has a child with a handicap." Likewise, some family members criticized the mother's caregiving.

Thus, appraisal of support by mothers in the curent study revealed that they experienced gaps in support appropriate to specific caregiving burdens and encountered stressful interactions with partners and health professionals in particular.

Discussion

There were no apparent differences between the three illness groups in the primary and secondary burdens experienced by the mothers, or in the sources, types, and appraisal of social support they received. This finding is congruent with the recently recommended non-categorical approach to the definition and classification of chronic health conditions (Perrin et al., 1993). In keeping with the later onset of diabetes, the only significant differences between the groups were that diabetic children and their mothers were older. It is unclear why these mothers also had a higher educational level.

Specificity of Support for Stressors

At least 50% of the mothers reported the effect of caregiving demands on their other activities within the home and on their relationships with their partners. That caregivers lack time for their self care and activities outside the home has been described previously only in adult populations (Gottlieb, 1989; Stoller & Pugiliese, 1989), with the exception of one small study (Ray & Ritchie, 1993). Others described the impact only in relation to family activities (Teague, 1993), marital relationships, and family functioning (Drotar, Crawford & Bush, 1984: Tomlinson & Mitchell, 1992). In the current study the vast majority of mothers experienced all these secondary demands, indicating that they need to meet all the usual role expectations as well as those related to the child's illness. Nevertheless, neither the mothers nor their partners considered change in maternal or paternal role expectations beyond the care of the ill child. This is consistent with the work of Anderson (Anderson, 1990; Anderson & Elfert, 1989) who reported that the extra burdens of caregiving almost always fall to the mother. Fathers, in another study, never or only sporadically accompanied the child during visits to health care providers (Knafl, Breitmayer, Gallo & Zoeller, 1992). Indeed, mothers usually coordinated the health care services of the child (Desquin et al., 1994). Gottlieb

(1991) also reported the role conflict experienced by family caregivers of seniors with chronic illness. Other factors that have been shown to contribute to maternal strain include severity of the child's illness, problematic behaviours of the child, family conflict, adhering to the prescribed regimen, and conflicted relationships with health professionals (Gibson, 1986; Havermans & Eiser, 1991; Quittner, DiGirolamo, Michel & Eigen, 1992; Thompson, Gustafson, Hamlett & Spock, 1992).

More than 94% of mothers in the current study identified their spouses/partners, immediate family members, and health professionals as key sources of support. Spouses or partners and health professionals have been well documented in previous studies (Barbarin, et al., 1985; Konstantareas & Homatadis, 1989; Ray & Ritchie, 1993; Savedra, Tester & Ritchie, 1987; Van Cleve, 1989) as key members in the social networks of mothers dealing with children's chronic illnesses. Consistent with previous reports, the mothers in this study all described needing and/or receiving emotional and informational support; however, most also discussed affirmational support and needed instrumental support.

The helpfulness of various types of support varied with the specific source of the support and the particular demand or stressor, as Cutrona (1990) proposed in her discussion of optimal matching models. Detailed analysis of the mothers' descriptions showed that specific sources of support were related consistently to the specific types of support and specific stressful situation or caregiving burden for which the support was required.

As in two previous reports (Bailey, et al., 1992; Havermans & Eiser, 1991), mothers of children with diabetes reported a need for practical support with their children's care. It seemed that this care was seen so clearly as part of the mother's invisible work that it was ignored as a major maternal need (Anderson, 1990). However, our study showed that such support is not always available, suggesting that its absence creates stress.

Mothers expected informational and affirmational support from health professionals, particularly in relation to the child's physical care demands and requirements for health care. However, less than one-third of the mothers described receiving such support. Only 25% reported receiving understanding (emotional support) from professionals in illness or health care situations. While some mothers were extremely positive about the information they received, others expressed concerns about the negative interactions they experienced with health professionals and the insufficient or inappropriate information provided. Dakof and Taylor (1990) also reported that health professionals are valued for informational support.

The mothers referred to child care support received from health professionals more than to this support from other sources only when their children were ill or hospitalized. Otherwise, the spouse/partner and the immediate family were the expected or actual sources of support in relation to most caregiving demands. Similarly, studies by Elliott (1991) and Bailey et al (1992) revealed that mothers of children with chronic illnesses found support from family and friends to be more helpful than that from professionals.

Most frequently mothers received support from their spouses/partners in the form of assistance with care of the child. Although emotional support from partners is typically valued (Dakof & Taylor, 1990), it was described infrequently. In the current study, the most common type of emotional support from partners, reported by 41% of the mothers, was listening to mothers' difficulties with meeting personal needs. Regardless of the type of illness, a consistent pattern of specialization emerged: specific types of support were received from specific sources for particular burdens.

Stressful Interactions

It has been shown that when people encounter negative interactions such as avoidance or criticism, it can offset supportive functions (Brenner et al., 1989; Malone, 1988). It is noteworthy that negative features of social relationships appear to correlate more strongly than positive features with diminished perceived support and increased psychological symptoms (Coyne & Downey, 1991). A significant number of mothers described receiving stressful support (absent, miscarried or conflicted), particularly from health professionals and partners. Misguided or absent informational support from professionals is detrimental (Eckenrode & Gore, 1990; LaGaipa, 1990). Borkman (1990) distinguished professional knowledge from that based on first-hand experience. Health professionals are socialized to believe that expert solutions take precedence over experiential solutions (Gottlieb & Farquarson, 1985); this fosters asymmetrical professional/layperson relationships (Barbarin & Chesler, 1986; Clarke, 1986; LaGaipa, 1990). One study of families of children with chronic conditions revealed how traditional relations between health professionals and families could be conflicted and disempowering (Chesler, 1991). Thus the negative interactions that some mothers encountered with health professionals may be due to socialization, differences in knowledge and power bases, and the health care system. One study of 41 families of children with chronic illness revealed a type of guarded alliance between parents and professionals (Knafl et al., 1992). Similar findings were reported by Thorne (1993). As the development of reciprocal trust (Thorne & Robinson, 1988) is essential in the relationship between family caregivers and health professionals, more egalitarian relationships that recognize the significant knowledge and skills of mothers are needed. Health professionals need to communicate, be technically competent, exchange information, establish a relationship with

the child, foster parental competence, and be supportive (Desquin et al., 1994; Knafl et al., 1992).

More than 25% of the mothers described stressful interactions with their partners in relation to their children's physical care. This appraisal most frequently arose because the spouse did not contribute to the child's care; mothers seemed more concerned about absent support and miscarried helping than conflict. It has been reported elsewhere that spouses' absence and lack of helpfulness are associated with mothers' role stress in caring for children with chronic or critical illness (Quittner, et al., 1992; Tomlinson & Mitchell, 1992). The effectiveness of support received from spouses may be diminished if it is less than that expected (Cohen, 1992); support expectancy can predict deterioration of spousal relationships (Levitt, Coffman, Guacci-Franco & Loveless, 1993). Conflicted support and miscarried support efforts often occur in intimate relationships (Cohen, 1992; Coyne, et al, 1988; Eckenrode, & Gore, 1990). The most crucial sources of support are intimate or close relationships; yet these relationships have inherent difficulties, particularly when caregiving is required (Coyne, Ellard, & Smith, 1990). Caregivers may become emotionally over involved, overloaded, and over committed; this may lead to negative adaptational outcomes (Baillie, Norbeck, & Barnes, 1989; Coyne, Wortman & Lehman, 1988; LaGaipa, 1990).

