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FALL EDITORIAL

A Blueprint for the Development of the Profession of Nursing: The Legacy of F. Moyra Allen and Joan Gilchrist

Coincidences never cease to amaze me. This issue of the *Canadian Journal of Nursing Research* was decided upon over two years ago and the timing of its publication was chosen to coincide with the end of the year-long 75th anniversary celebrations of McGill University, the University of Toronto, and the University of Western Ontario. As we prepared to go to press, I came across the federal government Status of Women's announcement that this year's theme for Women's History Month (celebrated in October) was Leaders, Scholars, Mentors: The History of Women and Education. As I reflected, nursing has been blessed with remarkable nurse-educators whose ideas and courage shaped the development and direction of Canadian nursing. In effect, this anniversary year has been a celebration of their careers.

Leaders have an impact on collective development, whereas mentors leave their indelible imprint on the individual. Each of us has been mentored by an individual(s) who took a special interest in our life and career by sharpening our mind and stimulating ideas, providing those unique opportunities that set us on a new course, and/or bolstering confidence and encouraging risk-taking. Not all mentors are leaders, but most leaders are mentors. Moyra Allen and Joan Gilchrist belong to the latter group.

I dedicate this editorial to these two women because of their very special association with this journal and McGill University. During their long tenure at McGill's School of Nursing, Moyra Allen founded this journal and served as its first editor, while Joan Gilchrist was the director.

These two remarkable women dominated the local, national, and international scene for over three decades. Their influence extended beyond the walls of McGill University and the boundaries of the Montreal nursing community. Their ideas and actions permeated the recesses of Canadian nursing and stretched beyond our national borders. These two women, so different in their approach and style, shared so much in common. Their talents and skills complemented

each other and together they were able to create, innovate, and push the nursing agenda forward in Canada. They set nursing practice, nursing research, nursing administration, and nursing education along new courses. For their outstanding contribution to the development of Canadian nursing, they have been honoured by universities, governments, and professional associations.

Honours and awards are expressions of recognition by the collective. However, they fail to convey the depth of influence of a life changed, a career enhanced. I was fortunate to have them as my mentors during the formative years of my own career. Their legacy lies in the principles that governed their careers that served as a blueprint for the development of nursing.

Moyra Allen and Joan Gilchrist understood the importance of continuity and change, the essential ingredients of growth. They built on the ideas of their predecessors by changing and modifying them in response to changing societal needs. Earlier leaders at McGill understood that the strength of professional identity and pride was rooted in a clear understanding and vision of nursing. While others defined nursing in terms of the medical model or medicine's mission, the leaders and educators of McGill had developed a strong nursing perspective. Building on these ideas and values, Moyra Allen identified the focus of nursing and its approach to care that distinguished nursing from other professions. Under her leadership, colleagues and students continued to build on and refine these core concepts that are now articulated within the McGill Model of Nursing. Many of these ideas were innovative for their time, and now, 20 years later, have found their way into mainstream thinking. Moyra Allen delineated the boundaries and gave us the language to communicate about nursing. Both women understood that decisions stemmed from a clear conceptualization of nursing. What appears to be a truism is in reality seldom practised.

Their lives were characterized by vision and action. Moyra Allen was considered the visionary, the dreamer, while Joan Gilchrist was known as the manager and implementer par excellence. In reality, they each possessed both qualities but in varying degrees. Their skills complemented one another and together they achieved more than would have been possible if they had worked alone. Their accomplishments are impressive: together they mounted new educational programs, established the first research unit in Canada in nursing and health care, developed the first demonstration units for nursing practice, created vehicles and forums for the dissemination of nursing ideas on research and education, and the list goes on.

I believe their success can be traced back to their ability to keep their eyes fixed on the "far horizon"; they never veered too far off course. They were able to reach their "far horizon" because they understood that there were many pathways to their goal. They created these pathways by recognizing opportunities and turning them to their advantage. They sensed the moment and knew how to seize it.

Moyra Allen and Joan Gilchrist illuminated the pathway for me, McGill University, and Canadian nursing. We, the inheritors, are grateful for their legacy.

Laurie N. Gottlieb
Editor

ÉDITORIAL DE L'AUTOMNE

Esquisse pour le développement de la profession d'infirmière : L'héritage que nous ont laissé F. Moyra Allen et Joan Gilchrist

Les coïncidences m'étonnent toujours. On a décidé il y a deux ans de faire le présent numéro de la *Revue canadienne de recherche en sciences infirmières* et on a choisi sa date de parution pour qu'elle corresponde à la fin de l'année des célébrations du soixante-quinzième anniversaire de l'université McGill, de l'université de Toronto et de l'université de l'ouest de l'Ontario. Comme nous allions mettre sous presse, j'apprenais que le gouvernement fédéral avait annoncé que la condition féminine serait le thème de cette année pour le Mois de l'histoire des femmes (célébré en octobre) et dont l'intitulé était : *Dirigeantes, femmes de lettres, mentors : histoire des femmes et éducation*. Je me faisais la réflexion que les sciences infirmières avaient eu la chance d'avoir de remarquables infirmière monitrices dont les idées et le courage avaient façonné l'évolution et l'orientation des sciences infirmières au Canada. En réalité, cet anniversaire fut la célébration de leur carrière.

Les dirigeants ont un effet sur l'évolution collective tandis que les mentors laissent des traces indélébiles sur la personne. Chacun de nous a été guidé par quelqu'un qui s'est particulièrement intéressé à notre vie et à notre carrière ; cette personne a affiné notre intelligence et stimulé notre réflexion, nous donnant ainsi l'occasion unique qui nous a permis d'aller dans une nouvelle direction, nous faisant confiance et nous incitant à prendre des risques. Tous les mentors ne sont pas dirigeants mais tous les dirigeants sont des mentors. Moyra Allen et Joan Gilchrist sont de cette race.

Je dédie cet éditorial à ces deux femmes à cause de leur association très spéciale avec la présente revue et avec l'université McGill. Au cours de leurs nombreuses années de fonction à l'école des sciences infirmières de McGill, Moyra Allen fonda la présente revue et en fut la première rédactrice en chef, et Joan Gilchrist en fut la directrice.

Ces deux femmes extraordinaires occupèrent le devant de la scène au niveau local, national et international pendant plus de trois décennies. Leur ascendant s'exerçait bien au-delà de l'université McGill et de

la communauté des infirmières de Montréal. Leurs idées et leurs activités pénétrèrent tous les recoins des sciences infirmières au Canada et franchirent nos frontières. Ces deux femmes, si différentes par leur méthode et leur style, avaient énormément en commun. Leurs dons et leurs compétences se complétaient et elles pouvaient, ensemble, créer, innover et faire avancer les programmes de sciences infirmières au Canada. Elles donnèrent une nouvelle orientation à la pratique infirmière, à la recherche, à l'administration et à la formation en sciences infirmières. Leur contribution exceptionnelle au développement des sciences infirmières au Canada leur a valu les honneurs des universités, des gouvernements et des corporations professionnelles.

Les honneurs et les récompenses sont l'expression de la reconnaissance de la collectivité; ils ne traduisent pas, cependant, la profondeur de l'influence sur une vie qui se trouve changée, une carrière propulsée. J'ai eu la chance de les avoir pour mentors durant mes années de formation. L'héritage qu'elles m'ont transmis réside dans les principes qui gouvernaient leur carrière et qui servirent d'esquisse au développement de la profession d'infirmière.

Moyra Allen et Joan Gilchrist connaissaient l'importance de la continuité et du changement, facteurs essentiels à la croissance. Elles se basèrent sur les idées de leur prédécesseur, les modifiant en fonction des besoins changeants de la société. Les premiers dirigeants de McGill savaient que bien comprendre et avoir une vision claire des sciences infirmières donnerait toute sa force à l'identité et à la fierté de la profession. D'aucuns définissaient les sciences infirmières comme modèle médical ou mission de la médecine, les dirigeants et les éducateurs de McGill avaient élaboré une solide perspective pour les sciences infirmières. À partir de ces idées et de ces valeurs, Moyra Allen établit l'aspect le plus important des sciences infirmières et une méthode de soins qui distinguait les sciences infirmières des autres professions. Sous sa direction, collègues et étudiants continuèrent à faire évoluer et à raffiner ces deux concepts-clés qui sont maintenant clairs au sein du modèle de soins infirmiers de McGill. Nombre de ces idées étaient novatrices pour leur temps. Maintenant, vingt ans plus tard, elles se sont répandues dans l'opinion dominante. Moyra Allen fixa les frontières et la terminologie pour la communication concernant les sciences infirmières. Les deux femmes savaient qu'une conceptualisation claire des sciences infirmières influencerait sur les décisions. Ce qui semble être un truisme est en réalité rarement mis en pratique.

La vision et l'action caractérisaient leur vie. Moyra Allen était considérée comme la visionnaire, la rêveuse tandis que Joan Gilchrist avait

pour réputation d'être la gestionnaire, celle qui, par excellence, exécutait les projets. En fait, elles possédaient toutes deux ces qualités mais à des degrés divers. Leurs compétences se complétaient et ensemble, elles réussirent ce qu'une seule personne n'aurait pu accomplir. Ce qu'elles réalisèrent est impressionnant : ensemble, elles élaborèrent de nouveaux programmes pédagogiques, elles mirent en place la première unité de recherche en sciences infirmières et en soins de santé au Canada, elles mirent au point les premières unités de démonstration pour la pratique des soins infirmiers, elles inventèrent des moyens et organisèrent des forums pour faire connaître les idées des sciences infirmières sur la recherche et sur l'éducation, etc.

Je crois que leur réussite est due à leur capacité de garder les yeux rivés sur des horizons lointains ; elles ne s'en éloignèrent jamais beaucoup. Elles parvinrent à les atteindre parce qu'elles savaient qu'il y avait de nombreuses façons d'arriver à leur but. Elles trouvèrent ces façons en saisissant les occasions et en en tirant avantage. Elles sentaient le moment et savaient comment le saisir.

Moyra Allen et Joan Gilchrist tracèrent la voie pour moi, pour l'université McGill et pour les sciences infirmières au Canada. Nous qui bénéficions de ce précieux héritage en sommes très reconnaissants.

Laurie N. Gottlieb
Rédactrice en chef

Focus: History of Nursing

GUEST EDITORIAL

Nursing History: Some Issues and Insights

This special issue on nursing history reflects a renewed interest in nursing's past and a growing body of scholarship in this relatively untapped field of study. It provides a sample of historical research in Canada and gives insight into current issues in nursing history.¹

In **Designer's Corner**, Diana Mansell draws attention to a key methodological issue in historical research. She questions the integrity of research based primarily on written documents created by nursing's "elite" and reflecting activities of leaders rather than rank-and-file nurses. Mansell's arguments can be weighed within the context of the articles in this special issue.

Two articles focus explicitly on nursing leaders. Baldwin's discourse on Mona Wilson, an early public health leader in PEI, is largely biographical. It has the charm of traditional nursing history in which leaders were the conveyers of the values, beliefs, and legacy of nursing. What is new in this work is the analysis of Wilson's life as a case study of networking as a force in women's public and private lives. Ross Kerr and Paul, on the other hand, focus on a small segment of Helen Penhale's life, on her efforts and ultimate failure to implement an integrated baccalaureate nursing program. This study of a nurse leader in confrontation with institutions reinforces the thesis that nurses were not just an oppressed group; nursing leaders also had to contend with obstacles within their peer group.² Analysis of these events provides invaluable insight into the social, political, and economic forces that shaped current issues in nursing. Although Mansell's arguments about the elite focus of historical data are well taken, these articles provide convincing evidence that nursing still has much to learn, even from its "elitist" records.

Zilm and Warbinek, in their study of the early years of tuberculosis (TB) nursing in British Columbia, come closer to meeting Mansell's challenge to bring the rank-and-file nurse into nursing history. The

authors draw upon both traditional documentary sources and oral history tapes and interviews with nurses who had TB, or TB nursing experience, to describe care provided in institutions and the beginning of nursing care in the community. With the recent increase in drug-resistant TB, this article is timely and leaves the reader anticipating the authors' further research on the day-to-day care of TB patients.

Finally, a comment for readers who may not be familiar with historical research and are confused by the absence of the "usual" research headings.³ It may help to know that historians are rather smug about their meticulous research, critical analysis of sources, and persuasive written arguments. Having completed their painstaking search and rigorous intellectual activity, successful historiographers discretely re-bury the evidence in footnotes. You should expect to find enough detail in the notes to establish the integrity of the work and to enable you to critically examine the same sources. I hope this sample of nursing history will whet your interest in learning more about our past and about historical research.

Ina Bramadat
Guest Editor

Ina Bramadat, R.N., Ph.D., is Associate Dean, Undergraduate Programs, and Associate Professor in the Faculty of Nursing, The University of Manitoba. She is Past President of the Canadian Association for the History of Nursing/ Association canadienne pour l'histoire du nursing (CAHN/ACHN).

Notes

1. For a recent, informative overview of the issues and state of the art (and science) in nursing history, see the guest editorial by Kathryn McPherson and Meryn Stuart, "Writing nursing history in Canada: Issues and approaches," *Canadian Bulletin of Medical History*, 11 (1994):3-22.
2. Natalie Riegler presents an excellent case for this thesis in "The Work and Networks of Jean I. Gunn, Superintendent of Nurses, Toronto General Hospital, 1913-1941," Ph.D dissertation, Department of Education, University of Toronto, 1992.
3. Several years ago, I submitted a nursing history manuscript to *Nursing Papers*, the precursor of the *CJNR*. The response was, alas, swift: "Nursing Papers is a **research** journal. Occasionally we publish theory papers, but they would have to be of more general interest to nurses." As an untenured academic, I decided it would be suicidal to pursue historical research in Canada, and did clinical research for my dissertation. Being invited as guest editor for this special nursing history issue is both historically and personally significant to me.

Le point : Historique des sciences infirmières

ÉDITORIAL INVITÉ

Historique des sciences infirmières : Quelques questions et réflexions

Ce numéro spécial sur l'histoire des sciences infirmières reflète l'intérêt renouvelé porté au passé des sciences infirmières et montre un ensemble de connaissances en pleine croissance dans ce champ d'étude pratiquement vierge. Le présent numéro offre un exemple de recherche historique au Canada et donne un aperçu des questions courantes concernant l'histoire des sciences infirmières.¹

Dans *Le coin du concepteur*, Diana Mansell attire l'attention sur une question-clé de méthodologie pour ce qui concerne la recherche historique. Elle remet en question la valeur d'une recherche fondée principalement sur des documents rédigés par l'« élite » des infirmières et décrivant ce que font les cadres plutôt que les infirmières de la base. Le poids des arguments de madame Mansell peut être évalué dans le contexte des articles du présent numéro.

Deux articles traitent spécifiquement d'infirmières cadres. Ce qu'énonce monsieur Baldwin au sujet de Mona Wilson, qui fut l'une des premières infirmières en chef de santé publique à l'Île du Prince-Édouard, est largement biographique. On y découvre le charme de l'histoire traditionnelle des sciences infirmières où les chefs transmettaient les valeurs, les croyances et l'héritage de la discipline. La nouveauté dans ce travail, c'est l'analyse qui est faite de la vie de madame Wilson comme étude de cas sur l'importance de l'établissement de réseaux dans la vie publique et la vie privée des femmes. Par ailleurs, mesdames Ross Kerr et Paul s'intéressent à une partie seulement de la vie de Helen Penhale, de ses efforts et de sa tentative infructueuse de mettre en place un programme intégré de baccalauréat en sciences infirmières. Cette étude sur une infirmière cadre en conflit avec les institutions renforce la thèse selon laquelle les infirmières n'étaient pas les seules à être opprimées, les infirmières cadres également devaient

affronter les obstacles dressés par leurs pairs.² L'analyse de ces événements donne un aperçu inestimable des forces sociales, politiques et économiques qui ont façonné les questions actuelles en sciences infirmières. Même si les arguments de madame Mansell sur l'accent mis sur l'« élite » dans les données historiques sont bien pris, ces articles sont une preuve convaincante que les sciences infirmières ont encore beaucoup à apprendre, même si c'est de rapports « élitistes ».

Dans leur étude sur les soins précoces de la tuberculose en Colombie-Britannique, mesdames Zilm et Warbinek relèvent presque le défi de madame Mansell, à savoir faire entrer les infirmières de la base dans l'histoire des sciences infirmières. Les auteures se fondent sur des sources documentaires traditionnelles, sur des enregistrements de traditions orales et sur des entrevues avec des infirmières atteintes de la tuberculose ou bien ayant participé au traitement de tuberculeux, pour décrire les soins prodigués dans les établissements de soins et les débuts des soins infirmiers dans la collectivité. Avec la récente recrudescence d'une tuberculose résistant à l'action des médicaments, leur article, fort opportun, fait que le lecteur attend avec impatience leur recherche plus approfondi sur le rôle des infirmières au niveau des soins quotidiens prodigués aux tuberculeux.

Comment le lecteur, novice dans la recherche historique, peut-il lire ces articles de façon critique ? La méthode n'est pas expliquée selon les rubriques habituelles. S'agit-il vraiment de recherche ?³ Il est peut-être utile de savoir que les historiens sont plutôt infatués quant à leur recherche méticuleuse, leur analyse critique des sources et leurs arguments convaincants. Lorsqu'ils ont terminé leur laborieuse recherche et leur activité intellectuelle rigoureuse, les historiographes couronnés de succès enterrent discrètement les preuves qu'apportent les notes en bas de page. On devrait normalement trouver assez de détails dans les notes pour permettre d'établir l'intégrité du travail et pour pouvoir examiner de façon critique les mêmes sources. J'espère que cet exemple d'historique de sciences infirmières vous incitera à vouloir en savoir davantage sur notre passé et sur la recherche historique.

Ina Bramadat
Rédactrice invitée

Ina Bramadat, R.N., Ph.D., est vice-doyenne pour les programmes d'étudiants de premier cycle et professeure agrégée à la faculté des sciences infirmières à l'université du Manitoba. Elle fut présidente de l'Association canadienne pour l'histoire du nursing (ACHN).

Notes

1. Pour une vue d'ensemble récente et instructive des questions et le nec plus ultra de l'histoire des sciences infirmières, voir l'éditorial des rédactrices invitées, mesdames Kathryn McPherson et Meryn Stuart, « Writing nursing history in Canada : Issues and approaches », *Canadian Bulletin of Medical History*, 11 (1994) : 3-22.
2. Nathalie Riegler présente un excellent cas dans sa thèse de doctorat *The Work and Networks of Jean I. Gunn, Superintendent of Nurses, Toronto General Hospital 1913-1941*, faculté de l'éducation permanente, Université de Toronto, 1992.
3. J'ai proposé, il y a plusieurs années, un article sur l'historique des sciences infirmières aux *Nursing Papers*, l'ancêtre de la Revue canadienne de recherche en sciences infirmières. La réponse, hélas, ne se fit pas attendre : « *Nursing Papers* est une revue de **recherche**. Nous publions parfois des articles théoriques, mais ils doivent être d'un intérêt plus général pour les infirmières. » Comme je n'étais pas professeur titulaire, je décidai qu'il serait suicidaire de poursuivre des recherches historiques au Canada, et je me consacrai à la recherche clinique pour ma thèse.

Interconnecting the Personal and Public: The Support Networks of Public Health Nurse Mona Wilson

Douglas Baldwin

La vie de l'infirmière de santé publique Mona Gordon Wilson montre l'importance de la vie privée des femmes pour expliquer leurs activités publiques. Même si la vie et la personnalité de Mona ont été également façonnées par son sexe, sa classe sociale, son groupe ethnique, son célibat et sa place dans une société patriarcale, le présent article affirme que l'établissement de réseaux féminins et de groupes de soutien a été essentiel à sa réussite en tant que personne publique. Après le résumé des points marquants de sa vie publique, l'étude montre l'importance de l'établissement de réseaux féminins et de groupes de soutien au cours de ses années d'études en sciences infirmières, durant les années qu'elle a passées à l'étranger avec la Croix Rouge américaine, puis comme infirmière en chef de santé publique à l'île du Prince-Édouard et enfin alors qu'elle était à la retraite.

The life of public health nurse Mona Gordon Wilson reveals the importance of women's private lives in explaining their public activities. Although Mona's life and personality were also shaped by her gender, class, ethnicity, single status, and place in the patriarchal society, this article contends that female networking and support groups were essential to her success as a public person. Following a brief synopsis of the highlights of Mona's public life, this study examines the importance of female networking and support groups in Mona Wilson's early years as a nursing student, in her years overseas with the American Red Cross, as chief public health nurse on Prince Edward Island, and in retirement and old age.

In 1975, Carroll Smith-Rosenberg's path-breaking article, "The Female World of Love and Ritual," revealed that a network of intimate supportive relationships among American women during much of the eighteenth and nineteenth centuries enabled them to function successfully in society.¹ Nancy F. Cott's subsequent examination of the diaries and letters of young women written between 1780 and 1835 confirmed the importance of female friendships in providing women with needed emotional security.² Subsequent studies have shown that the role of women's friendships and networks of love and support have been crucial to their success as political activists, Western pioneers, missionaries, and professionals.³ To these studies, anthropology has contributed

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the concepts of kinship ties and networking as decisive factors in shaping women's lives and providing emotional nurturing.⁴

Until the late 1970s, the importance and even the existence of women's friendship were obscured and trivialized by historians, who based their theories of adult development on male experiences.⁵ In addition, male-biased research methodologies emphasized the public life of their subjects over their private lives, and praised independence and autonomy versus interdependence and connectedness. Feminist scholars, however, argue that it is equally as imperative to gather and analyze information about people's private lives, and to reveal the relationships between a person's public and private lives.⁶ As Veronica Strong-Boag acknowledged in 1991, "Canadian women's history is now recognizing biography as a genre which, for all its largely conservative antecedents, may allow that detailed consideration of the interplay of private and public worlds which is essential if women's lives are to be understood."⁷

Career Highlights

Mona Gordon Wilson, the third child of Harold and Elizabeth Wilson, was born in 1894 in the prestigious Rosedale area of Toronto, Ontario.⁸ Her father owned a popular sporting goods store in Toronto, and belonged to several of the city's exclusive organizations. The family mingled with the city's commercial, political, and social elites. After graduating from the Toronto Model School, Havergal Ladies' College, and the Lillian Massey School of Household Science in Toronto, Mona departed for Baltimore, Maryland, in 1914 in quest of a nursing diploma at the Johns Hopkins Hospital School of Nursing. Following graduation from Johns Hopkins in 1918, she enlisted in the American Army Nursing Corps, and sailed to France in December 1918. The next year she joined the American Red Cross Society in Siberia. Quartered in Vladivostok, Mona worked in a women's medical ward and trained Russian nurses' aides in the principles of practical nursing. By the time Mona left Siberia at the end of February 1920, she had witnessed a failed coup attempt and had watched helplessly as mounted Bolshevik soldiers rode into her hospital ward looking for deserters.