In close support relationships, the coping of one partner influences the coping behaviours used by the other (Coyne & Smith, 1991). The mothers described their efforts to maintain their marriages and cope with their spouses' lack of participation in caregiving and ineffective coping with having chronically ill children. The parents of children with a chronic illness exhibited gender differences in coping responses to a common stressor (Gottlieb & Wagner, 1991). Such differences can engender conflict in spousal relationships. Women tend to be exposed more than men to negative interactions, perhaps due to their caregiving roles; yet they benefit more from supportive interactions (Schuster, Kessler & Aseltine, 1990; Shumaker & Hill, 1991). Women have more complex social networks than do men, and are more likely to give all types of support to others (Belle, 1987; Shumaker & Hill, 1991). Reciprocity has a greater influence on women's support satisfaction than men's (Antonucci & Akiyama, 1987). Some mothers in our study expressed concern about lack of reciprocity with their spouse; others seemed to believe that the spouses lack of contribution to child care might be offset by his financial contribution to the family. In intimate long-term relationships immediate or in-kind reciprocation is rarely necessary (Antonucci & Jackson, 1990; Clark & Reis, 1988). In our study mothers reported miscarried helping efforts, conflicted interactions, support that was anticipated but absent, and inadequate reciprocity in relationships with partners and health professionals. Support intervention and intervention research are therefore needed.

Conclusion

Overall, the mothers in the current study seemed to be isolated in their caregiving roles. The sources and types of support that they received in relation to specific burdens were scattered and inadequate. For example, partners provided some instrumental support but little emotional support. Health professionals provided informational support only in relation to the children's illness episodes or physical care, but not in relation to fostering the children's psychological or social development or meeting the mothers' personal needs. These gaps in support and the stressful interactions experienced by mothers point to the need for support interventions. The mothers most commonly recommended support from individual peers, illness peer groups, and phone buddies. Thus, support is needed from people who have first hand experience with similar stressful situations. Peers can offer informational, affirmational, emotional, and practical support. Furthermore, peers and peer groups can supplement deficient support from partners, family, friends, coworkers, and professionals (Katz, 1993; Stewart, 1990). Nurses need to mobilize support for mothers of children with chronic conditions and test support interventions through research.

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Leadership: A Nursing Perspective

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Le groupe de travail pour les Collaborative Nursing Education Models (Modèles d'enseignement en commun des sciences infirmières) représente une collaboration fructueuse entre infirmières-cadres. On a étudié la nature de la direction au sein du groupe de travail; cela faisait partie d'un projet de recherche plus vaste qui examinait le processus de collaboration évoluant durant les quarante mois de son existence (d'octobre 1987 à février 1991). On a utilisé une méthode d'étude de cas qualitative et rétrospective. Les données collectées venaient de l'analyse des documents que le groupe avait rédigés et de trente-six entrevues semi-structurées avec les vingt-huit participantes au groupe de travail. Les résultats et les conclusions sur la direction ont été validés au cours d'une entrevue finale du groupe qui comprenait huit participantes sélectionnées. Les résultats de cette étude soutiennent les affirmations suivantes : les femmes dirigent différemment des hommes, et la direction est un processus collectif plutôt que le rôle spécifique d'une seule personne qui influencerait le travail des autres membres du groupe. On a découvert également que la direction effectue une rotation parmi les participantes, en fonction des questions étudiées et des compétences des personnes présentes. Ces résultats sont en désaccord avec les théories positivistes de direction qui prévalent actuellement dans les manuels de gestion en sciences infirmières.

The Task Force for Collaborative Nursing Education Models was a successful collaboration involving female nurse administrators. The nature of leadership in the Task Force was studied as part of a larger research project examining the process of collaboration that evolved over the 40 months of its existence (October 1987–February 1991). A retrospective qualitative case study approach was used. Data were collected from an analysis of documents that had been generated by the group, and from 36 semi-structured interviews with the 28 Task Force members. Findings and conclusions about leadership were validated during a final group interview with eight selected members. Findings of this study support the following contentions: women lead differently than men, and leadership is a collective process rather than a specialized role assumed by a single person who influences the work of other group members. Leadership was also found to rotate among group members according to the issue being considered and the expertise of those present. These findings did not support the positivist theories of leadership prevalent in current nursing management text books.

Leadership has been an important part of nursing management literature for several decades. Many articles and textbooks for novice and experienced nurse managers espouse a particular theory or concept of leadership. Most approaches to nursing management are borrowed from the copious literature of business, psychology, sociology, political science, public administration, and educational administration. Unfortunately such borrowing means that nurses are unaware of the uncertain state of knowledge about leadership and recent widespread discontent among social science researchers with the knowledge accumulated (Calas & Smircich, 1988; Dachler, 1988; Hunt,

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Baliga, Dachler & Schriesheim, 1988; Reed & Hughes, 1992; Shakeshaft, 1987; Yukl, 1989).

Almost all nursing management literature on leadership reflects a positivist, empiricist tradition of social science scholarship. As Dachler (1988) notes, this perspective of science is based on the assumption that the reality to be investigated is concrete and objective. Leadership is seen as a reality that exists separate from the scientist who observes it. Scientific progress means that isolated facts are accumulated and aggregated into some sort of relationship so that the observer comes closer to "knowing" the true nature of leadership. Examples of empirical theories of leadership often discussed in nursing management literature include Path-Goal (House, 1971; House & Mitchell, 1974), Situational Leadership (Hersey & Blanchard,1969, 1988), Normative Decision Theory (Vroom & Yetton, 1973), Contingency Theory (Fiedler, 1967; 1978), Transformational Leadership (Burns, 1978), and Charismatic Leadership (Conger & Kanungo, 1987, 1988; House, 1977). A review of commonly used nursing management texts shows that these theories still constitute the backbone of current presentations of leadership (Hibberd & Kyle, 1994; Marquis & Huston, 1992; Marriner-Tomey, 1992; Sullivan & Decker, 1992).

Recently, a different set of assumptions about the nature of science has focused interest on the processes by which researchers come to understand leadership phenomena (Dachler, 1988). Leadership is seen as something that cannot be known independent of the scientific observer; rather leadership is a reflection of the way in which a society chooses to define and ask questions about it. Understanding leadership becomes an ongoing process rather than a finite objective. There is no single theory or conceptualization of leadership. Within this evolving paradigm, leadership can be conceptualized as a product of complex social relationships in which leadership is a collective process shared among group members. The basic unit of analysis is the group rather than the individual. Leadership need no longer be conceptualized as a specialized role assumed by a single individual who has influence over other members of a work group.

Since gender may influence the ways individuals and groups define leadership and engage in it, leadership can also be expanded to include knowledge arising from feminist perspectives. Historically, most subjects of leadership research have been white males. As Shakeshaft (1987) noted, such research "is an outgrowth of a male-only conceptualization that presumes the universality of the male experience" (p. 160). Only recently have women been included in leadership research, and then primarily in empirical studies comparing leadership styles of women and men (Baird & Bradley, 1979; Camden & Witt, 1983; Eagly, Makhijani, & Klonsky, 1992; Forsyth, Schlenker, Leary, &

McCown, 1985; Helgeson, 1992; Loden, 1985). Meta-analysis of such research led Eagly and Johnson (1990) to conclude that "The view ... that women and men lead in the same way should be very substantially revised" (p. 248). This acknowledgement of gender-related differences in leadership styles has resulted in what Calas and Smircich (1992) call the "women-in-management" literature, and has predisposed women to what Stivers (1991) identified as a leadership dilemma. Women must either be better than men at leadership as already defined by men or change organizations to better fit women's leadership values and characteristics.

Background of the Study

The investigators' dissatisfaction with current positivist theories of leadership derived from research on male subjects stimulated exploration of leadership in an all-female work group. The investigators' own extensive experiences in such groups supported an initial notion that women lead differently than men. This notion was reinforced by the realization of the uncertain state of knowledge about leadership and the recent widespread discontent with the knowledge accumulated. It was further reinforced by the paucity of research on female leadership; the ways in which all-female work groups experience and engage in leadership has not been researched. In 1987 a unique opportunity to examine leadership in an all-female work group arose: the directors of five nursing education programs in a major Canadian city formed a Task Force for Collaborative Nursing Education Models (hereafter called the Task Force) to explore ways to increase student access to baccalaureate nursing education. The directors represented three hospital diploma programs, one community college diploma program, and one university baccalaureate program. Membership in the Task Force expanded from five to nine during its first year, then to 28 as other nursing education stake-holders were invited to join. Three years after its inception, the Task Force had developed a four year baccalaureate program in nursing to be offered collaboratively by all five schools and had received provincial government approval. The Task Force overcame many obstacles to achieve this goal, including protracted "foot-dragging" by the provincial government department responsible for approving new programs. This innovative program would more than double the number of graduates entering the labour force with a degree in nursing.

The purpose of the current article was to highlight findings about leadership that resulted from a qualitative study of this successful collaboration of female administrators. The authors focus exclusively on leadership as experienced by the Task Force. The following research questions guided the overall study: What was the process of collaboration that evolved over the 40 months of the existence of the Task Force? How were decisions made? How was conflict handled? How was leadership demonstrated?

The investigators expected that the leadership experience of the all-female Task Force would be different from traditional concepts of leadership espoused in nursing management literature and that these differences would reflect a collective process shared among group members rather than a specialized role assumed by a single individual.

Social World of the Task Force

The Task Force began as a group of female nursing program directors who had not worked together before, although some individual members had previously known each other in various roles. At the outset, there were many biases and considerable mistrust. Participants at the first few Task Force meetings commented that they were "not overly optimistic" about the outcome of the endeavour. When the nursing profession had called for a baccalaureate degree in nursing as the basis for entry to practice, this had created considerable conflict among nurses in general, and this conflict was reflected in Task Force members' initial interactions with one another. In the beginning, mistrust was focused on the university, which was perceived as having a power advantage and suspect motives for entering into a collaboration with the diploma programs. According to members, the "demystifying of the Faculty of Nursing," which occurred early in the life of the Task Force, facilitated the development of trust. Over time, a high level of trust developed, particularly among program heads, to the extent that they immediately informed each other when government officials phoned them separately for any reason. This was very different from their previous way of operating in which such calls would have been treated as confidential.

In the beginning, Task Force members were concerned about maintaining separate identities and spoke about "our students" and "our program." They worried about being "consumed" by the university. They were concerned about how each school would fit into the new program and what their future roles might be. This uncertainty was ameliorated somewhat when the university faculty agreed to focus on teaching the third and fourth years of the collaborative baccalaureate program, leaving the first and second years to the collaborating partners. The decision to have one standard curriculum, made a year after the first meeting of the Task Force, indicated a lessening of the need to maintain separate institutional identities and was a strong indicator of mutual trust. The process of collaboration involved preparing a jointly sponsored baccalaureate program without organizational amalgamation of the participating schools. Each nursing school retained distinct organizational autonomy, continued to report to its own board, retained its faculty under existing collective agreements, and continued to operate as a distinct corporate entity.

Initially, Task Force members were concerned that all partners should be treated equally and participate with equal voice. There was uncertainty about "a level playing field," especially after one of the schools became a department of the university with first choice of student transfers into third year of the baccalaureate program. This preferential treatment was an issue for the other schools, until an offer was made to forgo it and students from all four diploma schools had equal opportunity to transfer. Because of enrolment limits in the university, only half of all students admitted to the first year of the collaborative baccalaureate program could be accommodated in third year. The remainder would take a diploma completion option with subsequent access to post-R.N. baccalaureate programming. The criteria used in selecting students for transfer, the number of students each partner could transfer, and who would make the final decision were major issues for the Task Force. It was important to the diploma schools that the university not assume complete control over transfer. A fair solution was achieved by deciding that the number of students transferred from each school would reflect the proportion of all collaborative program students admitted by that school. Each school would rank their own students according to previously agreed upon general criteria of academic and clinical performance, and the university would accept these rankings. Fairness was also promoted by equal representation on all Task Force committees so that no single school could exert undue influence.

Method

A retrospective case study using qualitative methods was employed to investigate the process of collaboration experienced by the Task Force (Woods & Catanzaro, 1988). The case study approach was selected as most appropriate for examining the process of collaboration in detail from the Task Force members' perspective, rather than from a priori assumptions (Guba & Lincoln, 1994; Lincoln & Guba, 1985), and for exploring a previously unresearched phenomenon: collaboration among members of an all-female task group (Polit & Hungler, 1992; Treece & Treece, 1986). It also enabled collection of evidence for and against positivist theories of leadership (Burns & Grove, 1993). The study was retrospective because of the time needed to design it and secure research funding. The study examined how the collaboration came into being, how it changed over time, and what contributed to its success. Data collection began in mid-1990, almost three years after inception of the Task Force and six months before government approval of the proposed baccalaureate program. Consent for the research was obtained in writing from the Task Force before research funding was sought. Data collection was completed in mid-1993.

Document Analysis

The first step in the research was to analyze all Task Force meeting minutes, letters, proposals, news releases, and presentations to create a chart identifying events and decisions of the 40-month collaboration. This analysis identified three distinct phases in the work of the Task Force and provided chronologic documentation of key events and major decisions.