In May 1920 the Red Cross sent Mona to Tirana, the capital of Albania. Since Muslim women refused to be examined by male doctors, Mona and several other American Red Cross nurses conducted home visits in this war-ravaged country. Mona accompanied the mobile clinic into the mountains to preach the benefits of toothbrushes and soap and to conduct baby clinics. In Tirana, she helped to establish a small school

for training local nurses. In late June 1920, Mona hurried by car to the Adriatic coast, amidst a barrage of shells, to work in the Red Cross medical unit located about 10 kilometres from the warring Albanian and Italian armies. When the fighting ceased, the Italian Red Cross decorated Mona for her efforts.

Following the Armistice in August 1920, the American Red Cross dispatched Mona to Ragusa (now Dubrovnik) on the Dalmatian coast to care for 30,000 White Russian refugees who had escaped from the Crimea. Here, she clothed, fed, and nursed the expatriates back to health so they could be relocated elsewhere in Europe. In April, Mona travelled to Vir Pazar, Montenegro, where for the next nine months she organized Mothers' and Little Mothers' clubs, conducted home visitations, accompanied mobile clinics into the mountains, initiated school inspections, and was the resident nurse in an orphanage.

Mona returned to Toronto in January 1922. The following year she earned her Public Health Nursing Diploma at the University of Toronto and accepted the position of Red Cross Chief Public Health Nurse in Prince Edward Island. In the absence of a provincial health department, Mona and her small staff ministered to the Island's health needs for the next eight years. She initiated medical inspections in the schools, established dental clinics, Junior Red Cross clubs, tuberculosis chest clinics, crippled children's camps, and organized province-wide smallpox and diphtheria vaccinations. Touring the countryside, Mona preached the necessity of planting vegetable gardens, drinking milk, and eating wholesome food.

When the provincial government established a Department of Health in 1931, it appointed Mona Wilson Provincial Director of Public Health Nursing. In this position, Mona was later instrumental in training dental hygienists to conduct educational programs for improved dental health — the first time such personnel had been used in a public health department in Canada. She also played a major role in the establishment of the Division of Nutrition, and in the introduction of Child and Maternal Health programs. Except for the Second World War years, Mona held this position until she retired in 1961. In October 1940 the Canadian Red Cross seconded her as Red Cross Assistant Commissioner for Newfoundland. Here, she took charge of administering to the needs of shipwrecked soldiers and sailors on the North Atlantic Run. For this work she earned the nickname "the Florence Nightingale of St. John's," and received the Order of the British Empire.

In addition to these accomplishments, this dynamic woman helped to establish the Girl Guides, the Zonta Club, the Business and Profes-

sional Women's Club, and several other Island associations that sought to broaden people's vision and boost women's self-confidence. By the time of her death in 1981, Mona had been awarded the highest honour in Girl Guides (the Beaver, in 1957), in international nursing (the Florence Nightingale Award, in 1963), and in Prince Edward Island (Island Woman of the Century, in 1967).⁹

Network Formation as a Student Nurse¹⁰

Shortly after Mona's arrival at the Johns Hopkins Hospital in 1914, Elsie Lawler, Superintendent of Nurses, welcomed the prospective nurses into the Hopkins "family" and outlined the rules and regulations. The young women were instructed where to sit in the dining room, to stand in the presence of a superior, to obey orders immediately, to keep their rooms neat and ready for inspection at all times, to ask permission to leave the hospital grounds or to have visitors in the dorm, to keep their hair in a bun and tucked under their cap, and when to rise, eat, study, and retire. The nurses were expected to avoid boisterous laughter and frivolous activities, and to confine conversation while on duty to professional matters. Lower orders were not to fraternize with their superiors; nurses were not to become friendly with the patients or the staff. Careless work was punished by suspension, and dating a doctor brought dismissal.¹¹

How did young women such as Mona Wilson cope with the constant surveillance and physical and psychological stresses of nursing school? Social scientists have shown that friendships are especially important during times of transition, and admittance to nursing school certainly qualified as a transitional stage.¹² Separated from their families for the first time, alone, and immersed in a strictly disciplined environment, it seems only natural that the student nurses would create what Nancy Tomes has termed "a little world of our own."¹³ The fact that they shared their living arrangements with others in similar positions inevitably led to the blossoming of intimate friendships, and encouraged the young nurses to think of themselves as sisters. Like girls in boarding schools and colleges, the young nurses helped each other overcome homesickness and incorporated each other into their kinship systems.¹⁴

In discussing friendships formed at women's colleges, Barbara Solomon notes that it was natural for a girl to create a small group of peers "who knew each other's deepest thoughts and feelings....and gave each other respect and affection akin to love, as well as encouragement in their new adventure."¹⁵ Mona Wilson's personal correspon-

dence indicates that she formed her own surrogate family at Hopkins, which provided her with companionship, support, and self-respect. In keeping with the school's family metaphor, Mona's little clique of six or seven like-minded students of similar class and ethnicity referred to themselves as "our family," and adopted nicknames for each other.

Mona's Hopkins family included Marion Rossiter (Mary Anne), Phyllis Higginbothan (Phyl), Ruth Barton (Rufus), and several other students.¹⁶ These women provided each other with the emotional and spiritual support to endure the trials of nursing school. United by similar experiences and expectations, the nurses acquired an occupational identity that was later reinforced by membership in professional associations and through subscriptions to *The Johns Hopkins Nurses Alumnae Bulletin*.¹⁷ When graduation day came, the thought that she might not see her friends again cast a pall over Mona's mood. "I'm quite lost and forlorn these days," she wrote to her Toronto family, "it's awful to be bereft of one's dearest friends."¹⁸

Network Formation Overseas

In subsequent years, wherever Mona went, she quickly formed her own "family" of like-minded women, who shared experiences and assumed an emotional centrality in each other's lives. Although membership in the family expanded and contracted over the years, Mona always gained strength from her female friends and relied upon them for personal validation and career opportunities. Correspondence, visits, and international health conferences provided an informal network of health professionals that bridged the gap between public and private life. Many of these family members remained Mona's life-long friends and provided continuity and intimacy in her middle and old age.

In Europe, Mona's "private family" consisted of a tight-knit group of eight Hopkins graduates with similar tastes who remained together throughout their stay in France. They liked sweet foods, the theatre, long walks, dancing, visiting historic sites, and good conversation. These women were between 24 and 28 years old (except Ruth, who was in her mid-30s), and demanded that the males who temporarily attached themselves to their group be amusing and fun-loving.

Following demobilization, Ruth Barton and Judith Saville returned to work at Johns Hopkins, Alleyne Clarke began child relief work in New York, and Phyllis Higginbothan commenced private nursing in Ontario. Thus when Mona and Marion Rossiter sailed for Russia in 1918 they did so without their support group. Like the Johns Hopkins

School of Nursing, the American Red Cross (ARC) strictly enforced hospital discipline, and the Chief Nurse completed monthly efficiency reports for each nurse, evaluating off-duty deportment as much as nursing skills. Civilian clothes could be worn only in the personnel quarters, and nurses travelling in groups were requested to dress similarly.¹⁹ Violation of the rules met with swift punishment. One nurse was dishonourably dismissed from the service for getting married, and was asked to refund her expenses and return her Red Cross pin and membership card. Several other nurses were placed under close observation even though their work was excellent.²⁰ Dallas Ireland, for example, was doing "good work," but her attitude toward co-workers was reported to be "very undesirable." Like many of the other nurses, including Mona and Marion Rossiter, Dallas had enrolled in the ARC with her best friend (Julia Harrison), and they expected to remain together; but Dallas rarely saw Julia, whom the ARC sent into the interior. "The poor child is so unhappy here," Mona noted in her diary, "and so fearfully 'in wrong' with the Red Cross."²¹

As she had done elsewhere, Mona and other like-minded nurses formed their own little group, or family. Linked by common tasks and placed in an unfamiliar environment, the nurses in Vladivostok banded together for comfort and companionship. Mona's family included Marion, with whom she shared a room, Virginia Ward, Dallas Ireland, and about 10 others. Mona and Marion maintained a regular correspondence with Ruth Barton, signing their letters with such declarations as "Your children," and "One of the Inseparables." As she had done in France, and would later do in Albania and at the University of Toronto, Mona used her growing network of female friends to ensure future employment. When it became evident that the ARC would be leaving Siberia, she contacted Hopkins schoolmate Katherine Caulfield at the Rockefeller Foundation in China about working there, and wrote to another friend about opportunities in India.²²

Friendship with a Special Person

During her travels overseas, Mona's special relationship with Marion Rossiter sustained her through hard times. As roommates at Hopkins, and later as travel and work companions, Marion and Mona were inseparable. They talked about life into the early hours of the morning, visited each other's families, and spent summers together. In letters home, and in her diary, Mona referred to Marion as "my MaryAnne" or "my dearest friend." Perhaps the best example of their special relationship comes from August 1919 when the ARC summoned Marion to

Vladivostok but left Mona behind in Japan. "Absolutely desperate," the two friends pleaded with the ARC officials to allow Mona to accompany Marion, but to no avail.²³ The tone of Mona's diary now turned morose and desolate. On her 25th birthday she wrote in her diary, "How tragic it is to have to grow old despite oneself." Hospital work now seemed a terrible ordeal, and she stopped taking her evening walks. Each day Mona waited expectantly for a call to Vladivostok, and as the days dragged on she became more and more depressed.²⁴ Informed that she had to take the evening hospital shift, Mona was "on the verge of losing my disposition, and had to go on a walk to get in a better frame of mind."²⁵ Two days later she was almost at the end of her tether, and could alleviate her misery only by writing to Marion. Ultimately, Mona became sick, which was most unusual for her, and was possibly stress-related.

Finally the cable came. After seven weeks, Mona was about to "see my Mary Anne again."²⁶ Immediately, the tone of her diary lightened. The day after the cablegram arrived she wrote that "the harbour was lovely with the moon and the lights on the small boats bobbing up and down."²⁷ Reunited in Siberia, the two friends continued to "tremble in our boots for fear we will be separated." At such times a "black cloud" seemed to be hovering over them.²⁸

Although Mona and Marion separated in 1922 when they returned to North America, they stayed in close contact. They exchanged frequent letters, and Marion visited Mona in Prince Edward Island in the summers and was introduced to her new friends. In 1925 Mona's private life was devastated. Whereas Mona had been prospering in her work on the Island, Marion was becoming increasingly depressed. In May 1924 Marion wrote that she was "in the depths" and longed "for a buddie — some congenial soul to talk with — and bat about the country."²⁹ Since the autumn of 1922 Marion had been medical superintendent at St. George's School for Boys in Newport, Rhode Island, but was now considering a change. She wrote that she might just "drift for awhile and might take a PH [public health] course, after which you will simply have to work with me."³⁰

All such plans were abruptly terminated in September 1925 when Marion died from tuberculosis. Mona's older sister, Helen, was sympathetic:

I am so sorry Mona, it will be dreadfully lonely for you without her. One grows so away from other people when one has a real real friend — and then there is that hopeless gap in one's life — and it will seem

almost impossible to bridge. My dear — you must be feeling sore and blue, and almost a thing accursed.³¹

This was exactly how Mona felt. "The dear, dear girl," she wrote sadly to her sister Jane:

I feel unutterably lonely to know she is not any place to chat with through letters or have the hope of joining up and going off together — but am glad that her suffering is over at last....but I feel that there is nothing worth while ahead of one now.³²

The days seemed without meaning. After a short business trip to Montreal, Mona unburdened her feelings to Jane. "How ghastly it all is," she wrote about returning to the old grind, "I'd give my hat to be going in the opposite direction....I shall have to stay on for another year — and then that will be four and time to move on to something else."³³

Marion's death left a huge emotional gap. At Johns Hopkins they had roomed and studied together. These close bonds were strengthened by their shared experiences in France, Vladivostok, Albania, and Montenegro. They faced imminent death together, called each other by pet names, shared sorrows, joys, and anxieties, and connived to ensure that the authorities did not separate them. Mona had shared her private and emotional world with no one else. Her behaviour changed noticeably after Marion's death, which illustrates the importance of exploring one's private life for understanding the public person. Whereas Mona had once been fun-loving and reckless, just "one of the girls," she now acted the head nurse, became obsessed with her work, and remained aloof from her co-workers.

Network Formation as Chief Public Health Nurse in PEI

When Mona arrived in Prince Edward Island in 1923 she faced a daunting task. Partly because of the province's poor financial situation, there were virtually no public health facilities. PEI was the only province without a Department of Public Health, a tuberculosis chest clinic, a bureau of vital statistics, a hospital out-patient department, a tuberculosis sanatorium, and a provincial laboratory.³⁴ After meeting with the Red Cross board of directors, and learning how wide-ranging her responsibilities were, Mona felt like weeping, and by the end of the day she was ready to return to Toronto, "so low do I feel."³⁵ Her lodging at the YWCA provided no reason to change her mind. The women boarders took every occasion to sing hymns, and invited her to evening prayers. "Something tells me," she wrote her parents that night, "that I

will be expected to attend church on Sundays or I will be an outcast — this is certainly no place for me.”³⁶

Fortunately, she soon became part of another surrogate family (although she stopped using this word), which stroked her self-esteem, provided emotional support and a sense of belonging, and helped her in her endeavours. Steeped in nursing traditions of hierarchical authority, and restrained by her own sense of class, Mona avoided forming close associations with her staff.³⁷ Instead, she relied for emotional support upon an expanding network of single women of similar class.

Mona formed close bonds with the Holman family in Summerside, one of the most prominent PEI families. She soon became a close friend of Carrie Holman. Since Gladys Holman had attended Havergal and Nora Holman was a Johns Hopkins graduate, Mona had much in common with the entire family. Carrie was Vice President of the Red Cross Society for Prince County, a member of the Canadian Council for Child Welfare, and secretary of the Prince County Children’s Aid Society, so they met frequently on work-related issues. Half a century later, when Mona donated her antique furniture to the Heritage Foundation, she recalled the early days at the Holman estate:

What gracious living there used to be. I remember how we used to sit around the fire in the living room of the Holman Homestead while Mrs Holman read to us — Carrie, Gladys & me. How I loved the feeling of that cultured setting, the restfulness of the surroundings after a busy day of travelling the country districts & wallowing through the wet clay roads.³⁸

She needed just such an environment to rest and recharge her batteries.

In Charlottetown, Mona acquired another circle of friends. Like the Holmans, these companions were usually service-minded, independent, intelligent, middle- to upper-class single women who also liked to picnic, swim, and take walks. Despite her busy work schedule, Mona expanded her circle. With Kitty Peters, Mary Prouse, and Emily McCollum she tramped in the woods on Saturdays, often returning with flowers to decorate the office. In the winter she skated, snowshoed, and played badminton with another group. After Marion Rossiter visited the Island in the spring of 1924 she wrote she liked Mona’s new friends and that “everyone raved about the wonderful work you were doing.”³⁹

Such was the strength of her many new friendships that after the first few years in the province Mona never seriously considered

leaving. Her sisters often tried to convince her to move to Toronto, but to no avail.⁴⁰ After visiting PEI, an acquaintance remarked:

[Mona] knows nearly everyone on the Island...[always speaking] with love and enthusiasm of her beloved "Island" and its people. [She] is known and respected by all who know her and their number is legion....No one is more highly respected and admired than Miss Mona Wilson.⁴¹

As Mona's career flourished, she developed close ties with other intelligent and ambitious female public-health leaders in Canada and the United States, such as Charlotte Whitton and Margaret Grier. Mona corresponded frequently with like-minded career women in this expanding network and met them regularly at conferences. When Mona announced her retirement in 1961 a friend wrote, "I can hardly bear it. CPHA annual meetings without my roommate!!!"⁴² Mona's public and private lives were intermixed. Each sustained the other.

Network Formation and Voluntary Associations

Like the friendships that bridged the public and private spheres of Mona's life, the Girl Guide movement united her personal and work worlds. In 1934, she became the first president of the Charlottetown Girl Guides Association. The fact that Guiding was grounded in British values and attracted "respectable" women such as the wives of the premier, the lieutenant-governor, Island physicians, and members of the clergy appealed to Mona's class-consciousness. Camping dovetailed with her love of the outdoors and conformed with the public health movement's emphasis on fresh air and country living. The Guiding movement also provided opportunities to cultivate female friendships. When she sailed with 34 other Canadian Guiding leaders to England in 1936 to attend the Coronation of King George, for example, Mona enjoyed herself immensely. She was selected patrol leader, and had a great time singing camp songs, chatting with the other Guiders, giving concerts for the passengers, and joining in frequent gales of laughter. At the same time, she took advantage of the opportunity to learn as much as she could about Guiding practices elsewhere in Canada.⁴³

Under Mona's leadership the Guiding movement blossomed. She established a permanent summer camp, created a Ranger Company, wrote a weekly newspaper column for Guides, published a monthly bulletin for out-of-town companies, and created a crippled children's Extension Company. When Mona stepped down as Provincial Commissioner in 1937 the number of Brownies and Girl Guides had multiplied by thirteen.⁴⁴ In these efforts she was aided by the large

number of friends, such as Carrie Holman, and public health nurses, Mary MacNutt and Elaine Harrison, who joined Guiding under Mona's leadership.

The Importance of Family

Mona also drew upon the supportive love of her family to sustain her. At Hopkins, she hung a family photograph on the wall to keep up her spirits, and wrote regularly to her parents, including messages of encouragement for her younger sisters. Her letters were colourful and wonderfully descriptive, revealing an irrepressible excitement with life. Separate notes to her father were addressed to "My Dear Dad," 15-year-old Jane was "Jinnie," and Margaret was "Monkey." Mona often signed these letters with such flourishes as "the Idiot Abroad." In the following years, she corresponded regularly with her sisters, who often holidayed on the Island and interacted with the women in her network.

Mona's family was also important to her success as Chief Public Health Nurse. After less than three months on the job in PEI, Mona faced her biggest and most important task. The climax of each Island summer was the Provincial Exhibition in Charlottetown. Islanders came from all over the province to view livestock and crop displays, exhibit their best pure-bred stock, watch harness races, and be entertained by vaudeville shows. The Red Cross executive expected Mona to organize a booth to inform Islanders of the Society's activities and to teach them proper health habits. Mona had been worried about this aspect of her job for several months and in desperation had enlisted the help of her mother and two younger sisters. Her mother procured health brochures, while Margaret and Jane inspected the Red Cross booth at the Canadian National Exhibition in Toronto and sent their sister detailed accounts and drawings of its physical appearance, copied examples of graphs and charts on such topics as infant mortality and tuberculosis, and noted the title of each poster. "What you want," Jane explained, "is a few lurid pictures of these old bugs at work — or as I suggest some microscope play for the PE Islanders!"⁴⁵ Following the success of her exhibit, Mona wrote in appreciation:

I do want to thank you most awfully for sending all the literature and dope on the Toronto Ex — for your letters crammed full of suggestions, and yours Jane about the posters etc — and your remarks on bugs etc. and microscopes were so delicious that I went around grinning all day and chuckling over them.⁴⁶

In old age, Mona grew even closer to her siblings, whose shared experiences provided her with an important anchor to the past.⁴⁷

Although her brother never visited PEI, he wrote every week, reminded her of approaching family birthdays and anniversaries, and enclosed clippings from Toronto newspapers. Mona once replied that she felt especially good on Sunday knowing her brother was thinking of her.⁴⁸ Margaret and Jane became frequent visitors after Mona suffered strokes in 1974 and 1978. The sisters enjoyed their time on the Island. They visited Mona's friends, who became theirs, and sat on each other's beds at night gossiping about family, friends, and old times.⁴⁹

Although Mona was steeped in female communities in her public and private lives, her sense of sisterhood rarely extended beyond class boundaries. As Chief Red Cross Nurse, and later as Superintendent of Public Health Nursing, she possessed considerable community status and wielded significant power over her public health nurses. Mona kept her distance from the nurses. She ate lunch in her office, rather than with the secretary and the nurses. Twice a year or so she invited the staff to her home, but she rarely developed personal friendships with her workers, and when she did it was usually after they had left her employ.

When the Canadian Red Cross Society supplied Mona with several young female volunteers to assist her in Newfoundland, she attempted to limit the women's social activities and insisted that they behave like officers and maintain a cordial but not-familiar attitude with the rank and file. One day, after Mona insisted that a staff member write a note thanking the Governor for hosting a dinner party, and deliver it the next morning before breakfast, the young women just shook their heads and thought of her as *pusser*, a naval word for a person who insists on ceremony and traditional behaviour.⁵⁰ Although they occasionally shared a good laugh, Mona and her staff tended to exist in two separate worlds after working hours, and when the Red Cross recommended that Mona share a house with these women she objected to living in such "close proximity to my workers."⁵¹

Although the nurses referred to Mona as a "dictator," the "colonel," and a "strict disciplinarian," Mona took a great interest in the well-being of her staff. She regularly visited retired nurses and took them for drives in the country. When Dorothy Cox accepted a job with the World Health Organization in India, Mona personally redirected all her mail, looked after her finances, and corresponded with her several times a year. If the Division's secretary was swamped with work, Mona cheerfully assisted her.⁵² When Ruth Ross talked about quitting because she was having trouble with her old car, Mona said, "'You take my new car'. She was very anxious for her staff, you see."⁵³ Eleanor Wheler,

who had worked with the Victorian Order of Nurses in New Brunswick and had been a nursing supervisor in Ontario before going to PEI, was particularly impressed with Mona's supervisory abilities:

I don't know how she did it. She made me want to work my fingers to the bone, but I don't know how she did it. That's one thing I couldn't do when I was supervising in Ontario. She loved directing, she had a tremendous enthusiasm for it, it was her whole life. You could just feel the magnetism, you tried to live up to it.⁵⁴

It is doubtful, however, that Mona could have maintained such working relationships without her rich friendships and networks of support.