Phase I. The first phase began with the initial meeting of the Task Force in October 1987 and ended with establishment in February 1989 of a standing committee for curriculum development, nicknamed 4C (Collaborative Coordinating Curriculum Committee). Significant events and decisions of Phase I were: the university offered to concentrate on teaching the third and fourth years of the baccalaureate program, a philosophy was developed, it was decided that all sites should have one standard curriculum, and a standing committee with equal representation from all schools was created to oversee curriculum development (4C).

Phase II. The second phase began in March 1989 with the development of proposals for formal approval by the five schools and the requisite government departments. The size of the Task Force increased by six members during Phase II and three new standing committees were created: Research and Evaluation, Public Relations, and Faculty Development. Curriculum development was spearheaded by the existing 4C. The Task Force shared information with stake-holders (e.g., nursing service administrators, health care associations, and unions) and solicited their input and support. As Phase II progressed, the Task Force began to encounter overt opposition from the provincial ministry of education, which culminated in ministry refusal to approve the program for implementation in the fall of 1990.

Phase III. The third phase began in February 1990, as the Task Force addressed government's concern about the number of students to be admitted to the program. This phase was characterized by intense and complex activities; the number of significant events and major decisions made outnumbered those made in either Phase I or Phase II. During Phase III, the provincial shortage of nurses disappeared as hospitals began laying off staff. By late 1990, the 100 diploma graduates per year reduction that would result from the collaborative baccalaureate program was no longer a concern to the government. Phase III ended in February 1991 with restructuring of the Task Force into a large Advisory Board and a small Administrative Council comprised of the original five program heads, plus a sixth program head from a regional college.

Interviews

Interviews were conducted by two trained graduate research assistants to minimize bias, since the investigators were well known to members of the Task Force. Each interviewer conducted 14 interviews. Both had previous extensive interviewing experience and were oriented to this research through role-playing interviews with one of the investigators.

All interviews were audio recorded and transcribed for data analysis. Transcripts were coded using the interview questions. The three investigators individually processed data from taped and transcript copies of each interview by unitizing, categorizing, and filling in patterns (Lincoln & Guba, 1985). Data processing resulted in a narrative that was entered into a computer file. These individual narratives were subsequently discussed and debated at research team meetings before being combined and synthesized. Synthesized team-generated narratives were then entered into a another computer file.

Round One. The events, decisions, and chronologic phases identified in documentary analysis were used to create a semi-structured guide for interviews with the initial nine members of the Task Force. These lengthy interviews focused on members' perceptions of the impact of the documented events and decisions. Members were read a standard chronologic synopsis for each of the three phases and asked to elaborate on events and decisions. A set of summary questions concluded each phase. They were asked how decisions were made, how conflict was handled, how leadership was demonstrated within the Task Force, and what members' perceptions were of the collaborative venture during that phase.

Round Two. To narrow the focus of subsequent interviews and ensure a manageable amount of data, specific foci were chosen for the second round of interviews with the 19 individuals who joined the Task Force after its first meeting. These foci were: decision making, conflict resolution, and leadership. Members were interviewed in the order in which they joined the Task Force, and were asked questions only regarding the phases during which they were members.

Interviewers began by reading a standard synopsis of the phase during which the member joined. Members were then asked how they came to join the Task Force and what was going on in the Task Force when they joined. For each of the phases they were a Task Force member, they were asked: (a) What do you recall about the process of decision making within the Task Force during that time? (b) Were there any disagreements among Task Force members? If so, how were they resolved? (c) Were there any situations involving conflict that you recall? If so, how were these resolved? (d) What was your

perception of the group's satisfaction with decisions taken? With the process of decision making? (e) How was leadership demonstrated in the Task Force during this time? (f) Is there anything else you'd like to comment on about this phase?

After the data had been processed, additional topics were identified for which more information was needed, for example, the impact of the government appointed provincial nursing consultant on the collaborative process, and Task Force members' reactions to participating in an aggressive provincial lobby to obtain approval for the collaborative program.

Round Three. Third round interviews were conducted with eight Task Force members to ensure saturation of the data and confirm investigators' understanding of conflict resolution, decision making, and leadership within the Task Force. These members were selected on the basis of their ability to clearly articulate their ideas as evidenced in earlier interviews.

Final Member Check

To test for factual and interpretative accuracy, and to provide evidence of credibility, a final member check was conducted in a group meeting with eight selected Task Force members (Guba & Lincoln, 1994; Lincoln & Guba, 1985). These members represented each of the collaborating schools and all had been Task Force members for at least one year. The meeting was tape recorded and subsequently transcribed. It began with a highlighting of the nature and purpose of the study and an overview of the research methodology. Members were asked to provide feedback on the overall credibility of the case study, to identify any major concerns or issues, and to comment on errors in facts or interpretation. There was total consensus on the investigators' interpretations of conflict resolution, decision making, and leadership, and split consensus on conditions associated with the process of successful collaboration.

Role of the Researchers

Research was conducted by three investigators. A team approach, reflecting researchers' expertise, was used during data collection and analysis. One investigator was a member of the Task Force from its inception until its transformation into the Administrative Council. The other two had not been members. Several factors contributed to the trustworthiness of the study: intimate knowledge of the Task Force and its scope of functioning, the prolonged engagement of the investigators, and the use of multiple data sources and collection methods (Lincoln & Guba, 1985).

Ethical Issues

One of the investigators outlined the proposed study and answered questions at a meeting of the Task Force. Then permission to access Task Force documents and members was obtained in writing. Task Force members were subsequently contacted by telephone to schedule interviews. At the interview, any additional questions were answered and informed consent was obtained in writing. Task Force members were advised that they could withdraw at any time without penalty; however, none did and a 100% response rate was obtained. Although confidentiality could not be guaranteed, anonymity was provided by reporting findings only in aggregate form, and by not naming individuals, their agencies or the geographic locale.

Data Analysis and Results

Round One

Raw data from verbatim transcripts of each interview were individually processed by each investigator by unitizing and categorizing (Lincoln & Guba, 1985, pp. 344-350). Unitizing involved identifying discrete units of information that encapsulated a single idea or a unique meaning. Each unit was the smallest piece of information that could stand alone and offer insight about leadership. Some units were as small as a phrase, while others were as large as a paragraph. These units were coded by the respondent's name and the interview round, and entered into a computer file. Units were then sorted into provisional categories by grouping those with similar characteristics together until all units had been accounted for. Provisional categories were examined for internal homogeneity and external heterogeneity, and if necessary, units were re-sorted. The categories were then named. At a team meeting, each investigator's computer file was discussed and debated before being synthesized into a team-generated classification schema. These were then entered into a computer file identified by interview question and interview round.