The Importance of Support Groups in Retirement and Old Age

Several of Mona's friends commented that she was not prepared to retire in 1961. "For many of us," Mona wrote a nursing friend shortly after her forced retirement, "there just is no such state. You are one of those and so am I."⁵⁵ Contemporary studies show that occupational prestige is critical for single, working women's sense of self-esteem and satisfaction.⁵⁶ The literature on aging suggests that loss of self-esteem after retirement can be prevented by participation in community activities. Volunteer work provides social contacts, a chance to share skills and life experiences, and an opportunity to contribute to society.⁵⁷ Prior to her retirement, Mona was generally too busy to participate in many volunteer organizations. In 1961, however, she threw her energies into establishing a branch of the Zonta Club in Prince Edward Island. Olga Cloke, the Canadian organizer for Zonta, described how she relied upon Mona in recruiting members:

[Mona] knows nearly everyone on the Island....I cannot speak too highly of her and of what she had done for Zonta and for me. She was ever ready to drive me, to advise me on personalities, to introduce me to men and women she thought might be helpful.⁵⁸

Zonta International recruited executive women who wished to promote high ethical standards, improve the status of women in business and the professions, serve the community, and advance the cause of world peace.⁵⁹ As an honorary member, Mona chaired a committee that discussed the role of the United Nations, researched the need for day-care centres in Charlottetown, and worked at Red Cross blood clinics. As Zonta historian she helped edit the club's book, *Women of the Century*. And as chair of the Zonta committee on highway safety, Mona designed a grey reflector armband for pedestrians to wear at night. She also organized PEI's first defensive driving course.⁶⁰

In addition to the importance of volunteer activities in bridging the gap between paid employment and retirement, studies on aging indicate that friendships become more important in retaining self-esteem in the elderly. A study of 50 never-married women born between 1884 and 1918 discovered that their female friends were the chief source of validation, companionship, and intimacy in their 20s and 30s; these friendships solidified and deepened in middle and late-middle age; and retirement brought even deeper commitment.⁶¹ Friends who share gender, personal and generational experiences, and economic position become more significant for each other after retirement and are a major source of intimacy and emotional support. Old friends are valued listeners and confidantes, and can be depended upon for moral support and short-term aid in times of sickness.⁶²

Mona's Hopkins classmates such as Ruth Barton and Ruth Wood served as reminders of past adventures and as eager travelling companions; and Islanders such as Kitty Peters, Marge Malone, and Kitty Sadler provided spiritual nourishment and intimacy. These long-time friends shared similar experiences and supplied a sense of meaning in her old age.⁶³

Prior to her stroke in 1974, Mona and several friends made a pact not to tell their relatives if anything happened to them until the problem was solved one way or the other.⁶⁴ Mona favoured equitable friendships, in which one party was not always reliant upon the other.⁶⁵ Such a relationship was no longer possible with her sisters Jane and Margaret: they were younger than her and still quite healthy, and she did not want to be a burden to them. The first stroke awakened Mona to her own mortality, and she made a will. Several friends had already died. Ruth Wood died in 1967, and two years later her "very, very, very dear friend," Ruth Barton, had a fatal heart attack. In 1971 her older sister Helen suffocated in her sleep when her house caught fire. Mona's letters began to contain numerous references to her past. For the first time in 50 years Mona referred to Marion Rossiter. Although the literature on such self-reflection equates reminiscence with the approach of death and an increased sense of vulnerability, life-review also serves to provide the elderly with a sense of significance and meaning to their life and prepares them for death.⁶⁶

Conclusion

When Mona Gordon Wilson died quietly in a nursing home on November 11, 1981, she left her adopted province considerably better than she had found it. The *Charlottetown Patriot* wrote upon her retirement in 1961: "Nurse extraordinary, personal friend and confidante of countless Island farm wives, Miss Wilson had a career in this province which can only be equalled by the depth of her understanding of the health problems of its people."⁶⁷ The Island had changed a great deal in 38 years. Children drank milk rather than sweet tea for lunch, and their mothers provided them with balanced, nutritional meals. Every family had toothbrushes, and children under 13 received free fluoride treatment. Smallpox, diphtheria, tuberculosis, and maternal mortality were no longer menaces, and crippled children were cared for by the province.

These were Mona's public successes. However, without the support, love, and nurture of her siblings, her network of professional associates, and her private "families" of female friends, she would not have endured the rigorous training of nursing school, the perils and loneliness of conditions in Siberia and the Balkans, and the male-dominated public health profession in Prince Edward Island. These support groups gave her self-respect and confidence, supported her public endeavours, secured her employment, offered sage advice, and provided recreation time to recharge her batteries before re-entering the hectic world of public health nursing.

If Mona Wilson's life is representative of those of other single, working women born at the turn of the century, then it is imperative that an examination of their life stories include the contributions of female networking and support groups to their success in the public sphere.

Endnotes

1. Carroll Smith-Rosenberg, "The Female World of Love and Ritual: Relations Between Women in Nineteenth-Century America." *Signs: Journal of Women in Culture and Society* 1, (1975).
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 8. Mona's siblings included Helen (1890), Harold MacKenzie (1892), Jack (1896), twins Jane and Doris (1900), and Margaret (1905). Doris died in 1906, and Harold during the First World War.
 9. Primary sources of information for understanding Mona Wilson's private life included the large collection of letters, diaries, speeches, photographs and other memorabilia that she stored under her bed, which, along with the PEI Red Cross records, are now housed in the Public Records and Archives Division, Prince Edward Island; interviews with approximately 30 relatives, friends, and co-workers provided additional insights into her personality; assessments of Mona as a student nurse located in The Alan Mason Chesney Medical Archives of the Johns Hopkins Hospital, and material on her work for the American Red Cross located in the American National Archives and at Stanford University; the Zonta Club correspondence located in the PEI Red Cross office in Charlottetown. Additional material written by and about Mona included those contained in such contemporary journals as the *Canadian Nurse*, *The Canadian Red Cross Junior*, and the *Dominion Dental Journal*.
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24. Letters from Marion to Ruth Barton and Harold Wilson reveal that Marion was equally upset about the forced parting. Marion to Ruth, 23 August 1919; Marion to Mr. Wilson, undated, *ibid*.
25. *Diary*, 20 August 1919, PAPEI, Acc. 3652.
26. *Diary*, 6 September 1919.
27. *Ibid.*, 7 September 1919.
28. Marion to Ruth Barton, 12 October 1919, PAPEI, Acc. 3652.
29. Marion to Mona, 22 May 1924, PAPEI, Acc. 3652.
30. Marion to Mona, 8 December 1924, PAPEI, Acc. 3652.
31. Helen Lea to Mona, 2 October 1925, letter in author's possession.

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34. For a discussion of public health care on the Island, see Douglas Baldwin, "Volunteers in Action: The Establishment of Government Health Care on Prince Edward Island, 1900-1931," *Acadiensis*, Spring 1990.
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36. *Ibid*.
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Visions Realized and Dreams Dashed: Helen Penhale and the First Basic Integrated Baccalaureate Program in Nursing in the West, at the University of Alberta 1952-1956

Janet C. Ross Kerr and Pauline Paul

C'est en 1919 que des programmes fondamentaux de diplômes en sciences infirmières ont débuté au Canada à l'université de Colombie-Britannique. Ce programme-là et les autres qui suivirent ailleurs représentaient une forme non intégrée où un programme de diplômes en sciences infirmières offert par un hôpital était complété par des cours universitaires en lettres, en sciences humaines et en sciences appliquées. En 1942, l'université de Toronto mettait en place un programme de baccalauréat fondamental et innovateur en sciences infirmières. Il s'agissait du premier programme intégré où les sciences infirmières étaient enseignées par l'université et où ces cours étaient proposés conjointement avec des cours universitaires d'autres matières. Avant le rapport de la Commission royale d'enquête sur les services de santé de 1964, il y eut seulement deux tentatives pour mettre en place des programmes intégrés au Canada. L'université McMaster mit en place un programme en 1946 et l'université de l'Alberta en 1952, tentative qui se révéla infructueuse.

L'étude avait pour objet d'examiner la situation lorsqu'un programme fondamental de diplôme était mis en place puis terminé dans les années cinquante à l'université de l'Alberba. Il est important de comprendre le fondement de ce conflit pour comprendre certaines questions qui ont été cruciales avec le temps par rapport au mouvement concernant l'établissement de programmes universitaires fondamentaux de diplômes pour les infirmières et infirmiers. Il est également utile de saisir la discrimination relative au sexe des infirmières et des étudiants en sciences infirmières qui prévalait au niveau de la santé et de l'enseignement. Même si le conflit étudié à l'université de l'Alberta était très difficile pour les infirmières impliquées, et bien que la directrice qui s'était montrée assez téméraire pour mettre en place le programme quitta son poste lorsqu'on mit fin sommairement au programme, l'analyse des événements qui se sont passés donne un aperçu de l'ambiance dans laquelle baignait l'enseignement des sciences infirmières au niveau du baccalauréat et de certaines questions relatives à son évolution dans le temps.

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The first basic degree program in nursing in Canada was established at the University of British Columbia in 1919. This program and those that followed elsewhere were of the non-integrated form, wherein a diploma program offered by a hospital was supplemented by university courses in the arts, humanities, and sciences. In 1942 an innovative basic baccalaureate program in nursing was established at the University of Toronto; courses in nursing, given by the university, were offered in conjunction with university courses in other subjects. Only two other attempts were made to set up integrated programs in Canada prior to release of the Report of the Royal Commission on Health Services of 1964: McMaster University established a program in 1946, and, in an attempt that was ultimately unsuccessful, a program was established at the University of Alberta in 1952.

The purpose of this study was to examine the conditions surrounding the initiation and termination of a basic degree program in the 1950s at the University of Alberta, in order to understand the key issues in the movement to establish basic university degree programs for nurses, and the gender discrimination relative to nurses and nursing students that has prevailed in health and education. Although the conflict at the University of Alberta was a very difficult one for the nurses involved, and although the Director who had the temerity to establish the program relinquished her position when the program was summarily terminated, this episode in Canadian nursing history provides insight into the climate in which baccalaureate nursing education existed and into some of the issues relative to its development.

The history of nursing education in Canada has been characterized by slow progress, frustrating struggles, heartbreaking compromises, and, occasionally, well-deserved victories. Often the successes are more readily recalled than the hardships and setbacks that were an integral part of achieving important goals. Failure to analyze setbacks results in an obscuring of the effort required to improve standards of education and establish nursing as an academic discipline. The purpose of this paper is to explore a chapter in the history of nursing education at the University of Alberta that illustrates how the efforts of a strong nursing leader to establish an integrated degree program were stifled by powerful opponents. Since the context of nursing education at the University of Alberta is representative of that in Canadian universities in the 1940s and 1950s, an understanding of the conflict is useful in recognizing issues involved in establishing basic integrated degree programs in nursing.¹

Emergence of the Integrated Degree Program

University education leading to a degree in nursing began in Canada with the establishment of a degree program at the University of British Columbia in 1919. In 1920, national and provincial Red Cross societies provided funds to universities for courses in public health nursing which facilitated the establishment of degree programs in a number of universities. Since the courses were arranged in conjunction with a

diploma program offered by a hospital, responsibility for teaching all courses for which the degree was granted did not rest with the degree-granting institution. A series of surveys, including the Goldmark Report of 1923,² the reports of the Committee on the Grading of Nursing Schools of 1928 and 1934 in the United States,^{3,4} and the Weir Report of 1932⁵ in Canada, resulted in a new awareness of disquieting deficiencies in the education of nurses and drew attention to the need for courses and programs at the university level.

The introduction of an integrated degree program in 1942 at the School of Nursing of the University of Toronto was the culmination of 16 years of experimentation in basic educational preparation for nurses spearheaded by E. Kathleen Russell. It was made possible by a grant of \$250,000 from the Rockefeller Foundation. Although there was an outpouring of public support for nursing as an essential service during the war years, only this generous support allowed for the implementation of an integrated degree program at a time of significant social upheaval on the world stage when some university schools were struggling for their very survival.⁶

However, the majority of university schools continued to offer non-integrated degree programs and there was no movement to more expensive integrated ones. Between 1942, when the Toronto program was introduced, and 1967, with the Report of the Royal Commission on Health Services⁷ which castigated universities for continuing to espouse an educationally-flawed model, there were only two exceptions to this trend. The first was the establishment of an integrated degree program at McMaster University in nearby Hamilton, Ontario, in 1948; then in Western Canada, at the University of Alberta, an important attempt was made to establish a degree program in nursing, using the integrated program as a prototype.

Delegating Authority for Nursing Education to the University

The appointment of Helen Eileen Marie Penhale as Director of the School of Nursing at the University of Alberta followed the resignation of Agnes J. MacLeod, who had been on leave for active duty with the Canadian armed forces from 1943 to 1946. Miss MacLeod left the post of Director upon her return to Canada, to become matron-in-chief for the Department of Veterans' Affairs.⁸ At the time of her appointment, Miss Penhale had been a faculty member of the Institute of Public Health of the University of Western Ontario. A native of St. Thomas, Ontario, she was a graduate of the Mount Sinai School of Nursing in New York and held bachelor's and master's degrees from Teachers

College, Columbia University. The announcement of her appointment in the March 9, 1946, edition of the *Edmonton Bulletin* noted: "She is well known in Edmonton, having taught for two seasons at the university summer school for graduate nurses."⁹

Prior to Miss Penhale's appointment, the following item appeared on the agenda of the September 14, 1945, meeting of the University of Alberta Hospital Board: "Letter from Dr. Newton Re. Organization of Training School."¹⁰ In the letter, Dr. Robert Newton, President of the University and a member of the Hospital Board, put forward new ideas in relation to the structure and operation of the School of Nursing. He proposed that

the Director of the School of Nursing should have complete jurisdiction over the instruction of students both in the University and in the University Hospital, while the Superintendent of Nurses in the hospital should have supervision of service, duties, discipline, et cetera.¹¹

Dr. Angus McGugan, Medical Superintendent of the Hospital, pointed out that the University grants not only degrees to degree students, but diplomas to the diploma students, and that the University reasonably might expect a large measure of authority in the direction of those basic subjects dealing with the science of nursing, for instance such subjects as physiology, anatomy, et cetera.¹²

Dr. McGugan argued further that the Canadian Nurses' Association had developed standards for the nursing curriculum "in both the Science of Nursing and the Art of Nursing, and that one should be careful not to take any steps which would divorce the Art of Nursing from the Science of Nursing and vice versa."¹³ "It was further pointed out that control of the school of Nursing insofar as matters of policy and curricula are concerned is now vested in the Council of the School of Nursing."¹⁴ Following some discussion, it was concluded that University Hospital representation on the Council was sufficient to exercise control despite concern over the new arrangements whereby the University would assume control of the School of Nursing in its entirety.

The following statement underscores the extent to which senior nursing staff members of the School of Nursing participated in the nursing service of the hospital:

It was further indicated that hospitals depend upon their teaching staff for a great deal of hospital administrative work, particularly supervision. At the present time our Instructor of Nurses and our Surgical and Medical Supervisors make rounds in the hospital and are competent to act for the Superintendent and Assistant Superintendent of

nurses on holidays, weekends, and at such other times as occasion may require. The Superintendent was of the opinion that this arrangement should maintain and the Training School Officers should not regard themselves as teachers only with no responsibility for the operation of the hospital.¹⁵

It was noted that "while there is no set-up similar to Alberta's in Canada, there are several in the United States"¹⁶ and that Dr. McGugan was "of the opinion that the working arrangement between the University and the University Hospital should be as close as possible and that the Science of Nursing and the Art of Nursing should be intimately correlated." However, he cautioned that "we should not lose sight of the fact that we are graduating nurses and...should not attempt to graduate an individual qualified to carry on modified medical practice."¹⁷ The matter was deferred; Dr. McGugan was instructed to gather further information on this matter and to consult with the Medical Advisory Board, the Superintendent of Nurses and the Council of the School of Nursing.¹⁸ A reference in the minutes to the "unique" arrangement between the University Hospital and the University of Alberta indicates that the University Hospital administration was satisfied with the joint diploma and degree programs. The arrangement was undoubtedly unique in Canada at the time, and it is likely that there were few centres in the United States where hospital administrators held such a high degree of control over a university degree program in nursing.

At the next regular meeting of the Board there was again "considerable discussion...regarding the organization of the Training School."¹⁹ Board members asked that "representations" from the Superintendent of Nurses and the Medical Superintendent be "made available to the Board so that they may be studied prior to the next meeting."²⁰ Another deferral followed at the next meeting: "After considerable discussion it was decided to postpone any action on this matter until the members of the Board have had a further opportunity to consider the whole question."²¹ When Dr. Newton was absent from the November 9, 1945, meeting, the matter was deferred once again.²² The number of deferrals would indicate that the Board was unwilling to consider a matter involving the authority of the University in the absence of its President. It also hints at some apprehension over the form of organization proposed.

Despite lingering doubts, however, the proposal was approved unanimously at the following meeting, with Dr. Newton in attendance, and he moved "that a Director of the School of Nursing of the University of Alberta be appointed and that such Director have charge

of the instructional services both on the Campus and in the hospital."²³ A few months later the Dean of Medicine announced to the Board Miss Penhale's appointment: "Dr. J. J. Ower indicated that he had been requested by Dr. Newton to advise the meeting that Miss Penhale had been engaged as Director of the School of Nursing."²⁴ It is not known whether the new arrangements relative to the authority of the Director of the School had been made at the request of Miss Penhale as a condition of employment. However, this is likely given that approval of the changes preceded the announcement of her appointment by a scant four months. The question of whether or not there may have been some anxiety about the decision to alter the roles of the Director of the School of Nursing and the Superintendent of Nurses of the University Hospital is raised in an item in the meeting of the Hospital Board following the announcement:

The Superintendent indicated that in the near future it would be advisable that the duties of the Director of the School of Nursing be outlined clearly in order that there be no misunderstanding regarding the duties of the Director of the School of Nursing and the Nursing Superintendent of the University Hospital.²⁵

The matter was tabled in Dr. Newton's absence.²⁶ At the next meeting the following item was recorded in the minutes: "The matter of clarifying the duties of the Director of the School of Nursing and the Superintendent of Nurses at the University Hospital was presented for consideration. It was decided that this matter should not be considered until the Director arrives in Edmonton."²⁷

Further Debate on the Organization and Operation of the School

A question raised in correspondence from the Minister of Health was considered by the University Hospital Board at its meeting of September 13, 1946. Although the substance of the question itself is interesting, of particular interest here is the possible impact of the Minister's opinion on the vesting of administrative authority for the School of Nursing. The Minister

had questioned the advisability of requiring nurses to have senior matriculation standing as a prerequisite to admission to the Training School. It was pointed out to the Minister that senior matriculation is a requirement of admission to the University of Alberta and that the Training School comes under the administration of the University.²⁸

According to the minutes,

The Minister questioned this statement and contended that the University of Alberta Hospital Act of 1929 placed the authority for the

education and training of medical students and nurses under the Hospital Board: Section 7, Subsection c.²⁹

Since there apparently had been no previous discussion of this matter, it was deferred until the President of the University and the Dean of Medicine could consider it further. Nothing more was found in the Board minutes in relation to the Minister's interpretation of the 1929 University of Alberta Hospital Act except for a cryptic statement in the minutes of the December 27, 1946, meeting: "The Superintendent raised several questions regarding the administration of the School of Nursing and considerable discussion followed."³⁰ This discussion may or may not have referred to the question of legal authority for administration of the School of Nursing.

At the next bimonthly meeting of the Board, on January 10, 1947, Miss Penhale and the Instructor in Basic Sciences, Miss McIntosh, were invited "to make representations regarding the organization and operation of the School of Nursing."³¹ Miss Penhale provided the following possibilities:

The position of the Director of the School of Nursing, Associate Professor of Public Health Nursing and Health Education is not sufficiently clear to make for good working relationships. I have outlined two plans which might be considered. A third was presented to the body on October 12th, 1945.³²

She was referring to the plan submitted to the Board by Dr. Newton some five months prior to her appointment, which lends weight to the possibility that the reorganization requested by Dr. Newton had originally been raised by Miss Penhale as a condition of her employment. The two plans outlined by Miss Penhale before the Board included an arrangement known as Plan A:

- (a) The Director of the School is a campus official who has under her in the hospital a Director of Nursing Service and a Director of Nursing Education. The hospital officials here might continue to be known by their present titles of Superintendent of Nurses and Senior Nursing Instructor. These two, once a policy has been established, could function without detailed supervision. In case of any clash of interests or difference of opinion which they themselves could not reconcile, the Director of the School would arbitrate. If the difference were a major one, affecting policy, the Director would probably carry it to the Council of the School of Nursing for discussion and decision.³³

According to Miss Penhale's organizational design, in Plan B:

- (b) The Director of the School of Nursing is in charge of nursing education on the campus and in the hospital.³⁴

Since Miss Penhale and Miss McIntosh were not members of the Board, they then retired from the meeting. After some debate, the Board expressed approval of Plan A and "instructed the secretary to write the Director of the School of Nursing and request her to present a plan for the organization and operation of the School of Nursing, such plan to be forwarded to the secretary for presentation at the next regular meeting of the Board."³⁵ The administrative organization of the School of Nursing was the only item on the agenda of a meeting that lasted three hours, so this was clearly a controversial matter. Although both plans extended the authority of the Director of the School of Nursing, Plan A went further than Plan B, because implementation of a new program would require control of the sizeable nursing service component provided by students, and Plan A stipulated that the Director would have this control. Plan B was closer to the plan Dr. Newton had originally proposed in 1945, and would have had the effect of ensuring that the Director of the School of Nursing controlled nursing education both in the hospital and in the university, while she would have no responsibility for nursing service in the hospital.

The next meeting of the Board, on January 24, considered Miss Penhale's "A Proposed Plan of Organization and Operation of the School of Nursing." She was called in to "explain several details."³⁶ Dr. McGugan was recorded as recommending that the report be submitted to the Superintendent of Nurses and the Hospital Medical Advisory Board for their information and recommendations.³⁷ More revealing is a statement attributed to Dr. McGugan:

He also indicated that the plan proposed to delegate considerable responsibility and authority for nursing education and nursing services to the University either directly or through the Council of the School of Nursing, and referred to Section 7, sub-section c of the University of Alberta Hospital Act.³⁸

Clearly the earlier interpretation of the Minister of Health, that responsibility for the School of Nursing was vested in the Hospital by virtue of the provisions of the University of Alberta Hospital Act, had been accepted by Dr. McGugan and the Board. The Superintendent also "pointed out that the proposed plan would mean a material increase in the cost of the School of Nursing."³⁹ Following further discussion, Dr. Newton made the following motion: "That the Board approve Miss Penhale's plan in principle and ask her to begin putting it into effect as may be practicable. It was further requested that Miss Penhale keep the Board informed of her progress from time to time."⁴⁰

Although the plan was approved and the principals were so informed, the degree of concern over this matter appears to have been considerable. It is probable that the Board and the Superintendent were not completely satisfied that the new directions in nursing education taken by the University and the Hospital were practical and desirable. However, this was not the end of the discussion of Miss Penhale's plan. Although the plan was approved at the meeting of January 24, 1947, the first item on the agenda of the regular Board meeting of February 13 related to the matter again:

A revised draft of the organization of the School of Nursing, University of Alberta, was presented for consideration. The draft was considered at length. It was moved by Dr. Ower, seconded by Dr. Newton, that the revised draft, with certain alterations, be approved. Carried.⁴¹

It is perhaps significant that all of the motions on the reorganization of the School of Nursing at University Hospital Board meetings were made by the University President. Apparently Dr. Newton's support for Miss Penhale in her desire to establish an integrated degree program was unwavering, despite arguments put forward by the Hospital Superintendent.

An item on the agenda of the December 12, 1947, meeting provides some insight into the prevailing educational philosophy of members of the Hospital Board, in that it addresses concern about the contribution of nursing students to the Hospital:

The Superintendent pointed out that two preliminary students and one undergraduate in her second year had withdrawn from the School of Nursing. He pointed out further that this represented a loss of a very material sum of money to the hospital in the training of these individuals and that an attempt should be made to devise some safeguard for the prevention of withdrawals in the future.⁴²

Attrition of students was seen primarily in an economic light, undoubtedly because hospital operations were subsidized by the substantial contribution made by students. It appears that curriculum concerns and the educational needs of students were viewed as secondary to economic considerations.

Ideas and Values: Miss Penhale Earns Respect in the Community

The new Director of the School of Nursing clearly had to take command of a changing enterprise very quickly, as she was called to present plans for the organization and development of the School of Nursing within a

few months of her arrival at the University of Alberta. In a keynote address to a Canadian Nurses' Association convention, Miss Penhale articulated her concern for helping students to gain as much as possible from their education:

The future of nursing depends upon the vision we have for our own future and upon our ability to guide, encourage and direct our students toward being complete students. Encouraging students to master a body of knowledge and certain skills is not enough; we have a responsibility to start them on a program of self-education and to give them the fundamental insights and ways of thought that will enable them to draw the maximum profit from their later education in the school of experience.⁴³

Miss Penhale had a vision of education as self-directed and as a life-long process, concepts that educational philosophers would espouse in decades to follow. In the same address she enumerated attributes she considered essential to the "complete student": a high standard of conduct, discriminating judgement, devotion to truth, discipline, decision-making, action, initiative, and love of adventure.⁴⁴ She described the integrated baccalaureate nursing curriculum she and her colleagues had implemented:

The objective of the integrated academic and basic professional program is to select well-qualified young women and prepare them for community nursing service in hospitals and public health agencies; at the same time, to give them a perspective on the opportunities for professional women and needs of communities for their active participation as citizens.⁴⁵

Some two decades later, Miss Penhale made the following observation:

The type of program we attempted to design was one with a much broader base [broader than previous programs], especially in the social science area. It would require more courses in this discipline as well as requiring nurse-teachers qualified to help students utilize the concepts they had learned in the classroom.⁴⁶

Miss Penhale was particularly concerned by duplication of experiences in the clinical learning environment. While she believed that some repetition was valuable, she deplored wasting time that could be used to better advantage.⁴⁷

It is apparent also that Miss Penhale earned the respect of her peers as she became involved in professional activities soon after her arrival. She became acting President of the Conference of University Schools of Nursing, a national organization. She was also elected President of the

Alberta Association of Registered Nurses, in 1953, serving until 1955. At the University, the minutes of the Executive Committee of the Board of Governors of March 3, 1948, record her promotion: "Miss H. E. M. Penhale, from Associate Professor to Professor of Nursing, and to continue as Director of the School of Nursing, at \$4,500 per annum, from April 1, 1948 (Appointment to be extended without definite term)."⁴⁸ Within two years of her appointment as Associate Professor and Director of the School, Miss Penhale was granted a full professorship with tenure; it must be concluded that her performance was deemed highly commendable, if not distinguished within the university. Universities of the 1940s and 1950s were relatively small institutions and nursing education was a modest undertaking in comparison to other disciplines. It is likely that academic promotion and tenure rested primarily with administrators. In the case of Miss Penhale's promotion to Professor, the final decision probably rested with President Newton.

Conflict over Educational and Service Responsibilities

Following the approval of the new administrative structure for nursing education and service, it appears that the arrangement seemed at the outset to be satisfactory, notwithstanding the concern prior to the approval of the changes in February of 1947. The first indications of discord appear in the minutes of the May 13, 1949, meeting of the Hospital Board, with a reference to a special committee that had been appointed "to consider the matter of nursing services in the hospital."⁴⁹ The only matter described in any detail relates to the duties of the Director of the School of Nursing. The following presentation from Miss Penhale was read into the minutes:

In reply to your request to bring suggestions to the meeting in writing in order to expedite discussion may I present the following:

1. A Director was appointed on March 8, 1946. The specific duties of the Director were tabled and have probably never been too clearly defined.

The new set-up has been in operation almost three years and has obviously not worked. Is it wise to continue the present organization or revert back to the former set-up?"⁵⁰

It appears that Miss Penhale was unhappy with the division of responsibilities and had raised the matter for consideration. The Board response was reported as follows:

The Chairman directed that the questions raised in Miss Penhale's letter be considered at the two June meetings of the Hospital Board and that Miss Penhale be invited to attend the Board meeting on

Friday, June 10th, to discuss this matter, and that the Superintendent of Nurses, Miss Helen Peters, be invited to attend the meeting on Friday, June 24th.⁵¹

The conflict would apparently be played out before the Board, with separate appearances by Miss Penhale and Miss Peters, followed by discussion and decision by the Board.

Miss Penhale appeared as directed at the next regular meeting. The minutes note: "Miss Penhale, Director of the School of Nursing, was called to discuss the matter of the organization of the School of Nursing as she had questioned as to whether or not the presently existing organization was operating to the satisfaction of the Board."⁵² The minutes paraphrase Miss Penhale's representations:

The organization as it presently exists is satisfactory. The operation of the organization is not satisfactory in that according to Miss Penhale, Miss Peters still does a certain amount of the work that belongs strictly to the Department of Nursing Education and does not accept the responsibility for certain duties which belong to nursing service, particularly the matter of making rounds in the hospital.⁵³

At the meeting of June 27, "Miss Peters was then requested to come into the meeting in order that she and the Board might discuss certain phases of the organization and operation of nursing education and nursing services in the hospital."⁵⁴ Miss Peters indicated to the Board that she believed the existing organization to be satisfactory and also that it might "be expected that there will be some conflict of interests between those primarily interested in nursing education and those primarily interested in nursing service."⁵⁵ She intimated, however, that the problem was not as acute as Miss Penhale had suggested, stating that "differences of opinion and problems arising therefrom might be readily adjusted at conferences of the interested parties."⁵⁶ Miss Peters recommended that "the duties and responsibilities of the Director of the School and the Superintendent of Nursing Services should be clarified further, and specified in as much detail as possible."⁵⁷ Her opinion was that the day-to-day operation of the plan for organization approved by the Board was working much more smoothly than it had previously. Further downplaying the problem, she stated that "the most acute problem at present is the scarcity of graduate nurses."⁵⁸

The minutes which record the difficulty with the organizational plan considered by the Board use much more curt, abrupt language in describing Miss Penhale's representation than in describing Miss Peters' representation. As for resolution of the matter, the minutes include only the following statement to indicate the response of Board members:

"After Miss Peters left the meeting the Superintendent was instructed to deal with the whole matter in the light of the information which he had obtained at the various meetings held to discuss nursing problems in the hospital."⁵⁹

An Integrated Degree Program Is Established at the University of Alberta

In the meantime, Miss Penhale moved forward to revise the curriculum. Her plan was to eliminate the five-year non-integrated program in favour of a four-year integrated degree program, and this was approved according to a letter from President Newton to Miss Penhale on June 20, 1950:

The Board of Governors at a meeting June 16 approved the proposal of the School of Nursing, which came forward with the support of the Faculty of Medicine and the General Faculty Council, that beginning September, 1951, there be instituted an integrated course leading to the degree of Bachelor of Science in Nursing and that after September, 1950, no initial registrations in the present B.Sc. course in Nursing be accepted.⁶⁰

He noted that the curriculum for the program would also require approval by the Board of Governors and advised that it be forwarded to them as soon as possible so that it could be included in the 1951-52 calendar. The new four-year degree program was not introduced in 1951 as originally planned, however, because it took longer to prepare the curriculum and secure the necessary support and approvals from the relevant councils and boards.⁶¹

At the regular meeting of the University Hospital Board held on 23 February 1951:

A memorandum was presented from Miss H. E. Penhale relative to certain proposed changes in the nurses' training course. Essentially the memorandum recommended the introduction of the block system of ward training and the reduction of the Degree course from a five to a four year course. However the actual number of months spent in training in the Degree course essentially would be unchanged.⁶²

The Board deferred a decision on the matter, and it was not raised again until November, when it was reported that "a modification of the block system of student nurse training in the University of Alberta Hospital was proposed by Miss Helen Penhale, Director of the School of Nursing, who was interviewed by the Board."⁶³ Considerable discussion was recorded and the minutes note that "the Superintendent indicated that he questioned the advisability of any innovation at a time

when there will be a very material problem in the matter of obtaining staff for the entire new wing."⁶⁴ However, Dr. McGugan went on to say that "in the opinion of Miss Peters, upon whom the responsibility for staffing the hospital rests, the proposed block system would facilitate nursing services in the hospital."⁶⁵ The matter was tabled until the next meeting, when it was approved on the motion of President Stewart.⁶⁶ The programs themselves were considered by the University Hospital Board at the March 28, 1952, meeting, when "Miss Penhale presented a brief in the matter of proposed changes in the basic programme leading to the degree of B.Sc. in nursing."⁶⁷ After "prolonged" discussion, Dr J. W. Scott,⁶⁸ Dean of Medicine, made a motion to approve the program. The proposals had been approved at a special meeting of the Council of the School of Nursing a week earlier, on March 21. The motion also directed the secretary to inform the General Faculty Council of the University that approval was forthcoming from the University Hospital Board.⁶⁹

Following approval of the final version of the curriculum, the four-year degree program in nursing was implemented that September. Early the following year, a meeting of the Council of the School of Nursing considered the number of classes that would be admitted to the School of Nursing: "It was pointed out that with the change of the Degree course, there will now be three classes of pre-clinical students admitted each year."⁷⁰ Concern was expressed over the problems arising from the need to teach so many students simultaneously, and it was suggested "that the January class be eliminated."⁷¹ Perhaps more revealing is the statement that "the loss of diploma students in this class might mean a serious loss of graduates from this school who will be available later as graduate nurses for the staff of this hospital."⁷² The economic value of the student to the Hospital, as recorded in the minutes, foreshadows the difficulties that would ensue.

The Hospital Superintendent Moves to Thwart the New Program

Later that same year the Superintendent of the Hospital, Dr. McGugan, delivered what would be the death-knell of the new integrated program. At a special meeting of the University Hospital Board called on November 9, 1953, the sole item on the agenda was again "Organization Department of Nursing."⁷³ The minutes state ominously:

The meeting was called for the purpose of discussing the organization of the Department of Nursing. Dr. McGugan, Superintendent, reviewed the present organizational chart and outlined the difficulties

created by the Director of Nursing having dual responsibility to the University Hospital Board and the University Board of Governors.⁷⁴

Dr. McGugan indicated that the need for recommendations on the matter had been precipitated by the illness of Miss Peters, Superintendent of Nursing Services.⁷⁵ He recommended the following:

That a Director of Nursing be appointed in charge of all nursing service in the University Hospital and that the University Hospital School return to the arrangement in existence prior to 1945. The Degree nurses would receive their training on an internship basis but during the course of their three years in the hospital, would be under the supervision of the Director of Nursing of the University Hospital. The Director of Nursing of the University of Alberta would continue to indicate the subjects to be taught and the amount of time each nurse is to receive in each subject and would periodically require a report of each nurse concerned.

The Board voted in favour of the Superintendent's recommendation on the motion of Dean J. W. Scott, indicating that it was

in concurrence with the opinion of the Superintendent, that the question of divided authority as represented by the present position of Director of the University of Alberta and the University Hospital School of Nursing has created problems and would prefer that a separate school of nursing be established by the University Hospital and it is hoped that this school could operate in collaboration with the University of Alberta.⁷⁶

At the Executive Committee meeting of the Board of Governors of the University, "the President referred to administrative changes proposed by the University Hospital Board which would, in effect, remove responsibility for training and nursing service within the Hospital from the Director of the School of Nursing."⁷⁷ Further, the President reported that the Director "would still be responsible for the University's B.Sc. program, but Miss Penhale is not willing to stay on the University staff if the changes, to be effective January 1, 1954, are made."⁷⁸ The nature of the response of members of the Executive Committee of the Board of Governors is unrecorded in the minutes, save for the notation that "any such change, affecting the position of a member of the University, could not be made during the academic year, i.e., before May 15."⁷⁹ At the next meeting of the University Hospital Board, the response of the University Board of Governors was reported, indicating that they would be "agreeable to terminate the present arrangement as of May 15th, 1954."⁸⁰ The Board of Governors also made it clear that in the future candidates would be accepted from other diploma schools of nursing as well as those from the University Hospital, and that "it

would not be possible to present diplomas for University Hospital graduates at University Convocation."⁸¹

It is somewhat surprising, if not revealing, that at a meeting of the University Hospital Board Dr. Andrew Stewart, who had succeeded Dr. Newton as President of the University, proposed that "the Hospital Board proceed with the organization of its own school of nursing, to be effective May 16, 1954."⁸² His motion was carried. It can be concluded, since the minutes of the Board of Governors record no disagreement to Dr. McGugan's plan, and in light of President Stewart's motion supporting the decision to initiate a separate diploma School of Nursing, that the University failed to provide support for the four-year degree program offered by its own School of Nursing. Thus the program was summarily terminated on the recommendation of the Superintendent of the Hospital and the Hospital Board, with the concurrence of the President of the University and the University Board of Governors. On March 23, 1956, the Board of Governors of the University of Alberta was informed that Miss Penhale's resignation would take effect on August 31.⁸³

Why Was the Integrated Program Aborted So Soon After Its Inception?

The strongest opposition to the integrated program clearly came from the University Hospital, in particular from the Medical Superintendent, Dr. Angus McGugan. There is also evidence that the new Dean of Medicine, Dr. John W. Scott, failed to support it.⁸⁴ Dr. McGugan wrote in 1964:

With the appointment of the Associate Professor of Nursing of the University, Miss Helen Penhale, as the Director (August, 1946), the school became known and was in fact the University of Alberta School of Nursing (January 1947). This change was made against the advice of the hospital administration. Objections were based on the opinion that the principle of authority without corresponding responsibility is administratively unsound.⁸⁵

We do not know to what extent the Superintendent of Nurses of the Hospital, Helen Peters, supported the new program and the change in the organization of the School of Nursing. She became terminally ill with cancer in 1953, cited by McGugan as a factor leading to his recommending that the schools be separated. He wrote that Miss Peters

pioneered in the establishment of the recognition of nursing as a profession. She was definitely resistive to any attitude of condescension or patronage, or any attempt at domination directed at either herself,

any particular nurse, or at the profession in general by the nouveaux riches or nouveaux [sic] elevés.⁸⁶

So we see that a deep communication impasse between Miss Peters and Miss Penhale may have been the basis of the problem. Words spoken in 1977 by Dr. Scott, Dean of Medicine during the latter part of Miss Penhale's mandate, indicate his support for the Board's position: "The thing that concerns me today is that nurses are becoming more and more 'doctors' and the people who do the *nursing* are the nursing aides. I'm sure there still are dedicated nurses, but a great many of them only come around as executives and keep records."⁸⁷ Some 20 years after the fact, Dr. Scott maintained that the division of the two schools of nursing in Dr. McGugan's time "was a good thing."⁸⁸

It may also be that Jeanie Clark, appointed by Miss Penhale as First Assistant Superintendent of Nurses, failed to provide support for the new program when it was so badly needed. During Miss Peters' illness, Miss Clark, who had been her assistant, stepped into the position on an acting basis. Problems in the relationship between Miss Penhale and Miss Clark may be inferred from events described in Miss Penhale's memorandum to President Stewart on September 16, 1954. She states: "In my telephone conversation with Miss J. Clark, University Hospital, this morning, I was given to understand that the way in which I had handled two specific problems presented by two degree nurses, was considered as 'interference'."⁸⁹ These "problems" appear to have been battles for control of clinical education — battles predicated upon the financial value of the service to the hospital provided by students. To Miss Penhale, who had already lost her integrated degree program and much of her authority and responsibility through the actions of the Hospital Board and the University, this must have seemed like harassment.

Many factors weighed against Miss Penhale and the timing of the introduction of the four-year integrated degree program in nursing. In the postwar period there was an extreme shortage of nurses, which consumed and diverted the attention of hospital and nursing service administrators alike.⁹⁰ Students were seen as a work force of considerable value to the hospital, and their illness and attrition as a money-losing prospect. Since there were only two integrated university programs in nursing in the country at the time, both in Ontario, it can be concluded that understanding of this model of nursing education was limited. Evidence suggests that the Faculty of Medicine at the University of Toronto had been quite supportive of its own School of Nursing and the goals of its Director, Kathleen Russell. The lack of

equivalent support at the University of Alberta was undoubtedly an important factor in the failure to sustain an integrated baccalaureate degree program in nursing.⁹¹

In separate studies,⁹² Kirkwood and Kinnear attribute the low level of power wielded by nursing faculty members of the era to administrative structures unfavourable to women. The low status of nursing in universities meant that without the support of more powerful male colleagues progress was difficult. Western Canadian conservatism, the paternalism of the period, and the vise-like control of nursing by hospital and medical administrators allowed nursing leaders little or no opportunity to make autonomous decisions in their own schools. Nursing was as universally female as medicine and public hospital and university administrations were universally male. It is likely that gender stereotyping and bias played a major role in influencing processes and outcomes. There is also the question of the key players: whether the outcomes would have been different if the presidency of the University had not passed from Dr. Newton to Dr. Stewart, if Miss Peters had not become terminally ill, or if Drs. McGugan and Scott had held more liberal ideas about nursing and nursing education. It is clear that the principal stakeholders here, namely physicians and hospital administrators, wielded significant power over nursing education and nursing service. When they failed to support the goals and directions advocated by key nurses, the balance of power turned against the nurses, who were outnumbered and who were excluded from the table where critical decisions about their discipline were made.

Considering that Helen Penhale was well known in her field, one may wonder why concrete support did not come from bodies such as the Conference of University Schools of Nursing (later the Canadian Association of University Schools of Nursing). However, circumstances within this national organization were far from normal, because of postwar pressures. Member organizations struggled with shortages of qualified faculty and with a large influx of military nurses as students in university nursing programs. Little was accomplished at a national level, local needs taking precedence.

For much of the period between 1948 and 1951, Helen Penhale (Alberta) struggled [as acting president], with the help of the past-president, Kathleen Ellis (Saskatchewan), to keep the organization afloat while the president, Evelyn Mallory (British Columbia), and the vice-president, Sister Françoise de Chantal (Ottawa), were away on study leave.⁹³

After 1948 the Canadian Association of University Schools of Nursing lost much of its strength and unity of purpose when Kathleen Russell and Alma Reid, directors of the only integrated university schools of nursing in the country, objected to an independent role for the organization. They favoured working with the Canadian Nurses' Association to further the interests of university nursing education. This dissension in the ranks of the association rendered it powerless to fulfil its mandate, a situation that prevailed until 1958.⁹⁴

Why the Alberta Association of Registered Nurses did not object vehemently to the termination of the integrated degree program at the University of Alberta is a matter about which little information is available. Since Helen Penhale herself was its President and spokesperson during the program's transitionary period, the Association possibly believed that its representations would have been futile. The AARN had made many representations to the University about improving standards of nursing education over the years, since by virtue of the Registered Nurses Act of 1916 authority for monitoring standards of nursing education was vested in the University of Alberta Senate. According to Young,⁹⁵ such representations had fallen on deaf ears and the University consistently failed to fulfil its responsibility to ensure that standards of nursing education were maintained in the diploma nursing schools of the province.