Team-generated categories of homogeneous units of data were: *shared leadership, rotating leadership, formal leadership, informal leadership* and *leadership according to expertise. Shared leadership* encompassed units of data that inferred there was no single, acknowledged leader; leadership was provided by a variety of individual Task Force members. *Rotating leadership* related to the notion that there were leaders within the group and "different people at different times took leadership with different issues." *Formal leadership* was provided by the chairperson who kept the group on track and focused by arranging agendas, minutes, and locations for meetings, and by drafting discussion materials between meetings. *Informal leadership* by individual Task Force members was acknowledged. *Leadership according to expertise* was characterized by the comment: "Leadership just kind of went around the room, depending on what the issue was." It acknowledged that standing committees took leadership in their area of responsibility (e.g., curriculum design).

Round Two

Raw data from verbatim transcripts of each of the 19 Round Two interviews were processed as described for Round One interviews. Team-generated categories were: *rotating leadership, open style of leadership, formal leadership,* and *informal leadership. Rotating leadership* meant that everyone was a leader from time to time, depending on their expertise and the issue under discussion. *Open style of leadership* reflected "that everybody had an opportunity to speak" and "there was no one leader per se but everybody had a go at it at one point." *Formal leadership* was provided by the chairperson who organized the meetings and focused the group on issues, yet managed to move the agenda along. *Informal leadership* involved contributions of service agency representatives. No substantive change in leadership was recorded from Phase I to Phase II and there was still a strong sense of "shared" leadership with "no power-brokering" or "game-playing."

Round Three

The eight Task Force members interviewed in Round Three were asked how leadership changed as the Task Force grew in size and subcommittees were appointed. Because of the narrow scope of the question, responses were individually summarized before being synthesized into narrative format at a research team meeting. The resultant narrative was entered into a computer file identified by interview round. The nature of the data did not lend itself to processing by unitizing and categorizing.

The majority of the eight interviewees perceived no real change in leadership, while a few thought that the chairpersons of standing committees assumed more prominence. One member saw leadership as being centred in the deans and directors, and in particular, the university dean.

Discussion

Task Force members agreed there was no single leader, and consequently no specific style of leadership in the sense espoused by traditional positivist theories so prevalent in nursing management literature. The prevailing perception was of shared leadership, which rotated among Task Force members according to the issue being considered and the expertise of those present. Over time, some group members participated more frequently than others as leaders; however, no one individual emerged as a paramount leader. Leadership "was more a group leadership rather than a single leadership." Accordingly, "everybody that was on the [Task Force] committee was in a leadership position and it wasn't so much of who was going to provide leadership to the group, it was how can we work together to attain our common goals." As the

Task Force increased in size, especially during Phase III, the chairs of the subcommittees participating in Task Committee meetings further contributed to "dispersement of leadership."

Task Force members highlighted the facilitating role of the chairperson whose activities were described as "mak[ing] sense of it after the meeting as far as minutes or discussion, but keeping us on track too...so we wouldn't go off on a blue yonder and just ramble on and on." However, "It wasn't as if the only leadership was coming from the chair," because the position of the chairperson was "really more of a figurehead and someone who obviously has to organize the agenda and that sort of thing but not what you often think of as the leader or as a powerful person." In fact, a change in the chairperson during the last six months of the 40-month life of the Task Force was reported as having no impact on its activities.

This study supports the conception of leadership as a collective process shared by members of a group rather than a specialized role assumed by a single person. This is in keeping with the emerging trend conceptualizing leadership as a shared process embedded in social systems (Iannello, 1992; Yukl, 1989). Yukl noted that simple, unidirectional models of cause and effect that focus on what a leader does to subordinates have proven inadequate in explaining the complexities and nuances of leadership, especially in large, complex organizations staffed by professionals. Hospitals, public health agencies, and schools of nursing are examples of such organizations. Iannello concluded from a case study of a feminist peace group that the meaning of leadership in a non-hierarchical group is different from that in other organizations, partly because power is not handed to someone. Instead, power emerges as a product of the capabilities and skills of individuals. This approximates the individual expertise of Task Force members. Similarly, the rotating leadership and shared leadership within the Task Force reflect Iannello's finding that the peace group rotated tasks and developed a sense of collectivity suggestive of group rather than individual ownership of outcomes.

Results from the current study also lend credence to the contention that women lead differently than men. In particular, there was evidence of cooperative leadership characterized by debate and discussion, and problem solving based on a mix of empathy, intuition, and rationality. For example, it was noted that "We never took formal votes or anything like that but we had heated debates on some issues and would eventually arrive at consensus."

Importance to Nursing

Have nurse educators been teaching about leadership in ways intrinsically alien to an almost totally female population of students? Have we failed to teach

students how to deal with the difference between what bureaucratic health care agencies, designed by male administrators, perceive as ways of leading, and what female nurses are best at doing? Worse yet, by reinforcing non-female, non-nurse constructs of leadership have we failed to capitalize on the innate abilities of future nurses to influence and change the overwhelmingly male construct of management in health care agencies? These are provocative questions.

Hospitals and community health agencies in Canada are conservative in structure and function. They are often lead by non-nurse male managers who possess little understanding of nursing as a profession or nurses as individuals. Recent budget cutbacks have reinforced the hierarchical nature of Canadian health care agencies, despite earlier short-lived attempts at decentralization. "Down-sizing" of hospitals, in particular, has resulted in high unemployment among nurses and a tendency among those left to adapt and accommodate to existing conditions. In the vernacular, this translates into "putting up with" and "not rocking the boat." It is unlikely that nurses' attitudes and values about leadership can be changed while they are worried about retaining their jobs. However, it is worthwhile for educators to consider offering a different set of leadership values and practices to students who will, in a few years' time, become the practitioners of tomorrow. Since the proportion of graduates entering practice with a degree in nursing is increasing, it seems opportune to reconsider the leadership focus of Canadian university nursing programs.

Recommendations for Further Research

It is a design limitation of a case study that findings and conclusions cannot be generalized. Therefore, additional research on leadership in all-female nursing work groups is needed to confirm the accuracy of the conceptualization arrived at in the current study: Leadership is a collective process shared among group members rather than a specialized role assumed by a single person. Similarly, the concept of leadership that rotates among group members, according to the issue being considered and the expertise of those present, warrants further investigation. Such investigation should initially involve additional case studies of all-female work groups, followed by hypothesis testing research.

The leadership process in all-female nursing work groups should also be examined prospectively. As a retrospective case study, the current research relied on Task Force members' recollections, which may have been influenced by several factors. First, the Task Force was extremely proud of its accomplishment in planning, obtaining government approval, and implementing a very innovative baccalaureate program. They may have remembered their experiences in an unusually positive manner, glossing over less flattering recollections. Second, there was a significant time lapse for many members

between their involvement in the Task Force and their interviews, which may have impeded accurate recollection. Direct observation of group activities in future research would be especially helpful to examine leadership as it happens, rather than as it is recalled through retrospective self-report.

In today's rapidly changing world of health care and education, nurses must continue to position themselves as leaders. The strength of future nursing leadership may lie in overtly practising the cooperative, collaborative style of leadership intrinsic to women's groups rather than becoming "one of the boys." As large organizations such as hospitals, health units, and post secondary institutions restructure themselves to operate more efficiently with less staff, reduce management, and adapt to new technology, leadership will increasingly be played out in a climate of negotiation and collaboration instead of competition and one-upmanship. Nurses can lead the way.