Another factor making AARN intervention in the dispute difficult may have been divisions within the profession itself. The integrated program model was viewed by some nurses as usurping the power and authority of the major program model in nursing education at the time, the diploma program, and its sponsor, the hospital. Many nursing leaders who taught in and ran the diploma schools were strongly supportive of the diploma program and thus were disinclined to promote the development of competition in the form of an integrated degree program. The question of whether university education was appropriate for nurses was marked by overtones of unsupportive and highly discriminatory approaches to higher education for women. Whether to elevate nursing to university status from the diploma level, to allow women to attend university for four years when two was the norm for a nursing degree, and to forego the considerable revenues that accrued to hospitals from the nursing service provided gratis by diploma students were difficult issues in a society in which education for women was not valued.

The Conflict Is Settled — the Issue Endures

The intent in this paper was to explore the circumstances surrounding the development and implementation of a basic integrated baccalaureate degree program at the University of Alberta from 1952 to 1957. Miss Penhale came to the University of Alberta on the basis of an agreement with Dr. Newton that a new integrated basic degree program in nursing would be introduced. Critical factors included the nature of the agreement between the University and the Hospital for offering the programs and the relative degree of power carried by key individuals and the relationships that prevailed between them. A shift in the balance of power occurred when two central players were replaced during the transition. What became readily apparent is that the diploma and degree programs were highly intertwined in terms of the course of study, faculty, students, and the service provided in the hospital. In the absence of firm commitment of all parties, implementation of the new program would be extremely difficult. Although President Newton had supported Miss Penhale within the University and on the Hospital Board, his successor, President Stewart, took a contrary position and lacked commitment to the new integrated program. The hierarchical structure of universities at the time, the limited participation of women in universities generally, and the tenuous position of nursing as an academic discipline may explain the University's failure to come to Miss Penhale's defence. Issues of gender and the value placed on nursing as an academic discipline were also at play in the conflict over the goals and direction of the School of Nursing.

There is always some irony in history, and here it is found in the fact that slightly more than a decade after the integrated degree program introduced by Miss Penhale was terminated, a new four-year integrated program was established at the University of Alberta by her successor, Ruth McClure. The recommendations of the Royal Commission on Health Services of 1964, cited above, were clearly influential, as within a decade they resulted in closure of all non-integrated degree programs in Canada.⁹⁶ As forerunner of the integrated program established in 1966, the earlier program with two classes of graduates undoubtedly created a climate for eventual acceptance of the idea that the university should assume primary responsibility for the entire education of the nursing student in a degree program. Many Alberta nurses were deeply influenced by the ideas of Miss Penhale and the directions she advocated. When those who held the reins in the dispute over the program were succeeded by others, it became possible to make the case

for developing an integrated degree program in nursing at the University.

The termination of the program before the first class was even halfway through their program of studies is perhaps insignificant in the total scheme of things, for students would graduate from an integrated degree program offered by the University of Alberta 13 short years later. Failure is an important, if painful, means of learning. It is useful to examine such episodes to gain a greater appreciation of the complexity of change in large organizations, the nature of gender discrimination in health and educational settings, and the need for effective communication and true collaboration of all interested parties, in order to implement new program models successfully. This dramatic and well-documented episode in the history of university nursing education illuminates the interplay of forces facilitating and thwarting progress in curriculum innovation. Underscored are professional goals, including improving standards of university nursing education, achieving credibility for nursing as an academic discipline, and promoting equality for women in the university.

Endnotes

1. Primary sources of information include minutes of the University of Alberta Hospital Board, the Council of the Faculty of Medicine, the Council of the School of Nursing, and the Executive Committee of the Board of Governors at the University of Alberta; other documents in the University of Alberta Archives pertaining to the School of Nursing; School of Nursing calendars and yearbooks; and newspaper accounts. Although calendars and yearbooks are not specifically cited, they were consulted extensively and provided information of considerable value in relation to general knowledge of the situation in the School of Nursing and events occurring within the University Hospitals Board. Secondary sources include studies of nursing and nursing education and other documents.
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3. Committee on the Grading of Nursing Schools, May Ayres Burgess, Director. *Nurses, Patients and Pocketbooks* (New York: Committee on the Grading of Nursing Schools, 1928).
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5. George M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932).

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11. Ibid.
12. Ibid.
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14. Ibid.
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16. Ibid.
17. Ibid.
18. Ibid.
19. Minutes of the regular meeting of October 12, 1945, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 193.
20. Ibid.
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22. Minutes of the regular meeting of November 9, 1945, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 197.
23. Minutes of the regular meeting of November 23, 1945, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 199.
24. Minutes of the regular meeting of March 8, 1946, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 217.
25. Minutes of the regular meeting of March 22, 1946, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 218.
26. Ibid.
27. Minutes of the regular meeting of April 12, 1946, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 221.
28. Minutes of the regular meeting of September 13, 1946, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 234.
29. Ibid.
30. Minutes of the regular meeting of December 27, 1946, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 246.

31. Minutes of the regular meeting of January 10, 1947, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 247.
32. Ibid.
33. Ibid.
34. Ibid.
35. Ibid.
36. Minutes of the regular meeting of January 24, 1947, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 248.
37. Ibid.
38. Ibid.
39. Ibid.
40. Ibid.
41. Minutes of the regular meeting of February 14, 1947, UHBMM/AUAH, No. 4. (June 1940-February 1948), p. 250.
42. Minutes of the regular meeting of December 12, 1947, UHBMM/AUAH, Book No. 4. (June 1940-February 1948), p. 290.
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44. Ibid.
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47. Ibid.
48. Meeting of the Executive Committee of March 3, 1948, Executive Committee of the Board of Governors of the University of Alberta, AUA Acc. no. 71-164-10-12, p. 13.
49. Minutes of the regular meeting of May 13, 1949, UHBMM/AUAH, Book No. 5. (March 1948-April 1953), p. 63.
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52. Minutes of the regular meeting of June 10, 1949, UHBMM/AUAH, Book No. 5. (March 1948-April 1953), p. 67.
53. Ibid.
54. Minutes of the regular meeting of June 27, 1949, UHBMM/AUAH, Book No. 5. (March 1948-April 1953), p. 71.
55. Ibid.
56. Ibid.
57. Ibid.
58. Ibid.

59. Ibid.
60. Letter from President Newton to Miss Helen Penhale, June 20, 1950, School of Nursing - General, AUA Acc. no. 68-1-1070, box 95.
61. Minutes of the regular meeting of February 23, 1951, UHBMM/AUAH, Book No. 5. (March 1948-April 1953), p. 153.
62. Ibid.
63. Minutes of the regular meeting of November 23, 1951, UHBMM/AUAH, Book No. 4. (March 1948-April 1953), p. 190.
64. Ibid.
65. Ibid.
66. Dr. Andrew Stewart had succeeded Dr. Robert Newton as President of the University of Alberta in 1950; see Walter H. Johns, *A History of the University of Alberta, 1908-1969* (Edmonton, AB: University of Alberta Press, 1981), p. 489.
67. Minutes of the regular meeting of March 28, 1952, UHBMM/AUAH, Book No. 5. (March 1948-April 1953), p. 213.
68. Dr. John Scott succeeded Dr. J. J. Ower as Dean of the Faculty of Medicine in 1948; see Elise A. Corbet, *A History of Medical Education and Research at the University of Alberta* (Edmonton, AB: University of Alberta Press, 1990), p. 198.
69. Ibid.
70. Minutes of the regular meeting of the Council of the School of Nursing, January 28, 1953, School of Nursing, AUA Acc. no. 68-1-1069, box 94.
71. Ibid.
72. Ibid.
73. Minutes of the special meeting of November 9, 1953, UHBMM/AUAH, Book No. 6. (May 1953-January 1958), p. 25.
74. Ibid.
75. Ibid.
76. Ibid.
77. Minutes of the Executive Committee Meeting, November 24, 1953, Board of Governors and Executive Committee Minutes, AUA (January 1953-October 1954), p. 146.
78. Ibid.
79. Ibid.
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81. Ibid.
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83. Minutes of the Executive Committee Meeting, March 23, 1956, Board of Governors and Executive Committee Minutes, AUA, Acc. no. 71-164-13-15 (November 22, 1954-February 1, 1957).

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85. Angus McGugan. *The first fifty years. A history of the University of Alberta Hospital — 1914-1964* (Edmonton: University of Alberta Hospital, 1964), p. 37.
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88. Ibid.
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Early Tuberculosis Nursing in British Columbia

Glennis Zilm and Ethel Warbinek

Au début du siècle, la tuberculose était au Canada la principale cause de décès, le taux de mortalité étant en 1900 d'environ 200 pour 100 000 personnes. En 1944, ce taux était tombé à environ 20 pour 100 000 personnes. On estime qu'entre 1895 et 1945, les infirmières ont rempli un rôle nouveau, unique en soi et essentiel à l'enraiment de la maladie. Le présent article rapporte la première phase d'une étude qui a consisté à examiner le rôle des infirmières dans l'enraiment de la tuberculose en Colombie-Britannique entre 1895 et 1945. L'étude préliminaire couvre la période allant de 1895 à 1920, alors qu'en Colombie-Britannique les premiers cours universitaires destinés aux infirmières de santé publique n'étaient pas encore mis en place; cependant, les infirmières commençaient à jouer un rôle important pour la santé publique en soignant les tuberculeux. À partir de sources primaires et secondaires, les auteurs établissent des données de base, étudient les soins prodigués précocement aux tuberculeux en Colombie-Britannique, énumèrent les événements cruciaux et fixent la poursuite éventuelle de la recherche.

Tuberculosis was Canada's leading cause of death at the turn of the century, with a mortality rate in 1900 of about 200 per 100,000 population. By 1944 mortality was reduced to about 20 per 100,000. It is postulated that between 1895 and 1945 nurses filled a new, unique, and essential role in bringing the disease under control. This article reports on the first phase of a study to examine the role of nurses in controlling TB in British Columbia between 1895 and 1945. This preliminary study covers the period 1895 to 1920, when B.C.'s first university courses for public health nurses had not yet been established but during which nurses began to play a significant public health role by nursing TB patients. Drawing on primary and secondary sources, the authors establish baseline data, examine early TB nursing care in B.C., identify critical events, and determine whether the research should proceed.

In Canadian schools of nursing at the close of the 1800s the generally accepted maxim was that at least one student nurse from every class would die from tuberculosis.¹ Tuberculosis (TB), also called *consumption*, *the wasting disease*, *phthisis*, and *the white plague*, was Canada's leading cause of death at the turn of the century. The mortality rate in 1900 was estimated at about 200 per 100,000 population.² Even in the 1920s, when it was known that TB was a preventable communicable disease, at least one student nurse in every class was likely to get the

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disease and spend a year or more in a sanatorium. Esther Paulson, who later became one of Canada's authorities on nursing patients with the disease, reported that five of her 17 first-year classmates in 1926 became TB patients.³ With the discovery in 1944 of streptomycin as a specific drug effective against the tubercle bacillus, the disease could be cured. However, without the contributions of hundreds of nurses during the 1920s, 1930s, and early 1940s the disease could not have been brought under control and mortality reduced to about 20 per 100,000 by 1944.⁴ Now, with drug-resistant strains of TB on the rise, a review of the history of TB nursing is relevant. Estimates are that one third of the world's people are infected with *Mycobacterium tuberculosis*. Annually, eight million new cases are identified and 2.9 million deaths occur worldwide.⁵

This article is based on a review of historical materials related to early TB nursing in British Columbia from 1895 to 1920.^{6,7} It reports on the first half of an ongoing study of TB nursing in B.C. that arose from a still-larger historical research project that led to a book on nursing education at the University of British Columbia (UBC).⁸

The research questions that guide the TB study are:

1. What was the nature of TB nursing in B.C. between 1895 and 1945? What were the specifics of care at various points during the 50-year time span: (a) in hospitals, (b) in sanatoria, and (c) in the community?
2. What was the role of public health nurses in B.C. during this period in bringing TB under control (e.g., public education, case finding, follow-up treatment, care, and rehabilitation)?
3. Did the care given by nurses make a difference by reducing mortality and disability?

This article concentrates on the first phase of the study — TB nursing in B.C. from 1895 to 1920. It was decided to tackle this period to discover whether new sources and unpublished material relating to TB nursing care in B.C. were sufficient to warrant continuing. The major questions to be answered in this phase of the study therefore were:

1. What kind of TB care was offered by nurses in B.C. during the period 1895 to 1920?
2. Is there sufficient evidence to warrant proceeding with the second phase of the study?

This article provides background to the complete study by supplying information on early TB care in hospitals, establishment of and care in B.C.'s TB sanatorium at Tranquille, and the beginnings of public health nursing care in the community. The article closes with remarks on the establishment of the public health nursing baccalaureate and diploma programs in UBC in 1919 and 1920, which were strongly influenced by the need for public education on TB — still Canada's number-one killer disease in 1920.

History of the Disease

TB has infected humans for at least seven thousand years.⁹ *M. tuberculosis*, causative organism, is ubiquitous but most humans can resist the disease unless overcrowded conditions, poverty, poor housing, poor nutrition, or other immuno-suppressive disease conditions (e.g., HIV/AIDS) weaken their resistance. Serious outbreaks of TB infections and epidemics, including those of the 1990s, occur when host conditions are favourable to the spread of the disease.

The first hospital dedicated to the care of consumptives opened in 1840 in England¹⁰; the crowded, unsanitary, slum-like conditions in rapidly growing European cities following the industrial revolution encouraged the spread of the disease. In 1867 Jean-Antoine Villemin, a French physician studying phthisis, presented the results of his research to an international medical meeting, "demonstrating for the first time that TB was a specific and communicable disease."¹¹ The tubercle bacillus, as it was then called, was identified in 1882 by Robert Koch, a German physician, lending credence to the new "germ theory" of disease and its spread. Wilhelm Roentgen's discovery of X-rays in 1895 provided a base for diagnosing and following the progress of pulmonary cases.

Canada's first TB hospital opened in Muskoka, Ontario, in 1897. The TB hospitals, or sanatoria, attempted to isolate infected individuals, protect their families and communities, and provide an environment for the three essential principles of treatment: rest, good nutrition, and fresh air. However, nurses soon grew concerned about the emotional effects of separating a patient from family and friends for long periods. Charlotte Aiken, in her 1916 nursing textbook, advised that "freedom from worry and cheerful, comfortable surroundings" was a fourth principle of TB treatment. She considered it a mistake to remove a patient from familiar surroundings "under the delusion that a change of climate [would] cure him."¹²

However, public health authorities had become concerned with protecting of the community. By the turn of the century, hospitals in most communities provided treatment for acute cases in "infectious disease" wards or separate buildings. A tent formed the first TB ward at the Vancouver General Hospital until its TB building (a small wooden structure called Ward O) was opened in 1907.¹³

Whether in hospital or a sanatorium, education of patient and family about "contagion" was a key objective of nursing care along with isolation and symptomatic treatment until the patient either died or built up resistance. Although the most contagious, most common, and most recognizable form of TB was (and still is) pulmonary infection, the bacillus also could invade almost any site in the body and form small nodules, or tubercles (hence the name). It caused joint disease, kidney disease, meningitis, peritonitis ("consumption of the bowel"), and adenitis. Infections in the lymph glands and joints often were caused by the bovine variety of the disease through drinking unpasteurized milk or eating beef from TB-infected cattle. Tubercular joint disease was extremely common, with 80 to 90% of diseases of joints (most commonly involving the hip) caused by tubercle bacilli.¹⁴ Tubercular meningitis was essentially a disease of childhood, almost inevitably leading to death within a short period.

Tuberculosis Care in Hospitals 1895-1920

Treatment of TB from the late 1890s to the 1920s was often primitive and ineffective. For example, Watson describes treatment for meningeal TB:

An ice-bag should be applied to the head, and the bowels should be freely opened; for this calomel in young children answers admirably. Counter-irritation applied to the back of the neck or the shaven scalp in the form of blisters or stimulating liniments is recommended by some....The diet must consist principally of milk. The room should be kept darkened and absolute quietness observed.¹⁵

Treatment for pulmonary TB offered more hope and was a little more humane. There were two types of pulmonary TB — chronic and acute, the latter being rapidly fatal. The hope for patients experiencing the chronic type lay in arresting progress of the disease so that nature could achieve resolution.

In 1893, Isabel Adams Hampton, in one of North America's first nursing textbooks, described nursing care for chronic TB. The "cure" was a stay of a year or more in a sanatorium, usually located in a dry,

mountainous area, which was supposed to facilitate breathing.¹⁶ Sanatoria focused on open-air treatment, with an emphasis on warm, absorbent clothing, good food (especially milk, cream, butter, and suet), a great deal of outdoor life, rest, and exercise that could be tolerated without fatigue. Cod liver oil was prescribed for all kinds of TB, and by the turn of the century had come to be considered a "food," to be given to all patients, rather than a drug. However, it was not palatable and patients objected to a tablespoon or more three or four times a day.¹⁷

Care of sputum was a major focus in nursing, to control the spread of TB. Hampton recommended that sputum be burned immediately or deposited in a strong disinfectant solution:

Patients must be made to use sputum-cups; they should never be allowed to expectorate into a handkerchief, or in fact anywhere except into the proper receptacles. The sputum-cups can be sterilized by steam or by being boiled in a 2 per cent. soda solution.¹⁸

Many authorities still thought the disease was hereditary, but Hampton made this astute observation:

We scarcely need the support of a theory of heredity in consumption: when we think of a child kissing a parent, perhaps many times daily, over whose lips thousands of tubercle bacilli are hourly passing, and when we think of that same child inhaling the dried bacilli and their spores, which always float about in the dust of a house containing tuberculous patients, it would seem strange that the disease does not occur more often.¹⁹

The early symptoms of pulmonary TB indicated a lesion in the lung that would break down and spread rapidly into adjacent healthy tissue. Eventually there would be spread to the regional lymph nodes and into the bloodstream, after which foci could develop in any organ. The primary symptom was an abnormal increase in sputum, often blood-streaked. Other "constitutional symptoms" included a "troublesome, hacking cough," loss of appetite, loss of weight, fatigue, general lassitude, increased respiration, "flushed cheeks and bright eye" low-grade febrile reaction, particularly in the afternoon, copious clammy perspiration, and excessive sweating at night.²⁰

Treatment was addressed at relieving symptoms and reflected the medical armamentarium of the time. Watson advised such treatments as antiseptic inhalations or antiseptic drugs given by mouth; both methods included substances like creosote, carbolic acid, eucalyptus oil, turpentine, iodine, and friar's balsam. Chest pain was relieved by "painting iodine over the seat of the disease," and "blisters" or liniment were applied. For cough, a mixture containing "morphia" was often

ordered. Night sweats were treated by dressing the patient in flannel clothing, sponging the body with tepid water to which a little vinegar was added, or administering belladonna solutions. Quinine was sometimes ordered to bring down an excessively high temperature. Loss of appetite and stomach irritability were usually treated with "bitters," often combined with arsenic. Not unexpectedly, diarrhea was also prevalent in these patients. Treatment for diarrhea involved a lead/opium pill or bismuth/copper remedies. Watson noted, "When these measures failed, the opium-and-starch enema often proved successful."²¹

Hemoptysis (the coughing up of blood) was a dreaded symptom, indicating spread of the lesion into a blood vessel in the respiratory tract. Hemorrhage was a frightening experience for both patient and nurse. Watson advised that "the nurse must enjoin absolute quietness in the recumbent position, with the head and shoulders raised."²² A light icebag would be placed on the chest and small lumps of ice would be given to the patient to suck. Talking was forbidden. Hot-water bottles were applied to the feet and the nurse plotted pulse and temperature findings religiously. Medications used to keep hemoptysis in check included ergot, turpentine, acetate of lead, and sulphuric acid; further, it was felt that the diet "must be restricted to slops."²³ It was essential for the nurse to know how to deal with hemorrhage during a violent coughing spell. One early textbook recommended that all TB wards have a large hemorrhage basket containing the requisites for prompt treatment — the 1920s equivalent of a "crash cart"; these included ice caps and an ice pick, rubber bibs, basins, towels, large gauze squares, and morphine sulphate, atropine sulphate, and nitroglycerine.²⁴

Nursing Care in B.C.'s Tranquille Sanatorium

In B.C. at the turn of the century, wealthy patients with consumption would move to dry, mountainous climates to "take the cure." In the 1890s two ranches in the Tranquille Creek area near Kamloops staked out in the 1860s by William Fortune and Charles Cooney began to accept consumptives as boarders. The boarders lived in tents, shacks, or small cabins near the ranch houses and generally took care of themselves as long as they could. Mary Cooney Norfolk, daughter of Charles Cooney, became well known as a "lay nurse," offering care to the consumptives on the Cooney ranch under the supervision of Kamloops physician Dr. R. W. Irving.²⁵ A Mrs. Fortune offered good food and some care at the Fortune ranch.²⁶

At the turn of the century public concern was being expressed because of the rapid spread of the disease and because of the lack of care and isolation facilities. In 1900 the Canadian Anti-Tuberculosis Society was set up in Toronto. By 1904 B.C. community leaders and physicians recognized the need for a similar organization, and the Society for the Prevention and Treatment of Consumption and Other Forms of Tuberculosis was formed to help bring "the plague" under control. It lobbied the government for funds and took on the task of raising money on its own to develop a sanatorium. This organization arranged to purchase the Fortune ranch for \$58,000 and to build a proper sanatorium on the site.

Hatfield provides anecdotes about the change from the lay nursing system to the new, professional approach to care. The new régime, supported by the provincial medical health officer, Dr. C. J. Fagan, had decided to scrap the old furniture that had been purchased along with the Fortune property:

This furniture was old and, when the coverings had become dirty, another layer had been put over it, so that some of the chairs had six layers and certainly were not sanitary. Dr. Fagan decided to have these burned up. When Mrs. Fortune saw him there was a battle royal. He told her that the chairs and furniture were loaded with germs and had a lot of tubercle bacilli in them. She... said that she had lived there for thirty years and had never seen any.²⁷

The new Tranquille Sanatorium, the centre of TB treatment for the entire province, was opened to 10 patients on November 28, 1907, with Dr. Irving as medical superintendent and Jean Matheson as lady superintendent. Miss Matheson, a graduate of Regina General Hospital, had been matron of Royal Inland Hospital in Kamloops when it opened its nursing school in 1904. Her salary in 1908 was \$60 per month.²⁸ By 1910 the hospital had accommodations for 49 patients, four nurses, and 12 attendants. Its official name was the King Edward Sanatorium and the surrounding ranch was the Alexandra Ranch. Miss M. Thomas became superintendent of nurses in 1913. Some of the older buildings were closed and new ones were erected.

Care of patients in "the San," as it was soon called, was generally "light" nursing, with an emphasis on teaching patients how to care for themselves, how to prevent spread of infection, and how to teach their families to look after them. The cost of keeping a patient in Tranquille was estimated at \$55 per month, and the average stay was 200 days.²⁹ Patients were nursed in large, screened veranda rooms open to the fresh air. One nurse recalled that in winter nurses had to wear their

coats and when patients were awakened for their six a.m. temperature routines they would have frost all around their faces and on the top of their blankets.³⁰ The regimen of rest, fresh air, and good nutrition generally proved successful in arresting the disease. For example, in the first 18 months of operation the Tranquille Sanatorium, 66 patients were discharged, with 23 of these able to take up their customary lives and 20 others able to return home in remission although not able to return to work or active lifestyles; in 17, the disease was considered "progressive" (incurable but no longer infectious), but only six patients had died.³¹

The isolation from families also resulted in a decreased spread of the disease. On the other hand, family life was considerably disrupted by the long hospitalizations.

Nurses working in sanatoria or on hospital TB wards rarely contracted the disease. They appreciated the importance of good technique and the emphasis on patient teaching. The vulnerable nurses were those who worked on the general wards, where they were exposed to undiagnosed TB patients, in situations where they frequently were overworked, tired, and worn out by the typical 64-hour work week.³²

Tuberculosis Nursing Care in the Community, 1895-1920

Public health care in B.C. was in its infancy at the turn of the century. Organization of public health services began in 1893 with establishment of the Provincial Board of Health. The first provincial permanent medical health officer, Dr. Charles J. Fagan, was appointed in 1899. Before this, temporary medical health officers coped with emergencies, such as outbreaks of smallpox or other contagious diseases.

Two of Dr. Fagan's primary goals were to bring TB to the public's attention and to attempt to get it under control. He was instrumental in forming the Society for the Prevention and Treatment of Consumption and Other Forms of Tuberculosis and in initiating a public education campaign. By 1901 use or sale of milk from TB-infected cows was prohibited and TB was made a notifiable disease, meaning that, by law, all cases were to be reported to public health authorities.

The Victorian Order of Nurses (VON), founded in 1897, had pioneered community nursing in Canada and had introduced training in community nursing, including TB care. The first professional visiting community nurse in B.C., Isabelle Maud Hill, was appointed VON nurse in Vancouver in 1901.³³ In 1914 she was hired by the anti-tuber-

culosis society in Vancouver³⁴ and became the first nurse in B.C. to work full time in TB care. Miss Hill was a pioneer nurse specialist.

The society and the public health authorities were especially concerned with public education about TB and with health in the schools. Two pamphlets were issued by Dr. Fagan's department in 1908; the first dealt with "the scourge of consumption and modern methods of combatting its ravages" and the second contained advice to children in language they would easily understand, such as "Don't spit on slate or use any slate that others have spit upon" and "Don't eat candy or chewing gum that others have sucked or bitten pieces off."³⁵

Curricula in nursing schools stressed the contagious nature of TB and that its control depended upon public education. Graduates, most of whom worked as private-duty nurses in homes, were therefore aware of the need to teach hygiene to adults and children alike, and because they were well prepared and knowledgeable school boards and private societies began to hire them.

In 1912 the *Vancouver News Herald* carried the following ad:

The Vancouver Girls' Auxiliary of the Anti-Tuberculosis League is anxious to secure the services of a capable and well-trained nurse upon whom they can rely to second them in their efforts to combat consumption in this city. The nurse will be expected to visit cases of consumption and advise as to the best methods of treatment as well as "giving instruction in preventive measures."³⁶

A similar ad in the *Vancouver Province* asked for a nurse to "instruct the ignorant and encourage the wise."³⁷ The nurse who was hired for the part-time position was a Miss A. Gillis, a graduate of Boston City Hospital who had considerable experience in district nursing in New York's East Side. She drew up a 10-point job description that included the revolutionary idea of regular follow-up visits for all patients discharged from hospitals or sanatoriums.

In 1913 "a deputation of ladies from the Vancouver Anti-Tuberculosis Association" urged the police commission to enforce the bylaw against expectoration. They recommended that notices in English, Italian, Chinese, and Japanese be posted to inform people that "they must not spit on the sidewalk."³⁸ Bylaws were passed in many locations and many of these remain in effect today.³⁹

Local, provincial, and national anti-TB societies continued to introduce programs, especially in large centres such as Vancouver. In 1914 a free clinic was set up in Vancouver through donations from the Rotary Clubs, with Miss Hill staffing the clinic to do case finding and follow-

up visits. She was appalled at the crowded living conditions and poverty that she saw, and with financial assistance from the anti-TB society was able to assist in some of the situations.⁴⁰

In addition to the community nursing care provided through the VON and the anti-TB society, municipal and provincial governments were beginning to hire nurses for health education and follow-up for contacts of infectious diseases, including TB. The first school nurse in Vancouver, Elizabeth Breeze, was appointed in 1910 to help supervise the health of 9,800 children in Vancouver's 16 schools.⁴¹ Several other B.C. communities, such as New Westminster and Victoria, also hired nurses through their school board budgets.

In 1911 the *Medical School Inspection Act* was passed by the B.C. Legislature. Shepherded through by education minister Dr. Henry Esson Young, it provided for a physical examination for every school-child in the province at least once a year. However, since few physicians were available, the provincial health department began to recognize that nurses could effectively fill this role. Dr. Young (who left politics in 1914 and succeeded Dr. Fagan as Secretary of the Provincial Board of Health) began pressing for advanced education in public health nursing. This was a factor leading to the establishment of Canada's first university baccalaureate program in nursing, at UBC in 1919.⁴²

Nursing Program at UBC

Dr. Young was a strong and influential advocate of a degree program for public health nurses. He believed they could carry out essential education in many areas, including prevention and control of TB. Because of the work they were already undertaking, Dr. Young recognized the expanded role that public health nurses could play in government service.

Another factor in the establishment of the UBC nursing department in 1919 was increasing concern over the poor health of young men called up for military duty for the First World War. Following the war the League of Red Cross Societies recommended that its member organizations concentrate on preventing disease (especially TB, venereal diseases, and malaria) and promoting health. The proposed UBC degree program would have a strong public health component as well as a strong administration component for its final year. Its advocates therefore thought it would be eligible for some of these funds.

Instead, the Canadian Red Cross Society called for short, certificate courses for public health nurses, and suggested that its provincial

branches offer subsidies to universities for post-graduate education for public health nursing.⁴³ In 1920 the B.C. branch provided a \$5,000-a-year salary for three years for a public health "chair." A department of public health, separate from the department of nursing, was set up. Dr. R. H. Mullin, head of both the UBC department of bacteriology and the Provincial Laboratories, was considered the logical choice to run the program, but he elected to share his salary with a nurse to ensure that the program was truly a nursing one.⁴⁴ These Red Cross funds, although administered separately, also helped launch the baccalaureate program.

The nurse chosen to head the public health nursing certificate course was Mary Ardronie MacKenzie, who had been the chief superintendent of the VON in Ottawa from 1908 to 1917.⁴⁵ Mary Ard. MacKenzie, as she was called, had a B.A. degree from the University of Toronto and a "Higher School" teaching certificate. She had taught high school in Quebec before taking a nursing course in Boston and additional midwifery training in New York. After a few years teaching nursing, she took the VON post. Mary Ard. MacKenzie was also the second president (1912-14) of the Canadian National Association for Trained Nurses (later renamed the Canadian Nurses' Association). When she left the VON she moved through three short-term appointments at the senior level in the United States, but was pleased to return to Canada to become associated with UBC for three years.

The first program was a 14-week public health nursing course for 26 graduate nurses, starting November 15, 1920, and ending in late March 1921. The content was communicable disease education and prevention generally, but TB was given special consideration and the students were required to do TB fieldwork. The new Rotary Clinic for Chest Diseases in Vancouver was one of the fieldwork sites. The graduates were intended to be generalists in the area of child and family health, but their work centred on infectious disease control, especially identification and control of TB.⁴⁶

A majority of graduates of the five-year degree program also were expected to go into public health. Thus in the first four years as well as the final one, in which they could specialize in either public health or administration and teaching, strong emphasis was placed on a scientific base for nursing. The first two years of the program, taught on campus, were "heavy on the sciences."⁴⁷ These sciences included bacteriology, which was taught by Dr. Mullin; through his efforts, the UBC nurses received the most current information on the pathology of TB.

The nursing texts of the early 1920s provide an interesting view of how TB nursing was taught and of how course content had changed since the turn of the century. Although advances in microbiology had led to laboratory tests that could confirm a diagnosis of TB, the lab procedures were costly. "Observation" of signs and symptoms was of prime importance in making differential diagnoses, especially for nurses who would be working in the community, screening patients and referring them for appropriate treatment. Thus nursing texts described the distinctive early signs and symptoms of TB. The environment was a major factor for the nurse to consider, although some texts of the 1920s still mentioned heredity as a cause. Several pages might be devoted to the various signs and symptoms of TB, such as the type of cough (hacking). Appearance of sputum was a major component of course content. Public health nurses were usually responsible for the collection of sputum specimens from patients: this required careful attention both to obtaining a sample of the required quantity and quality and to ensuring that the nurses did not infect themselves through handling specimens.

Several small but effective nursing measures introduced in the early 1900s helped prevent the spread of TB. Since tubercle bacilli can form spores resistant to drying and remain infectious for years outside the body, sterilization methods (a domain of nursing) included burning, exposure to sunlight for four or more hours, and boiling. Early in the century, nursing texts stopped recommending that handkerchiefs be boiled and ironed and began recommending the use of newspaper squares or inexpensive cheesecloth handkerchiefs that could be placed in bags and burned.⁴⁸ Nurses were able to pass on these modest cost-saving techniques to families, as newspaper squares were available even to families in poor economic circumstances.

Tuberculosis in the Closing Years of This Period

In the 25-year span covered in this article, TB care and TB nursing changed markedly. Bacteriological research led to a greater understanding of the cause of TB and the method of its spread. Medical and scientific advances occurred, such as pneumothorax treatment for cases of rapidly advancing pulmonary TB; introduction of air into the pleura caused the lung to collapse, which put it into a state of "rest."

The Mantoux, or tuberculin, test, introduced in 1908, was particularly helpful in case finding and by 1920 was being used to determine whether nurses and doctors had been infected. X-ray technology was developed considerably during the period under review, although it

was expensive and potentially dangerous (however, the full extent of the dangers had not yet been recognized).

The number of patients in the sanatorium at Tranquille grew steadily during this period, but running the San was becoming expensive for the anti-TB society. The Tranquille administrators had pressed for hospitals to take on more acute cases partly as a cost-saving measure, since the San was more suited to the treatment and care of chronic patients. The provincial government supplied a basic grant and municipalities also provided funds, usually based on the numbers of their residents admitted to the San. Patients paid for a portion of costs based on a sliding scale according to their means. A large amount of money came from the society's public fund-raising efforts, but the sanatorium frequently ran a deficit.⁴⁹ Just at the end of the period under review the provincial government was debating the merits of taking over the operation of the Tranquille sanatorium, which it did in 1921. The hospital, all its property, and many of its supporting grants were turned over to the province and the anti-TB society became the Tranquille Tuberculosis Publicity Society, still concerned with raising funds but also returning to its educational and promotional functions.

Mortality rates were dropping. Whereas in 1900 the mortality rate was estimated to be about 200 per 100,000 population, in 1921 the B.C. rate had fallen to 77.8 per 100,000.⁵⁰ Although there was still a long way to go, a downward trend was evident.

The main development in the fight against TB during this period, however, was the organization of public health services and the recognition that nurses were of prime importance in educating the public and in finding new cases and having them treated. The few nurses involved with TB work in B.C. were proving effective. Public health and nursing leaders were recognizing the need for well-educated nurses with a strong background in science. This resulted in the introduction of public health nursing courses at UBC.

Discussion and Conclusion

Although it is too early in the course of this project to answer the research questions posed for the whole study, this first phase suggests that nursing care did indeed make a difference. Mortality and disability were reduced in these early years.

The data collected during the first phase and reported here provide a solid base for comparisons in the next phase. Specific information has been gathered on the kinds of TB nursing that were provided in hospi-

tals, sanatoria, and the community. The early role of public health nurses in B.C. in controlling communicable diseases had been identified. We have seen that nurses became active partners in public health programs to control TB.

The research suggests more than a coincidental relationship between the involvement of nurses in health promotion and successful efforts in the battle against TB. The results of the first phase of the project indicate that further study is warranted. More in-depth study of the period 1895 to 1920 should uncover information about nurses' day-to-day work with TB patients in hospitals, sanatoria, and the community — including their role in the social and emotional aspects of care — as well as about the health risks they faced themselves. The proposed second phase of the study (1920 to 1945) will cover a period in which nurses took a much more active role in public health and community care.

Such further research will be timely, because tuberculosis is once again on the rise in North America. The lessons of the past will have implications for the future.

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6. We drew largely on unpublished, uncatalogued primary materials that came to light during research for the book on the nursing program at UBC. We received a donation of documents from Esther Paulson, a TB nurse for 35 years (1929-1964). She was senior nurse administrator for the B.C.

Division of Tuberculosis Control, first director of nursing for the George Pearson TB hospital in Vancouver, and an active nursing leader serving as president of the Registered Nurses Association of B.C. and on the Boards of the Canadian Nurses Association and the Canadian Lung Association. We reviewed contemporary nursing texts from the period, especially those related to TB and TB nursing. We also have access to oral history tapes and interviews with several B.C. nurses who were TB patients or had TB nursing experience. We are doing a literature search of professional periodicals to identify pertinent items related to TB and its care; this area of research will be expanded in the next phase of the study.

7. Hatfield, W. H. (n.d.). *History of Tuberculosis in British Columbia* (Parts I and II). Unpublished manuscript available in the Esther Paulson papers. We were especially fortunate to obtain a rare copy of this unpublished manuscript, which was written by the Director of Tuberculosis Control for the Province of British Columbia from 1935 to 1951. He drew largely on primary sources that apparently have since disappeared; we know from other primary materials that he wrote to various nursing leaders for information while he was working on the manuscript, but their replies have not yet been found.
8. Zilm & Warbinek, 1994.
9. Nikiforuk, A. (1991). *The fourth horseman: A short history of epidemics, plagues, famine and other scourges*. Toronto: Viking. See also Tynes, L. Lee (1993). Tuberculosis: The continuing story. *Journal of the American Medical Association*, 270, 2626-2617, which provides an excellent overview of the history.
10. Canadian Tuberculosis Association (1967). *CTA Xmas Seal Kit, 1967: Press section — Newspaper fillers*. Unpublished typescript copy of information supplied to newspapers by CTA. Available Esther Paulson Papers.
11. "50 years of the Union." (1971, January). *Tuberculosis Quarterly Review* [publication of the International Union against Tuberculosis], p. 4.
12. Aiken, Charlotte A. (1916). *Clinical studies for nurses* (3rd ed.). Philadelphia: W. B. Saunders, p. 109.
13. Hatfield, I., n.d.; Kelly, N. (1973). *Quest for a profession: The history of the Vancouver General Hospital School of Nursing*. Vancouver: Vancouver General Hospital School of Nursing Alumnae Association.
14. Watson, J. K. (1905). *Handbook for nurses* (3rd ed.). London: Scientific Press.
15. *Ibid.*, p. 354.
16. Hampton, I. A. (1893). *Nursing: Its principles and practice for hospital and private use*. Philadelphia: W. B. Saunders (Facsimile edition, 1993).
17. Watson, 1905.
18. Hampton, 1893, p. 439.
19. *Ibid.*
20. Descriptions of symptoms come from various sources, esp. Weeks-Shaw, Clara S. 1901. *A text-book of nursing for the use of training schools, families, and*

private students (2nd ed.). New York: D. Appleton & Co., pp. 321-322; see also Watson, 1905, p. 321; Hampton, 1893; Hampton Robb, 1910.

21. Watson, 1905, p. 325.
22. *Ibid.*, p. 327
23. *Ibid.*
24. Aiken, 1916, p. 113.
25. Norfolk, W. (1979). *Cooney and his clan*. Prince George, B.C.: Sunshine Press.
26. Hatfield, I., n.d., p. 1.
27. *Ibid.*, p. 15.
28. *Ibid.*, p. 17.
29. *Ibid.*, pp. 16, 25.
30. Walker, Marion (1987). *Oral history interview*. Interview by Sue Holmes, May 2, 1987. Vancouver: RNABC Oral History Collection.
31. Hatfield, I., n.d., p. 25.
32. Smith, Marion (1987). *Oral history interview*. Interviewed by Anne M. Dunn, April 25, 1987. Vancouver: RNABC Oral History Collection.
33. Shore, Helen (1994). Isabelle Maud Hill (notes and CV). Unpublished papers available in the biographical files in the Registered Nurses Association of B.C. Helen Randal Library.
34. Hatfield, I., n.d.
35. *Ibid.*, p. 20.
36. *Ibid.*, p. 33.
37. *Ibid.*
38. *Ibid.*, p. 31.
39. Personal communication from R. Gill, B.C. Ministry of Health, TB Control, August 31, 1995, noting B.C. Regulations 142/59, Section 70. Also personal communication from the Office of the Clerk, B.C. Legislature, citing the Railway Act (1979), Ch. 354, part 36, related to spitting on trains.
40. Hatfield, I., n.d., p. 43.
41. Hatfield, I., n.d.; Green, Monica M. (1984). *Through the years with public health nursing: A history of public health nursing in the provincial government jurisdiction British Columbia*. Ottawa: Canadian Public Health Association, p. 7.
42. Zilm & Warbinek, 1994.
43. Gibbon, J. M., & Mathewson, M. S. (1947). *Three centuries of Canadian nursing*. Toronto: Macmillan, p. 342.
44. University of British Columbia (1920). *Senate minutes, Tuesday, April 20, 1920*. Vancouver: Author.
45. MacKenzie, M. A. (n.d.). Curriculum vitae. From the MacKenzie files in the Canadian Nurses Association Library. This sheet was a copy of a single-sheet résumé taken from the Mathewson files, Library, School for Graduate Nurses, McGill University. Information on her life is scant and was culled from a variety of sources. A file on her is available in the University of B.C.

School of Nursing Archival Collection and additional information has been supplied to the Canadian Nurses' Association and Registered Nurses' Association libraries.

46. University of British Columbia (1921). *UBC calendar 1921-1922, seventh session*. Vancouver: Author, p. 186.
47. Wood, Beatrice Fordham Johnson (1991). *Oral history interview*. Interview by Sheila Zerr, March 20, 1991. Vancouver: RNABC Oral History Collection. [Transcript by Ethel Warbinek available UBC SoN AC].
48. Compare Hampton, 1893, and Hampton Robb, 1910. Hampton Robb, Isabel (1910). *Nursing: Its principles and practice for hospital and private use* (3rd ed.). Toronto: J. F. Hartz. The author is the same person; Robb was her married name.
49. Hatfield, I., n.d., see esp. pp. 40, 60-61.
50. Wherrett, 1977, p. 255.

Designer's Corner

Sources in Nursing Historical Research: A Thorny Methodological Problem

Diana Mansell

Professionally trained nurse historians of Canadian nursing have intensified the interest in primary sources and the limitations associated with those sources of Canadian nursing history. These documents often pertain to the activities associated with a professional organization, hospital, or school of nursing. These sources shed light on developments in nursing but only from one perspective, that of leadership. Therefore, the picture of nursing that emerges is one-sided. This situation is not unique to nursing history research. It presents a methodological problem for all areas of historical research. In order to gain a more complete picture, the researcher requires evidence from the rank-and-file, or from those nurses who carried on with the practice of nursing.

The following anecdote appeared in the pages of a 1935 issue of *Canadian Nurse*:

Miss Marion Boa, a graduate of the School for Nurses of the Montreal General Hospital and of the McGill School for Graduate Nurses, has had a varied experience in administration and teaching in schools of nursing, and private duty nursing, and is now superintendent of the Aberdeen Hospital, New Glasgow, Nova Scotia. Being in need of an incubator for babies, and lacking the necessary funds, Miss Boa ingeniously improvised and had an inexpensive but efficient incubator made out of an ordinary wash boiler at a total of \$8.50...It all goes to

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prove that experience in the private duty field may be an excellent preparation for a hospital administrator, especially when it is amplified by the courses which are available in some of our Canadian universities.¹

What can be learned about the life of the "ordinary" nurse, given the fragmentary nature of the evidence and the bias towards the elite that are so apparent in documentary reports? Most nurses began their careers as members of the rank-and-file and, like Marion Boa, clearly benefited from that experience. These nurses had little time to record their experiences and, not surprisingly, relevant documents are hard to find. This dearth of evidence has resulted in a less than complete historical picture of nursing in Canada.

Thus, nursing history tends to be a celebration of those individuals who brought the profession through its developmental stages. Information from the rank-and-file nurse, however, would aid researchers in their quest for answers to questions related to class, status, and ethnicity. Furthermore, this critical examination would give a voice to those nurses whose experience of the profession was perhaps not celebratory but one from which nurses and nursing today might benefit.