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Acknowledgement

Book Reviews

Psychological Aspects of Women's Health Care: The Interface Between Psychiatry and Obstetrics and Gynecology. Donna Stewart and Nada Stotland (Eds.). London, Washington: American Psychiatric Press, Inc., 1993. 570 pp. ISBN: 0-88048-421-7

Reviewed by Leslie Myers

It is a relatively new phenomenon for psychiatrists to write about women's health issues from perspectives that both medical and feminist health practitioners could find useful. *Psychological Aspects of Women's Health Care* is a compilation of such work. That this book is coauthored by psychiatrists, and includes work by obstetrician-gynecologists, is evidence of the great shifts that have occurred in the past three decades with regard to consciousness about women's health issues, shifts that have reached into the heart of medicine. Central to these changes has been the massive entry of women into medicine and it is no accident that the majority of contributors to this book are female physicians.

Almost every conceivable topic related to women's reproductive health is addressed. The first section covers normal and complicated pregnances, fetal anomalies, psychiatric disorders and treatments during pregnancy, adolescent pregnancy, postpartum disorders and perinatal loss. The second section includes work on the menstrual cycle, infertility, induced abortion, menopause, AIDS, and on gynecologic pain, disease and oncology. The final section includes work on alcohol and substance abuse, eating disorders, sexual disorders, breast disease, violence, the experience of minority women, the male perspective and ethical issues.

The chapters are well-written and largely free from psychiatric terminology that would make comprehension difficult for a non-psychiatrist. Most of the authors provide a useful, up-to-date review of the research on their topic.

The book is strongest when the authors are addressing issues relating to disease, complication or psychiatric disorder. For example, Hillard writes with clarity and tangible compassion about the many wrenching issues that a woman with a pelvic cancer must face. Stewart and Robinson provide original insights into the impact of eating disorders on fertility, hyperemesis gravidarum, pregnancy outcomes and infant feeding. And Jensvold provides useful information on the interaction between medical and psychiatric disorders and

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premenstrual difficulties, as well as raising important political questions about the inclusion of Late Luteal Phase Dysphoric Disorder in the DSM-III-R.

The few weak areas of the book are those that deal with "normal" healthy aspects of menstruation, menopause, pregnancy and birth. This is perhaps not surprising, as medicine's mandate has traditionally been "to diagnose and treat disease". The critique that the "medicalization" of women's normal reproductive life events has been to the detriment of women's health has been made by many and the few problems in this book are largely related to this. For example, there is no reference to research on the effects of nutrition and exercise on women's difficulties with the menstrual cycle or with menopause. This research exists and many of the women who doctors will see are interested in what they can do to help themselves.

In the chapter on Normal and Complicated Pregnancies, the research cited on the effectiveness of prenatal preparation and on the high caesarean section rates in North America is dated, and the arguments, therefore, flawed. At several points, the author describes normal pregnancy in terms that have little to do with most women's experience of it (for example, as a time of "regression and passivity"). These problems are unfortunate given the good quality and usefulness of the author's work on complicated pregnancies, which again underlines where the strengths of the book lie.

The other most problematic section is in the chapter Sexual Assault, Domestic Violence and Incest. Again, most of this chapter is well-done and extremely important, particularly in describing the high incidence of violence and sexual abuse in the histories of many women with common psychiatric diagnoses. Very problematic, however, are two claims made by the author – that physical abuse by a spouse occurs equally to men and women, and that equal numbers of men and women kill their spouses. These claims are not supported by research (Saunders 1988). One gets the impression from this, and from a couple of the above-mentioned chapters, that some authors were asked to cover slightly broader territory than their specific area of expertise.

For Canadians, the book reads well (there are several Canadian authors, including one of the editors). There are only three areas that are specific to the American experience: the legal definition of rape/sexual assault, ethical issues around economic barriers to health care, and aspects of the experiences of minority women.

In summary, this book is intended as a dialogue among psychiatrists and obstetrician-gynecologists. Although many of the authors mention lay support groups and help from other health professionals as important, this is

not the focus. However, there is much important information in this book and it is encouraging to read of the number of psychiatrists actively involved in working on women's reproductive health issues from an informed and sympathetic point of view.

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Women's Health, Politics, and Power: Essays on Sex/Gender, Medicine and Public Health. Elizabeth Fee and Nancy Krieger (Eds.). New York: Baywood Publishing Company Inc., 1994. 376 pp., index. ISBN 0-89503-120-5.

Reviewed by Patricia Vertinsky

Women's Health, Politics, and Power: Essays on Sex/Gender, Medicine and Public Health consists of a collection of seventeen selected essays which were originally published in the *International Journal of Health Services* over the last decade and which combine well to illustrate the social production and construction of health and ill-health. "Together," suggest editors Elizabeth Fee and Nancy Krieger, "they present a framework for understanding the struggles over women's health that have occurred in this time period, and provide specific analyses of women's health in relation to race/ethnicity and class, the work of health care, the health of women workers, international reproductive health, sexuality, AIDS, and public health policy." (p. 3).

Women's Health, Politics, and Power is divided into seven sections ranging from topics on women and work, to studies of female sexuality and reproductive health and discussions of gender and social policy. Essays in the first section, "Women and Health: Frameworks" focus upon the social determinants of health and the need to address women's health in a more inclusive manner. Nancy Krieger and Elizabeth Fee argue that Western society has largely refused to deal with the ways in which sex/gender, race/ethnicity and class are inescapably intertwined with vast inequalities in health, continuing to assume that biology alone can provide answers to concerns about the complexities of women's health. Marsha Lillie-Blanton and others similarly condemn purely biological explanations for racial differences in women's

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health. They describe continuing disparities in the health of more than twenty-five million Latina and African-American women in the United States and show how a legacy of racial discrimination and segregation continues to bring diminished health and affect their quality of life. In particular they provide a framework for exploring the health consequences of being a primary caretaker in a frequently hostile social environment and challenge public health researchers and practitioners to deepen the level of understanding of the link between health and social conditions.