The raw material for the historian has always been the document. Indeed, it has been said: "There is no substitute for documents: no documents, no history."² In recent times, definition of the document has been expanded to include oral interviews, pictures, and artifacts. Nonetheless, for new disciplines such as nursing history, traditional documentary sources provide the basis for any investigation.

The documentary sources available to the historian of Canadian nursing have certain limitations. As McPherson and Stuart recently noted:

Historians of nursing bemoan the fragmentary nature of documentary evidence... Certain segments of nurses have demonstrated a more pronounced consciousness than other women or other workers about the historical significance of their lives and have attempted to record their experiences and to preserve the records created by their peers. This has often skewed the historical record toward the elite, formally trained, full-time practitioners, and has oriented the record towards the socially respectable or celebratory, leaving more marginal practitioners silent.³

Since sources are fundamental to the task of the historian, what are the methodological limitations associated with reliance on sources created by nursing leaders or professional associations? The *Canadian*

Nurse, for example, offers considerable information about leaders in Canadian nursing but little about the "ordinary" nurse. Indeed, from its inception in 1905 to 1960, the reader is given only occasional glimpses into the life of the bedside nurse. Although *Canadian Nurse* was the only journal available to nurses in Canada, only 30% of nurses subscribed to it until the 1940s.⁴ Furthermore, contributors to the journal tended to be national, provincial, or local leaders — perhaps because the "ordinary" nurse was occupied with the delivery of her nursing services. Therefore, little information could be gleaned from the rank-and-file nurse.

The same holds true when the researcher turns to records of national and provincial professional associations. Individual nurses frequently became involved first with their local organizations then moving to the provincial body and, finally, the national body. The investigator encounters the same individuals again and again. Even though this leadership had a significant impact on the professional career of the individual nurse, these records do not reflect the lives of "ordinary" nurses.⁵ In contrast to the leadership, the typical nurse often was married, offered her services in rural Canada, and was completely unaware of the activities of the professional association.⁶

Simply put, *Canadian Nurse* and records of various professional associations have significant limitations. Research based on these sources alone would portray Canadian nurses as a homogeneous group of white, Anglo-Saxon, Protestant, middle-class women. For example, a significant number of the recipients of honorary awards from the Canadian Nurses Association were members of the executives of provincial or national associations. Furthermore, *Canadian Nurse* only had four editors between 1905 and 1965, and during one eight-year period (1924-1932) Jean Scantlion Wilson held both the position of journal editor and Executive Secretary of the Canadian Nurses Association.⁷ The very limited number of nurses represented in these documents creates a definite bias. As a result, source material does not give a voice to those nurses who were actively involved in the mundane business of nursing.

Although it is impossible to obtain a full picture from these records alone, if they are combined with oral data, personal diaries, and correspondence, a more complete story may be available. These sources have yet to be truly tapped. They tend to rest among the memorabilia and recollections of elderly nurses and their families who may be unaware of their value. Acceptance of these new sources of data and the emergence of new technologies may make it possible to amplify the story of

nursing.⁸ In order to present a total history of nursing in Canada it is necessary to give voice to those who have remained silent, because, after all is said and done, "in the end it is the evidence itself that determines what case it is possible to make."⁹

Endnotes

1. "An Improvised Incubator", *Canadian Nurse* (CN), Vol. XXXI, No.1,p.17.
2. Paul Thompson. *The Voice of the Past: Oral History*. 2nd Edition. (New York: Oxford University Press,1988)p.51.
3. Kathryn McPherson & Meryn Stuart. "Writing Nursing History in Canada: Issues and Approaches", *Canadian Bulletin of Medical History*, Vol.11, Number 1, 1994,p.16.
4. For further documentation see CN, Vol. XVIII, No.8,p.480; XXVI, No.3,p.121; XXXVI, No.9,p.588.
5. See D. Percy correspondence, RG29, V-2355, Ottawa, National Archives of Canada.
6. Grace Agar. Audiotaped interview with the writer in Calgary, 1988.
7. Canadian Nurses' Association. *The Leaf and the Lamp*. (Ottawa: The Canadian Nurses' Association,1968)pp.73-79.
8. Projects are underway in both Alberta and Ontario to rectify the situation.
9. Keith Windschuttle. *The Killing of History: How A Discipline is Being Murdered by Literary Critics and Social Theorists*. (Australia: Macleay Press,1991)p.220.

Étude comparative sur les nécessités d'autosoin d'une clientèle féminine traitée pour un trouble dépressif

Claire Page et Nicole Ricard

Nurses' knowledge of the help they can offer women being treated for depression are primarily based on models borrowed from other disciplines rather than on those from nursing itself. Using Orem's nursing model (1991), this comparative, descriptive study (a) described the requisites for self-care, according the value ascribed to them by women being treated for depression; (b) compared these to those of women not being treated for an emotional problem; and (c) identified the types of assistance that would fulfil the self-care requisites perceived by women being treated for depression. The results indicated that, compared to women not being treated ($n = 30$), those being treated ($n = 30$) ascribed significantly higher values to self-help requisites related to assertiveness, mood, and self-esteem. In contrast, women in the comparison group attributed more importance to various means of improving their interpersonal relations. Women being treated for a depressive episode felt they needed assistance in areas mainly related to self-esteem, mood, and knowledge of depression to fulfil their self-care requisites. Only rarely did they consider the nurse or social network to be valuable sources of help. The implications of these results for nursing interventions is discussed. Recommendations are made on directions for further research.

Les connaissances qu'ont les infirmières et les infirmiers sur l'aide qu'ils ou elles peuvent procurer aux femmes présentant un trouble dépressif proviennent davantage de modèles empruntés à d'autres disciplines que d'un cadre de référence infirmier. À partir du modèle infirmier d'Orem (1991), cette étude descriptive comparative a permis a) de décrire les nécessités d'autosoin selon la valeur que leur accordent des femmes traitées pour un trouble dépressif, b) de les comparer à celles de femmes non traitées pour un problème émotif et c) d'identifier les besoins d'assistance perçus par les femmes traitées pour un trouble dépressif pour arriver à satisfaire leurs nécessités d'autosoin. Les résultats indiquent que ces dernières ($n = 30$) se distinguent des femmes non traitées ($n = 30$) par la valeur significativement plus élevée qu'elles accordent à plusieurs nécessités d'autosoin liées à l'affirmation de soi, à l'humeur et à l'estime de soi. De façon différente, les femmes du groupe de comparaison se distinguent par l'importance qu'elles attribuent à plusieurs buts visant l'amélioration de leurs relations interpersonnelles. Les femmes traitées pour un épisode dépressif ressentent le besoin d'être aidées surtout pour satisfaire des nécessités d'autosoin liées à l'estime de soi, à l'humeur et aux connaissances sur la dépression. Elles reconnaissent rarement l'infirmière, l'infirmier ou le réseau social comme sources d'aide valables. Les implications de ces résultats sur l'intervention infirmière sont discutées. Des recommandations quant à l'orientation de recherches futures sont formulées.

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Les infirmières et les infirmiers désirent apporter une aide spécifique et valable aux femmes présentant un trouble dépressif, mais leurs connaissances proviennent principalement de modèles développés par d'autres disciplines, plutôt que d'une orientation de pensée propre aux soins infirmiers (Rogers et Ulsafer-Van Lanen, 1985). Dans le but de développer un corps de connaissances spécifique pouvant guider la pratique, les infirmiers et les infirmières chercheuses tendent de plus en plus à poser des questions de recherche à partir d'une perspective infirmière (Adam, 1991 ; Fawcett et Downs, 1986 ; Fawcett, 1995 ; Pepin, Ducharme, Kérouac, Lévesque, Ricard et Duquette, 1994). La conception de la discipline infirmière proposée par Orem (1991) constitue un cadre de référence particulièrement pertinent dans l'étude des femmes présentant un trouble dépressif. Ces dernières ressentent souvent un sentiment d'impuissance qui les amène à remettre la responsabilité de leur santé et de leur bien-être aux professionnelles et aux professionnels de la santé. La richesse du modèle d'Orem réside dans la reconnaissance chez les personnes de leur capacité de prendre des décisions et de s'engager dans des actions dans l'intérêt de leur vie, de leur santé et de leur bien-être. Basés sur cette perspective, les buts de cette étude descriptive comparative étaient a) de décrire les nécessités d'autosoin selon la valeur que leur accorde une clientèle féminine traitée pour un trouble dépressif, b) de les comparer à celles d'un groupe de femmes non traitées pour un problème émotif et c) d'identifier les besoins d'assistance perçus par les femmes suivies pour un trouble dépressif pour arriver à satisfaire leurs nécessités d'autosoin. Orem (1991) définit les nécessités d'autosoin comme étant les buts généraux que les personnes poursuivent ou devraient poursuivre, pour améliorer leur vie, leur santé ou leur bien-être.

Problématique

La dépression est un problème sérieux qui affecte une grande partie de la population, plus souvent les femmes que les hommes (Boyer, 1990 ; Weissman et Klerman, 1977a). En effet, les taux de prévalence à vie de dépression majeure chez les femmes et chez les hommes sont respectivement de 8,2 % et 4,2 % (Boyer, 1990). La dépression n'est pas qu'un état de tristesse passager, mais un syndrome pathologique qui peut donner lieu à plusieurs nécessités d'autosoin particulières chez les femmes adultes. La dépression majeure se manifeste par une humeur dépressive ou par une perte d'intérêt pour toutes ou presque toutes les activités, associée à d'autres symptômes comme le cafard, l'irritabilité, le désespoir, le sentiment d'être au bout de son rouleau. La dysthymie se caractérise par une humeur dépressive présente la majeure partie du

temps, mais dont l'intensité n'est pas suffisante pour répondre aux critères d'un épisode dépressif majeur (American Psychiatric Association, 1989).

Afin de recouvrer leur bien-être, plusieurs femmes présentant un épisode dépressif sollicitent de l'aide à la clinique externe de psychiatrie ou y sont référées par leur médecin. L'aide traditionnelle qui leur est offerte se limite presque uniquement à la pharmacothérapie et à un suivi individuel visant essentiellement la disparition des symptômes cliniques (Straw : voir Comité de santé mentale du Québec, 1985). Plusieurs infirmières ou infirmiers se sentent impuissants à aider vraiment ces femmes qui leur rapportent leur détresse psychologique, ce qui les amène souvent à perpétuer auprès de cette clientèle des interventions courantes, découlant principalement du modèle médical. Par exemple, ils ou elles peuvent centrer leur attention essentiellement sur des tâches techniques, sur le traitement pharmacologique et sur la surveillance des symptômes (Chalifour, 1994).

L'approche traditionnelle encourage généralement peu les femmes à identifier leurs besoins réels, à les exprimer et à trouver les moyens qui leur conviennent le mieux pour les satisfaire (Corbeil, Pâquet-Deehy, Lazure et Legault, 1983; Doré, 1984, Guyon, Nadeau et Simard, 1981; Julien et al., 1981). À défaut d'augmenter leur propre capacité d'autosoin, plusieurs femmes tendent à reporter la responsabilité de leur bien-être sur les personnes chargées d'assurer leur traitement. Souvent, en dépit des soins qu'elles reçoivent durant de nombreuses années et du cours fructueux de la pharmacothérapie, plusieurs femmes disent continuer à se sentir inadéquates et apparaissent souvent très vulnérables (Bothwell et Weissman, 1977; Coryell, Scheftner, Keller, Endicott, Maser et Klerman, 1993; Goering, Wasylenki, Lancee et Freeman, 1983; Weissman, Kasl et Klerman, 1976; Weissman et Klerman, 1977b; Weissman et Paykel, 1974).

Les écrits sur les facteurs étiologiques et sur les modèles psychosociaux explicatifs de la dépression, ainsi que sur le fonctionnement psychosocial des femmes à la suite d'un épisode dépressif aigu, fournissent plusieurs indications sur les objectifs que devrait viser l'intervention auprès de cette clientèle. L'assistance infirmière, orientée selon la perspective proposée par Orem, est avant tout basée sur la reconnaissance de la capacité d'appropriation de soi et de la responsabilité des personnes face à leur santé. Il convient donc, pour arriver à préciser l'assistance à offrir aux femmes suivies pour un trouble dépressif, d'identifier les objectifs qu'elles-mêmes poursuivent, c'est-à-dire les nécessités d'autosoin qui leur apparaissent prioritaires. De plus, il

importe de savoir si ces nécessités d'autosoin leur sont spécifiques, c'est-à-dire, s'il existe une distinction significative entre les nécessités d'autosoin valorisées par cette population et celles reconnues par l'ensemble des femmes.

Aspects théoriques et conceptuels

Les étapes préliminaires à la réalisation de cette étude ont été structurées selon trois niveaux, soit conceptuel, théorique et empirique (Fawcett et Downs, 1986; Fawcett, 1995). Ces étapes seront décrites en détails dans un article ultérieur (Page et Ricard, sous presse). Cependant, il importe de les résumer ici pour faciliter la compréhension de cette recherche. D'abord le modèle conceptuel fournit les concepts généraux, abstraits, servant d'éléments fondamentaux à la base d'une recherche. Il s'agit d'un premier niveau d'abstraction. Ces concepts sont ensuite précisés par des concepts provenant de théories de niveau intermédiaire compatibles, pouvant être empruntés à d'autres disciplines, ce qui correspond au deuxième niveau d'abstraction. Ces théories conduisent vers la détermination d'indicateurs empiriques, c'est-à-dire des caractéristiques observables ou mesurables dans le monde réel. Ceci constitue le troisième niveau d'abstraction.

Niveau conceptuel. Le concept de nécessité d'autosoin, défini par Orem (1991) comme étant l'expression de buts généraux que les personnes poursuivent ou devraient poursuivre en s'engageant dans l'autosoin, constitue l'élément fondamental à la base de cette étude. L'autosoin correspond à la production d'actions délibérées, orientées vers soi ou vers son environnement, pour améliorer sa vie, sa santé, son développement et son bien-être (Orem, 1991, 1995). Les nécessités d'autosoin de type développemental sont associées à divers processus de développement, ainsi qu'aux conditions et aux événements se produisant aux différentes étapes du cycle de la vie et aux événements qui peuvent entraver le développement (Orem, 1987, 1991, 1995). Les nécessités d'autosoin reliées à l'altération de la santé sont associées aux différentes altérations structurales et fonctionnelles et à leurs effets, ainsi qu'aux diagnostics et aux traitements médicaux (Orem, 1987, 1991, 1995).

Niveau théorique. Dans cette étude, le concept de nécessités d'autosoin développementales a été précisé par des connaissances théoriques sur l'ajustement social des femmes dans l'accomplissement de leurs rôles, sur l'affirmation et la réalisation de soi. Ces clarifications proviennent des résultats de recherches sur l'ajustement social des femmes adultes pendant et à la suite d'un épisode dépressif, lesquels mettent en évidence de nombreuses difficultés souvent persistantes (Bothwell et

Weissman, 1977; Goering, et al. 1983; Paykel et Weissman, 1973; Weissman et al., 1976; Weissman et Paykel, 1974). Plusieurs nécessités d'autosoin peuvent donc être liées à l'ajustement social. Les concepts d'affirmation et de réalisation de soi proviennent en partie de trois modèles psychosociaux explicatifs de la dépression, soit la résignation acquise (Abramson, Seligman et Teasdale, 1978), l'altération des processus cognitifs (Beck, Rush, Shaw et Emery, 1979) et le manque de renforcements positifs (Lewinsohn, 1974), ainsi que des études sur les facteurs de risques de dépression chez les femmes adultes (Aneshensel et Stone, 1982; Brown, Andrews, Harris, Adler et Bridge, 1986; Corbeil et al., 1983; Doré, 1984; Goering et al., 1983; Hall, Williams et Greenberg, 1985; Warren et McEachren, 1983).

Des indications provenant de ces théories mettent en évidence, par exemple, l'importance pour plusieurs femmes déprimées d'arriver à rompre leur « habitude à l'impuissance », d'accomplir des activités gratifiantes, de développer des qualités nécessaires à leur réalisation personnelle, comme, entre autres, la capacité de s'affirmer, de prendre des décisions, de se faire confiance. Quant aux nécessités d'autosoin liées à l'altération de la santé, elles découlent des manifestations cliniques de la dépression et du besoin de développer des connaissances sur les mesures de prévention et de traitement de ce trouble.

Niveau empirique. À partir de ces aspects théoriques et d'instruments de mesure existants, on a rédigé une liste d'énoncés de nécessités d'autosoin auxquelles on peut attribuer une valeur en termes d'importance. Ces énoncés ont ici servi d'indicateurs empiriques. Plusieurs nécessités d'autosoin développementales sont inspirées de la Social Adjustment Scale (SAS), conçue par Weissman et Paykel (1974). La SAS a permis de décrire plusieurs difficultés d'ajustement social qui tendent à persister chez les femmes à la suite d'un épisode dépressif. Ses éléments peuvent donc être à la base de nombreuses nécessités d'autosoin susceptibles d'être particulièrement valorisées par cette clientèle. Les catégories de nécessités d'autosoin développementales sont les suivantes : travail ; vie sociale et loisirs ; relation amoureuse ; rôle parental ; unité familiale ; relation avec la famille éloignée et situation économique ; et affirmation, réalisation de soi. Cette dernière catégorie s'inspire principalement des indications provenant du modèle de la résignation acquise et de l'étude des facteurs de risques de dépression. La majorité des nécessités d'autosoin reliées à l'altération de la santé ont été formulées à partir des éléments de l'Inventaire de dépression de Beck (Beck, Ward, Mendelson et Erbaugh, 1961 ; Gauthier, Morin, Thériault et Lawson, 1982). Elles appartiennent aux catégories suivantes : bien-être physique, estime de soi, humeur et connaissances sur

la dépression. La liste d'énoncés de nécessités d'autosoin a été utilisée pour bâtir un instrument de mesure (voir la section « Instruments ») qui, dans cette recherche, a permis de répondre aux questions suivantes :

- 1) Quelles sont, selon la valeur qu'elles leur accordent, les nécessités d'autosoin développementales des femmes traitées pour un trouble dépressif? Quelles sont celles des femmes non traitées pour un trouble dépressif? Existe-t-il une différence significative entre les deux groupes?
- 2) Quelles sont, toujours selon la valeur qu'elles leur accordent, les nécessités d'autosoin reliées à l'altération de la santé des femmes traitées pour un trouble dépressif? Quelles sont celles des femmes non traitées pour un problème émotif? Existe-t-il une différence significative entre les deux groupes?
- 3) Quelle est la perception des femmes traitées pour un trouble dépressif quant à leurs besoins d'assistance pour arriver à satisfaire les nécessités d'autosoin qu'elles priorisent?

Méthode

Milieu et échantillon

L'échantillon, provenant d'un milieu semi-rural, a été formé de deux groupes de 30 femmes québécoises, âgées de 18 à 60 ans, habitant dans un rayon de 100 kilomètres du centre hospitalier où a été réalisée cette étude. Toutes les femmes ont participé à l'étude volontairement et ont signé un consentement éclairé après avoir été assurées de l'anonymat et du traitement confidentiel des données recueillies. Les femmes du premier groupe, qui en est un de convenance, étaient suivies dans une clinique externe de psychiatrie d'un centre hospitalier (minimum d'une visite mensuelle ou aux trois mois si une pharmacothérapie était en cours) pour une dépression majeure ou une dysthymie. Elles devaient avoir obtenu un score supérieur à 10 à l'Inventaire de dépression de Beck (Beck et al., 1961 ; Gauthier et al., 1982) ou être traitées avec une médication antidépressive. Un score égal ou inférieur à 10 indique l'absence de dépression.

Quant aux femmes appartenant au groupe de comparaison, elles devaient n'avoir présenté aucun problème de santé mentale ayant nécessité une aide professionnelle au cours des cinq dernières années. Elles ont été choisies au hasard dans la population, à partir de l'annuaire du téléphone. Pour les deux groupes, étaient exclues les femmes qui avaient déjà reçu un diagnostic de déficience mentale, de trouble

affectif bipolaire, de schizophrénie ou qui souffraient d'un syndrome cérébral organique, d'un problème requérant un suivi médical intensif, d'un handicap occasionnant une incapacité fonctionnelle ou d'un problème associé à l'alcoolisme ou la toxicomanie, sauf si la femme était sobre depuis au moins un an.

Instruments

L'Inventaire de dépression de Beck (IDB), version française du Beck Depression Inventory (Beck et al., 1961), a été utilisé dans le but d'évaluer la gravité de la dépression, de sélectionner les femmes du groupe à l'étude et de les comparer sur cette variable avec les femmes non traitées pour un trouble dépressif. L'IDB contient 21 éléments représentant une série de quatre à cinq énoncés gradués de 0 (neutre) à 3 (intensité maximale), cette échelle correspondant au degré d'intensité de différentes manifestations de la dépression. Le score de l'IDB est obtenu en additionnant les valeurs numériques correspondant à chacune des propositions choisies par la personne. Il varie de 0 à 63. Beck et al. (1961; voir aussi Gauthier et al., 1982) ne commencent à parler d'état dépressif qu'en présence d'un score de 11 ou plus, et d'état dépressif grave à partir d'un score de 19. Une étude sur la version française de l'IDB a démontré que le score de chacun des éléments était relié au score total ($p < .001$) (Gauthier et al., 1982). La consistance interne a révélé un coefficient alpha de 0,82. Pour un intervalle de trois mois, le coefficient de fidélité test-retest était de 0,75 ($p < 0,001$). Ces données démontrent les qualités psychométriques de cet instrument.