The important topic of the sickening effect (and often double exposure) of waged and domestic work upon women's health, underlined by Lesley Doyal in her brief history of the women's health movement in Britain, is carried into Sections 2 and 3, "Women and the Work of Health Care" and "The Health of Women Workers." Irene Butter et al., for example, document gender hierarchies in the health labour force to demonstrate how valued work functions, prestigious positions and scarce resources continue to be controlled largely by men. In "Sugar and Spice and Everything Nice: Health Effects of the Sexual Division of Labor among Train Cleaners" Karen Messing, Ghislaine Donoil-Shaw and Chantal Haentjens examine the familiar question of whether the sexual division of labour is based on biological differences between the two sexes, and show how the exclusion of women from many jobs because of their "natural" qualities (e.g. women do not like to do dirty jobs, they are unable to do heavy work or work involving complex technical skills etc.) is not necessarily borne out by events in the work place. In fact, far from respecting the different biologies of men and women the authors show that the sexual division of labour many times ignores differences. The physical load resulting from the fast workspeeds and intense time pressures characteristic of women's jobs in factories and offices, as well as the lack of recognition about the technical requirements of many women's jobs (which are often hidden from or ignored by supervisors) may have adverse effects on women's health. These adverse effects are documented in an interesting case study of train cleaners in France where researchers saw how the physical requirements of this apparently routine undemanding job generated a large number of health problems. Specifically the job of toilet cleaning was examined. This task is assigned invariably to women even though it has characteristics often thought to be associated with stereotypes of male jobs, i.e. it is physically demanding, requires technical knowledge and involves considerable exposure to dirt and filth. Yet, when the report documenting the need for less arduous conditions and better tools was submitted the specific recommendation that toilet cleaning tasks be rotated among men and women cleaners was strongly resisted by both sexes who, accustomed to sex-based task assignments, could not conceive of changing their view of the "appropriate" sexual division of labour even though it was clear that the work required skill, dexterity and physical endurance in a particularly dirty and unpleasant environment.

Women's reproductive health is next discussed in the context of developing countries. Ruth Dixon-Mueller shows how, unassisted by safe or affordable services, up to two hundred thousand women in developing countries continue to risk their lives from clandestine abortions in order to regulate their own fertility. In "The Untold Story," T.K. Sundari insists that high maternal mortality must be seen as "a reflection of the priorities set by an elitist system in which the poor and powerless do not count" (p. 187). Social and medical assumptions about women as sexual beings are further explored in Sections 5 and 6. Emily Martin's "Medical Metaphors of Women's Bodies", borrowed from her 1987 book *The Woman in the Body: A Cultural Analysis of Reproduction,* analyzes the medical profession's preoccupation with, and distortions of female sexuality, as does the work of Patricia Stevens and Joanne Hall on the medical construction of lesbianism. The latter show how moral condemnation of homosexuality has fed the medical construction of lesbianism as pathology which in turn has structured discriminatory and "exploitative" treatment by health care providers. In two separate studies of AIDS, women's lack of control over their bodies and their lives is shown to be particularly instrumental in placing them at increased risk for the disease and it is demonstrated how narrow constructions of women's roles have affected the design and delivery of AIDS prevention services around the world.

The essays in the final section explore gender and social policy in relation to health, focusing upon the "feminization" of poverty, family violence and the problems of older women. In looking at the aging population of women, Terry Arendell and Carol Estes show how "the policies of the 1980's shifted resources from women to men and from minorities to whites, leaving women to undertake an even larger burden of unpaid service and caring work" (p. 7).

This book is the second volume of essays selected from the *International Journal of Health Services.* Added to Elizabeth Fee's *Women and Health: The Politics of Sex in Medicine* (Amityville, N.Y.: Baywood, 1983), it provides an excellent resource for researchers and teachers by contributing to the fast-growing, interdisciplinary literature on women, gender and health and underscoring the need to address long-standing gender inequalities through broader and more cogent analyses of health issues, policies and services.

Happenings

History of Nursing in British Columbia Captured on Tape

Sheila J. Rankin Zerr

The Oral History Committee (1992) is a permanent subcommittee of the British Columbia (B.C.) History of Nursing Professional Practice Group of the Registered Nurses Association of B.C. (RNABC). The project was established in 1981 to commemorate the 75th anniversary of the RNABC. The goal was to capture past and present stories and activities of nurses of the province, and to document the development of nursing as we know it today. We have a rich heritage to explore and one of the methods chosen for recording our heritage was through the medium of the tape recorder.

Under the direction of Mary Nicol, a group of volunteers was trained in oral interview techniques. The original group completed 140 interviews. These audiotaped histories are on file and available through the RNABC library. Since the completion of the original anniversary project in 1988, the on-going committee of the B.C. History Group has added another ten audiotaped histories to the collection. The tapes are now accessible through RNABC's computerized library catalogue (Andrews, 1992). Computerized access allows members to search specific historical topics in the audiotape collection and to retrieve those items along with related print materials out of the library's book collection.

Joan Andrews (1992), RNABC librarian, has summarized the content of the tapes as follows:

> The recollections of these nurses are rich with meaningful stories about nursing's influence on health care in the 20th century. The subject matter is vast. Topics covered include nurses' early education and working conditions, nursing during both world wars, the evolution of the local Victorian Nurses, how the Depression of the '30s affected health care, private duty nursing, collective bargaining, formation of RNABC chapters, nursing native people in the province, men in nursing, and the poliomyelitis epidemic of the 1950s. (p. 33)

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The work of the B.C. history group continues to build a bank of historical audiotapes and data. The current criteria for selection of a nurse for an oral history recording has been identified by the Oral History Committee (1992) as follows:

1. A nurse whose basic nurisng education took place in B.C.
2. A nurse who graduated elsewhere but had nursing experience in B.C.
3. A nurse who has significant and interesting topics to relate about nursing in Canada and/or abroad.

The Biographical Committee (1993) of the B.C. History Group has developed a biographical summary form that now accompanies the oral audiotape. The summary asks the nurses to give biographical data and to identify major influences and mentors throughout their nursing careers. Biographical summaries are being sought from nurses currently practising in B.C. An effort is being made, if possible, to obtain biographical summaries from nurses with oral history audiotapes in the RNABC collection. These summaries are maintained and made available through a special file in the RNABC library.

Andrews (1992) identifies the goal of the efforts of B.C. nurses in attempting to capture their history:

> No matter how B.C. nurses view their past, it is their history in the making – at the local level – that the Oral History Project attempts to capture for posterity. RNABC members are welcome to examine their professional roots, particularly those that have been established here in B.C. during this century. Much of that history is not in print, but it is recorded and available throug RNABC's Helen Randal Library. (p. 33)

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Plaudits & Gripes

The Voice of Nursing
Has to be Loud and Clear

Cathy Lesage

This past fall, the 14th World Congress of the International Federation of Gynaecology and Obstetrics (FIGO) was held in Montreal. Over ten thousand specialists in women's health gathered to share, disseminate, discuss and debate new research and ideas in this diverse and rapidly growing field.

Given that nursing is so closely connected with women's health, one would assume the voice and vision of nursing would have been loud and clear at this huge, multidisciplinary conference. Unfortunately, this was not the case. Despite the fact that much of the research was essentially nursing's domain, the nursing perspective was virtually non-existent.

This lack of contribution from the nursing profession was apparent in all areas, most notably in discussions concerning reproductive technologies. For instance, one paper focused on the attitudes of medical residents, medical students, and nurses towards new reproductive technologies. It was found that nurses experienced a much higher number of "consciousness conflicts" than did the medical students or residents when it came to using these technologies and were much less likely to perform morally disagreeable procedures on patients.

The physician presenting the data stated that nurses have difficulty with decisions surrounding the use of new reproductive technologies because "nurses don't think about these issues very much." This comment went unchallenged, a reflection of the lack of nursing representation at the conference.

Nurses are only too aware that the conditions of women's health are directly related to family and societal health. Nurses should not be timid about presenting their research at massive, primarily medical conferences such as FIGO. These are the conferences where global health care policies are conceived and deliberated. Both professionally and publicly, they offer an excellent opportunity to let the world know what is going on in nursing because these are the conferences which are covered by the media. They can help to give nursing a voice – a voice that is seldom heard over the onslaught of exciting new technologies and the roar of threatened physicians.

Cathy Lesage, B.N.Sc., Dip. Jour., is a nurse freelance journalist, and recipient of the 1994 Canadian Nursing Association Media Award for Radio Documentary.

Cumulative Index cumulatif   Volume 26 – 1994

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TITLES

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Reviewers/Lecteurs

Volume 26 – 1994

The Canadian Journal of Nursing Research is indebted to the persons below who served as reviewers for Volume 26 of the CJNR. They gave generously of their time and shared their knowledge and in so doing have contributed greatly to the editorial process and to the development of nursing knowledge.

La Revue canadienne de recherche en sciences infirmières est reconnaissante envers les personnes ci-dessous nommées d'avoir révisé son volume 26. Ces personnes ont généreusement donné de leur temps et partagé leur savoir. Ce faisant, elles ont largement contribué au processus éditorial et au développement des connaissances en sciences infirmières.

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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

Acute Care

Winter 1995 (vol. 27, no.4)

Topics such as the individual's and families' response to illness, new approaches to care, the impact of new technology, and interdisciplinary approaches are welcome. Priority will be given to research reports. However, review articles will also be considered.

Editors: Dr. Laurie Gottlieb and Dr. Mary Grossman
Submission Deadline: August 15, 1995

Culture & Gender

Spring 1996 (vol.28, no.1)

Papers are invited that address the theoretical and methodological issues in conducting cross-cultural research. We are especially interested in receiving articles from a feminist perspective, that attempt to examine the intersection of gender, race and class in the conduct of nursing research, and that outline strategies for the utilization of research findings.

Guest Editor: Dr. Joan Anderson
Submission Deadline: October 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

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 limite pour les soumissions: le 15 mai 1995

Soins Aigus

publication: hiver 1995 (vol. 27, no.4)

Vous êtes invités à nous soumettre des articles portant sur les soins aigus. Les sujets peuvent concerner, entre autres, l'existence de nouvelles approches de soins, l'impact de nouvelles technologies, les réactions à la maladie, l'implication du malade et de la famille et la collaboration interdisciplinaire. Les rapports de recherche auront la priorité, Cependant, les articles critiques seront également pris en considération.

Rédactrice invitée: Dre Laurie Gottlieb et Dre Mary Grossman
Date limite pour les soumissions: le 15 août 1995

La Culture et le Sexe

publication: printemps 1996 (vol.28, no.1)

Les articles porteront sur les questions théoriques et méthodologiques dans la recherche interculturelle. Nous aimerions surtout des articles rédigés dans une optique féministe, qui tenteront d'examiner le croisement du sexe, de la race et de la classe sociale dans la recherche en sciences infirmières, et qui mentionneront des stratégies pour l'utilisation des résultats de la recherche.

Rédactrice invitée: Dre Joan Anderson
Date limite pour les soumissions: le 15 octobre 1995

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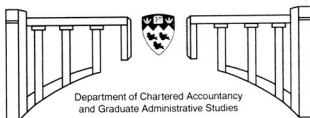
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Celebrating the Past; Looking to the Future

Calendar of 75th Anniversary Events – 1995

January 24, 1995	**Official Launching of Anniversary Year** Honoured Guests: Principal Bernard Shapiro, McGill University Dr. Lynn Curry, co-author of *Educating Professionals*
February 9, 1995	**Research Colloquium:** **"Nursing Research:** **A Look at the Past, Present, and Future"** Guest Speaker: Dr. Mary Ellen Jeans, Director General NHRDP, Health Canada
March 16, 1995	**Research Colloquium:** **"Measuring Uncertainty"** Guest Speaker: Dr. Merle Mishel, Professor, School of Nursing, University of North Carolina, Chapel Hill
March 23, 1995	**Research Colloquium:** **"Pain Management in Cancer Patients"** Guest Speaker: Dr. Elizabeth Farrell, Associate Research Scientist, City of Hope Medical Center, Duarte, California
March 30, 1995	**Research Colloquium:** **"Multisite Research"** Guest Speaker: Dr. Nancy Hester, Associate Professor, University of Colorado Health Sciences Center
April 20, 1995	**Research Colloquium:** **"Well-Being of Caretakers of Patients Suffering** **Dementia: A Longitudinal Study"** Guest Speaker: Louise Levesque, Professor, Faculté des Sciences Infirmières, Université de Montréal
September 22, 1995 Hôtel du Parc	Nursing Explorations Conference and Luncheon "Celebrating the Past; Looking to the Future"
November 17, 1995 Redpath	Anniversary Banquet (sponsored by the Hall Alumnae)

N.B. Readers can be encouraged to call the School if they are interested in attending any or all of the events. All research colloquiums take place at 4:00 p.m. at the School of Nursing, 3506 University Street, Wilson Hall, Room 110.

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Information for Authors

The Canadian Journal of Nursing Research is a quarterly journal. Its primary mandate is to publish nursing research that develops basic knowledge for the discipline and examines the application of the knowledge in practice. It also accepts research related to education and history and welcomes methodological, theory and review papers that advance nursing science. Letters or commentaries about published articles are encouraged.

Procedure: Three double-spaced typewritten copies of the manuscript on 8½ x 11" paper are required. Articles may be written in French or English. Authors are requested not to put their name in the body of the text, which will be submitted for blind review. Only unpublished manuscripts are accepted. A written statement assigning copyright of the manuscript to *The Canadian Journal of Nursing Research* must accompany all submissions to the journal. Manuscripts are sent to: The Editor, *The Canadian Journal of Nursing Research*, McGill University, 3506 University Street, Montreal, Qc H3A 2A7.

Manuscripts

All manuscripts must follow the fourth edition of the *Publication Manual of the American Psychological Association*. Research articles must follow the APA format for presentation of the literature review, research questions and hypotheses, method, and discussion. All articles must adhere to APA guidelines for references, tables and figures. Do not use footnotes.

Title page: This should include author(s) name, degrees, position, information on financial assistance, acknowledgements, requests for reprints, address, and present affiliation.

Abstract: Research articles must include a summary of 100-150 words containing information on the purpose, design, sample, findings, and implications. Theory and review papers must include a statement of the principal issue(s), the framework for analysis, and summary of the argument.

Text: The text should not exceed 15 double spaced typed pages. References, tables, and figures should follow the text.

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