Les différentes nécessités d'autosoin valorisées par les femmes ont été identifiées à l'aide d'un instrument développé pour les fins de cette étude. Dans un premier temps, nous avons rédigé une liste de 88 énoncés de nécessités d'autosoin. Par exemple, l'une des nécessités d'autosoin développementales en rapport avec la relation amoureuse était formulée de la façon suivante : « Être davantage capable de défendre mon point de vue lorsque je suis en désaccord avec mon conjoint ». Les répondantes devaient indiquer jusqu'à quel point il était important pour elles de satisfaire chacune des différentes nécessités d'autosoin proposées en utilisant une cote de 0 (pas du tout important) à 4 (extrêmement important). De plus, pour évaluer les besoins d'assistance perçus par les femmes suivies pour un trouble dépressif, on prévoyait deux questions ouvertes, l'une sur le besoin d'aide ressenti, et l'autre, sur les raisons de l'absence d'aide si cela était le cas. Par ailleurs, pour chacune des catégories comprenant une ou plusieurs nécessités d'autosoin auxquelles les femmes avaient attribué la cote 3

ou 4, il leur était demandé si elles ressentait le besoin d'être aidées en utilisant une cote de 0 (pas du tout) à 4 (excessivement), si elles recevaient de l'aide, et si oui, d'où provenait cette aide. Enfin, nous demandions aux femmes si elles connaissaient une personne à qui elles se sentaient à l'aise de demander de l'aide, et quelles étaient les deux personnes les plus en mesure, selon elles, de leur apporter cette aide.

Dans le but d'en vérifier la validité nominale, cet instrument a été soumis à sept experts dans le domaine. Ces derniers se sont prononcés sur la clarté de chaque énoncé de nécessité d'autosoin, sur leur pertinence en fonction du but de l'étude, ainsi que sur leurs caractères exclusif et exhaustif. Les commentaires reçus ont permis d'améliorer la formulation de 37 énoncés. Trois énoncés ont été ajoutés et un rejeté. À la suite de ces améliorations, le questionnaire comprenait 90 énoncés, soit 59 nécessités d'autosoin développementales et 31 reliées à l'altération de la santé. De plus, sur les conseils des experts, les questions ouvertes ont été enlevées. Ensuite, la validité des différentes catégories a été vérifiée à l'aide de cinq autres personnes dont le rôle consistait, à partir d'une liste de tous les énoncés mis en désordre, à replacer chaque énoncé dans la catégorie à laquelle il appartenait. Un accord acceptable (trois personnes sur cinq) a été obtenu pour 77 des 90 énoncés. Pour huit énoncés, une discussion avec les cinq personnes a permis d'en arriver à un accord. Cinq énoncés ont été reclassés dans d'autres catégories. Enfin, un prétest réalisé auprès de deux femmes suivies pour un trouble dépressif (scores de 21 et de 13 à l'IDB) a indiqué que le questionnaire pouvait être rempli dans un temps raisonnable (entre 90 et 120 minutes), qu'il permettait d'obtenir les renseignements désirés et que les termes utilisés étaient faciles à comprendre. À la suite des commentaires apportés par l'une de ces femmes, deux questions ont été ajoutées. Elles ont trait aux caractères suffisant et satisfaisant de l'aide obtenue.

Déroulement de l'étude

L'autorisation pour recruter les femmes suivies à la clinique externe de psychiatrie a été obtenue au cours d'une rencontre avec le directeur des services professionnels du centre hospitalier. Une liste de toutes les clientes âgées de 18 à 60 ans traitées pour un trouble dépressif a été dressée à partir de l'ensemble des dossiers de la clinique externe. Cette liste contenait 231 femmes. Le dossier médical de chacune d'elles a été vérifié afin d'exclure celles qui ne répondaient pas aux critères d'inclusion. Ainsi, 99 femmes ont été exclues parce qu'elles n'avaient pas été vues à la clinique au cours des trois derniers mois. De même, 55

femmes l'ont été pour diverses raisons (schizophrénie : 17, déficience mentale : 7, handicap ou maladie physique : 21, alcoolisme ou toxicomanie : 10, décédées : 3, distance supérieure à 100 kilomètres : 21, refus de l'intervenant ou de l'intervenante chargée d'assurer le suivi : 4). L'auteure principale prenait contact avec les femmes par téléphone pour leur expliquer le but de l'étude et solliciter leur participation. Huit d'entre elles n'ont pu être rejointes, cinq ont refusé de participer à l'étude. On rencontrait les femmes à domicile ou à la clinique externe de psychiatrie, à leur convenance. Après les avoir invitées à signer la formule de consentement, on leur posait les questions relatives aux données sociodémographiques et à l'histoire de la maladie, puis on leur présentait l'Inventaire de dépression de Beck auquel elles répondaient seules. Avant de passer à la partie du questionnaire concernant la valeur accordée aux différentes nécessités d'autosoin, l'auteure donnait aux participantes des explications claires sur la façon de répondre aux questions. Sept femmes ont dû être exclues, leur score à l'IDB étant égal ou inférieur à 10 et n'étant pas traitées avec des antidépresseurs. Enfin, deux autres femmes ont dû être exclues en raison du manque de cohérence de leurs réponses. Au cours de la collecte des données, trois femmes ont été référées par des intervenants ou des intervenantes pour compléter l'échantillon.

Pour former le deuxième groupe, 35 femmes ne présentant pas de problème émotif ont été recrutées au hasard par contacts téléphoniques. Ces appels permettaient de vérifier l'admissibilité des répondantes, d'expliquer le but de l'étude et de solliciter leur participation. Il était entendu avec celles qui acceptaient qu'elles recevraient un questionnaire par la poste. L'auteure décrivait de façon détaillée les trois parties du questionnaire, ainsi que la façon de répondre aux questions. Ces femmes étaient invitées à ne pas hésiter à contacter l'une des chercheuses au besoin pour obtenir des informations supplémentaires. Nous leur demandions de retourner le questionnaire dans les 15 jours. Au total, 26 questionnaires ont été retournés et 4 autres l'ont été à la suite d'un rappel. Deux questionnaires ont dû être rejetés, n'étant que partiellement ou non remplis. Deux autres femmes, recrutées de la même façon pour compléter l'échantillon, ont retourné leur questionnaire rempli dans les délais prévus.

Plan d'analyse des données

Les caractéristiques sociodémographiques et celles concernant l'histoire de la maladie des répondantes ont été résumées à l'aide de statistiques descriptives. Nous avons vérifié l'équivalence entre les groupes sur ces

variables par le test-*t* de Student ou le test du chi carré, puis nous avons calculé les moyennes des valeurs attribuées par les femmes à chacune des nécessités d'autosoin proposées. Le test-*t* a servi à déterminer s'il existait des différences significatives entre les deux groupes quant à ces valeurs. Les données concernant les besoins d'assistance des femmes du groupe à l'étude sont présentées à l'aide de distributions de fréquences et de mesures de la tendance centrale.

Résultats

Caractéristiques sociodémographiques des répondantes et équivalence des groupes

L'âge des répondantes se situe entre 20 et 58 ans ($x = 37,1$). Les deux tiers d'entre elles (70 %) ont 40 ans ou moins. Un peu plus de la moitié (51,7 %) ont de 12 à 15 années de scolarité. Plus de la moitié (56,7 %) sont mariées et plus des trois quarts (78,3 %) cohabitent avec un conjoint. Les deux tiers (63,3 %) travaillent à l'extérieur. La majorité (83,3 %) ont au moins un enfant, et plus des deux tiers (68,4 %) en ont au moins un à la maison. Les deux groupes sont comparables sur six des neuf variables sociodémographiques considérées, soit l'âge, l'occupation, le nombre d'enfants, le nombre d'enfants à la maison, le revenu personnel et le revenu familial. Cependant, les femmes du groupe de comparaison apparaissent significativement plus scolarisées que celles du groupe à l'étude ($p < .05$), plus nombreuses à être mariées ($p < .05$) et à cohabiter avec un conjoint ($p < .005$).

Histoire de la maladie

La majorité des femmes suivies pour un trouble dépressif (83,3 %) ont reçu le diagnostic de dysthymie, tandis que les autres (16,6 %) ont reçu celui de dépression majeure. Une médication antidépressive était prescrite à près de la moitié d'entre elles (46,7 %). Les scores obtenus à l'IDB indiquaient une dépression grave chez 16,7 % des femmes, une dépression modérée à grave chez 40 %, légère à modérée chez 6,7 %, légère chez 26,7 % et l'absence de dépression chez 10 %. Ces 10 % étaient cependant traitées avec une médication antidépressive. Inversement, nous notons l'absence de dépression chez 90 % des femmes du groupe de comparaison. Les femmes suivies pour un épisode dépressif obtiennent en moyenne 20,53 à l'IDB (dépression modérée à grave), comparativement à 3,43 (absence de dépression) pour les femmes du groupe de comparaison. Les normes québécoises pour l'IDB, produites

par Gauthier et al. (1982), donnent 6,45 comme score moyen pour une population générale adulte féminine. Nos résultats indiquent que le score moyen des femmes suivies pour un état dépressif est nettement supérieur au score de la population générale, tandis que celui des femmes du groupe de comparaison est légèrement inférieur. Les femmes du groupe à l'étude se distinguent vraiment de celles du groupe de comparaison par l'humeur dépressive qui les caractérise ($p < .01$).

Nécessités d'autosoin développementales

Les résultats relatifs à la première question de recherche, soit celle concernant les nécessités d'autosoin développementales, sont présentés au tableau 1. Ils indiquent que les femmes suivies pour un trouble dépressif, reconnaissent comme importantes (moyenne des valeurs égale ou supérieure à 2,5) 14 nécessités d'autosoin sur un total de 59. Les femmes du groupe de comparaison en reconnaissent 15. Chez les femmes suivies pour une dépression, 7 des 14 nécessités d'autosoin valorisées traduisent des buts liés à l'affirmation et à la réalisation de soi. Les deux plus importantes sont celles visant à augmenter leur confiance en elles et leur capacité de dire non. De façon tout à fait différente, 9 des 15 nécessités d'autosoin valorisées par les femmes du groupe de comparaison se rapportent à la relation amoureuse et au rôle parental. Les résultats du test- t indiquent l'émergence de deux modèles différents quant à la nature des nécessités d'autosoin valorisées. Comparativement aux femmes du groupe de comparaison, celles suivies pour un trouble dépressif accordent une valeur significativement plus élevée à plusieurs nécessités d'autosoin traduisant le développement de leur compétences personnelles (confiance en soi, capacité de dire non et de prendre des décisions). Quant aux femmes du groupe de comparaison, elles attribuent une valeur significativement plus élevée à des nécessités d'autosoin en rapport avec l'amélioration de leurs relations interpersonnelles (relation amoureuse, rôle parental, relation avec la famille éloignée).

De même, relativement aux nécessités d'autosoin ayant trait au travail, les femmes du groupe à l'étude accordent une valeur significativement plus élevée à la diminution de l'effort requis pour accomplir les activités habituelles, ce qui traduit un besoin plutôt orienté vers elles-mêmes. Par contre, les femmes du groupe de comparaison attribuent une valeur significativement plus élevée à la diminution des conflits vécus avec les collègues de travail, ce qui réfère, de façon cohérente, à la satisfaction souhaitée dans les rapports avec les autres.

Table 1

Nécessités d'autosoin développementales

| Nécessités d'autosoin développementales | Moyenne des valeurs pour chaque nécessité d'autosoin | | Différences significatives entre les groupes |
|--|--|------|--|
| | Gr.1 | Gr.2 | |
| A. TRAVAIL | | | |
| 1. Intérêt | 2,03 | 2,40 | N.S. |
| 2. Tension | 2,60 | 2,70 | N.S. |
| 3. Effort requis | 2,67 | 2,07 | S* Gr1 > Gr.2 |
| 4. Quantité | 1,83 | 1,73 | N.S. |
| 5. Efficacité | 2,40 | 2,40 | N.S. |
| 6. Conflits | 1,77 | 2,57 | S* Gr.1 < Gr.2 |
| 7. Culpabilité de faire garder les enfants | 1,18 | 1,40 | N.S. |
| 8. Concilier le travail à l'extérieur et au foyer | 2,75 | 2,04 | N.S. |
| 9. Ampleur du fardeau | 1,87 | 1,77 | N.S. |
| 10. Services de garderie | 1,29 | 1,59 | N.S. |
| 11. Travail apprécié par les autres | 2,40 | 2,67 | N.S. |
| B. VIE SOCIALE ET LOISIRS | | | |
| 12. Réseau social | 2,07 | 2,40 | N.S. |
| 13. Interactions sociales | 1,90 | 2,17 | N.S. |
| 14. Communication | 2,07 | 2,30 | N.S. |
| 15. Activités récréatives | 2,17 | 2,20 | N.S. |
| 16. Conflit | 1,70 | 2,20 | N.S. |
| 17. Sensibilité | 2,50 | 1,90 | N.S. |
| 18. Aisance en société | 2,73 | 2,53 | N.S. |
| 19. Solitude | 2,27 | 1,97 | N.S. |
| 20. Ennui | 1,97 | 1,33 | N.S. |
| 21. Loisirs | 0,87 | 0,93 | N.S. |
| C. RELATION AMOUREUSE | | | |
| 22. Communication | 2,77 | 2,80 | N.S. |
| 23. Exprimer son désaccord | 2,45 | 2,63 | N.S. |
| 24. Comportement de domination | 1,32 | 2,63 | S** Gr.1 < Gr.2 |
| 25. Conflits | 2,45 | 2,30 | N.S. |
| 26. Autonomie | 2,09 | 2,10 | N.S. |
| 27. Exprimer ses besoins | 2,45 | 2,63 | N.S. |
| 28. Marques d'affection | 2,00 | 2,60 | N.S. |
| 29. Intérêt pour la sexualité | 1,60 | 2,23 | S* Gr.1 < Gr.2 |
| 30. Problèmes sexuels | 1,20 | 2,33 | S** Gr.1 < Gr.2 |
| 31. Rencontres amoureuses | 0,97 | 1,87 | S* Gr.1 < Gr.2 |
| * : p<.05 ** : p<.01 N.S. : non significatif Gr.1 : femmes traitées pour un trouble dépressif Gr.2 : femmes du groupe de comparaison | | | |

| Table 1 (continued) | | | |
|--|---|------|--|
| Nécessités d'autosoins développementales | | | |
| Nécessités d'autosoins développementales | Moyenne des valeurs pour chaque nécessité d'autosoins | | Différences significatives entre les groupes |
| | Gr.1 | Gr.2 | |
| D. RÔLE PARENTAL | | | |
| 32. Présence auprès des enfants | 2,12 | 2,44 | N.S. |
| 33. Communication | 2,08 | 2,72 | N.S. |
| 34. Tensions | 2,16 | 2,44 | N.S. |
| 35. Marques d'affection | 1,72 | 2,64 | S* Gr.1 < Gr.2 |
| 36. Implication du conjoint | 1,90 | 2,54 | N.S. |
| 37. Équilibre entre les demandes des enfants et ses besoins | 2,16 | 2,88 | N.S. |
| E. L'UNITÉ FAMILIALE | | | |
| 38. Souci | 2,53 | 2,23 | N.S. |
| 39. Culpabilité | 2,40 | 2,07 | N.S. |
| 40. Sentiment d'abandon | 2,73 | 2,37 | N.S. |
| 41. Collaboration des membres de la famille | 2,14 | 2,37 | N.S. |
| F. RELATION AVEC LA FAMILLE ÉLOIGNÉE | | | |
| 42. Fréquence des contacts | 1,57 | 2,40 | S** Gr.1 < Gr.2 |
| 43. Communication | 1,60 | 2,37 | S** Gr.1 < Gr.2 |
| 44. Conflits | 1,63 | 2,17 | N.S. |
| 45. Souci | 1,67 | 2,10 | N.S. |
| 46. Culpabilité | 1,30 | 1,83 | N.S. |
| 47. Sentiment d'abandon | 2,07 | 2,07 | N.S. |
| 48. Autonomie | 1,10 | 1,73 | N.S. |
| G. AFFIRMATION ET RÉALISATION DE SOI | | | |
| 49 Défendre son point de vue | 2,40 | 2,30 | N.S. |
| 50. Besoin d'approbation | 2,20 | 2,17 | N.S. |
| 51. Capacité de refuser | 3,00 | 2,43 | S* Gr.1 > Gr.2 |
| 52. Précision de ses buts | 2,77 | 2,53 | N.S. |
| 53. Changements à apporter dans sa vie | 2,70 | 2,23 | N.S. |
| 54. Confiance en soi | 3,13 | 2,43 | S* Gr.1 > Gr.2 |
| 55. Sentiment d'impuissance | 2,63 | 2,13 | N.S. |
| 56. Autonomie financière | 1,93 | 2,43 | N.S. |
| 57. Prise de décision | 2,77 | 2,13 | S* Gr.1 > Gr.2 |
| H. SITUATION ÉCONOMIQUE | | | |
| 58. Gestion financière | 2,17 | 2,47 | N.S. |
| 59. Problèmes financiers | 2,20 | 2,77 | N.S. |
| *: p<.05 **: p<.01 N.S. : non significatif Gr.1 : femmes traitées pour un trouble dépressif Gr.2 : femmes du groupe de comparaison | | | |

Nécessités d'autosoin reliées à l'altération de la santé

Les résultats relatifs à la deuxième question de recherche, soit aux nécessités d'autosoin reliées à l'altération de la santé, sont présentés au tableau 2. Il ressort que 14 nécessités d'autosoin de ce type, sur un total de 31, ont été reconnues comme importantes par les femmes suivies pour un trouble dépressif. Une seule de ces nécessités d'autosoin appartient à la catégorie bien-être physique, celle en rapport avec la fatigue, tandis que les autres sont réparties entre les catégories humeur, estime de soi et connaissances sur la dépression. Quant aux femmes du groupe de comparaison, elles ont reconnu comme importantes seulement deux nécessités d'autosoin sur un total de 22 (elles n'ont pas répondu aux questions de la catégorie « Connaissances sur la dépression »).

Nous n'avons observé aucune différence significative entre les deux groupes pour 13 des 21 nécessités d'autosoin reliées à l'altération de la santé sur lesquelles ils ont été comparés. Cependant, des différences significatives ont été mises en évidence dans les catégories humeur et estime de soi. Comparativement aux femmes du groupe de comparaison, celles du groupe à l'étude attribuent une plus grande importance aux nécessités d'autosoin ayant trait aux contrariétés, à la tristesse, aux idées noires, à l'irritabilité, aux pleurs, aux idées suicidaires, à la perception d'avoir moins de valeur que les autres, et enfin, à la tendance à se faire des reproches de façon exagérée.

Table 2

Nécessités d'autosoin reliées à l'altération de la santé

| Nécessités d'autosoin reliées à l'altération de la santé | Moyenne des valeurs pour chaque nécessité d'autosoin | | Différences significatives entre les groupes |
|--|--|------|--|
| | Gr.1 | Gr.2 | |
| I. BIEN-ÊTRE PHYSIQUE | | | |
| 60. Durée du sommeil | 1,90 | 2,50 | N.S. |
| 61. Qualité du sommeil | 2,10 | 2,10 | N.S. |
| 62. Appétit | 1,00 | 1,00 | N.S. |
| 63. Poids | 1,47 | 1,77 | N.S. |
| 64. Fatigue | 2,73 | 1,73 | S** Gr.2 > Gr.2 |
| 65. Malaises | 2,40 | 2,07 | N.S. |
| 66. Préoccupations somatiques | 1,87 | 1,60 | N.S. |
| 67. Concentration | 2,33 | 1,73 | N.S. |
| * : p<.05 ** : p<.01 N.S. : non significatif | | | |

| Table 2 (continued) | | | |
|--|--|------|--|
| Nécessités d'autosoin reliées à l'altération de la santé | | | |
| Nécessités d'autosoin reliées à l'altération de la santé | Moyenne des valeurs pour chaque nécessité d'autosoin | | Différences significatives entre les groupes |
| | Gr.1 | Gr.2 | |
| J. HUMEUR | | | |
| 68. Insatisfaction | 2,30 | 2,40 | N.S. |
| 69. Importance accordée aux événements désagréables | 2,93 | 2,37 | S* Gr.1 > Gr.2 |
| 70. Tristesse | 2,93 | 1,43 | S** Gr.1 > Gr. |
| 71. Ruminations | 2,87 | 1,80 | S** Gr.1 > Gr.2 |
| 72. Pleurs | 1,97 | 0,97 | S** Gr.1 > Gr.2 |
| 73. Irritabilité | 2,60 | 1,63 | S** Gr.1 > Gr.2 |
| 74. Intérêt pour les autres | 2,03 | 2,00 | N.S. |
| 75. Idées suicidaires | 1,80 | 0,80 | S** Gr.1 > Gr.2 |
| K. ESTIME DE SOI | | | |
| 76. Valeur personnelle | 2,47 | 2,40 | N.S. |
| 77. Image corporelle négative | 1,93 | 2,33 | N.S. |
| 78. Sentiment d'être un échec | 2,80 | 2,53 | N.S. |
| 79. Déception de soi-même | 2,63 | 1,80 | S* Gr.1 > Gr.2 |
| 80. Blâme | 2,53 | 1,77 | S* Gr.1 > Gr.2 |
| 81. Acceptation de soi | 2,87 | 2,47 | N.S. |
| L. COMPRÉHENSION DE LA DÉPRESSION | | | |
| 82. Compréhension de la dépression | 2,70 | | |
| 83. Connaissance des médicaments prescrits | 2,05 | | |
| 84. Croyance d'une amélioration | 2,70 | | |
| 85. Connaissance des moyens à prendre pour éviter une rechute | 2,77 | | |
| 86. Crainte d'une rechute ou de la persistance du trouble | 2,73 | | |
| 87. Impression de manquer de courage | 1,83 | | |
| 88. Échanges avec des personnes dans la même situation | 2,07 | | |
| 89. Connaissance des moyens à prendre pour s'en sortir | 2,73 | | |
| 90. Peur d'être jugée | 2,13 | | |
| * : p<.05 ** : p<.01 N.S. : non significatif | | | |

Table 3

Moyenne des cotes traduisant la perception du besoin d'assistance et répartition selon l'aide reçue, les ressources et les caractères suffisant et satisfaisant de l'aide reçue.

| Catégories | N | Besoin d'assistance X | Aide Reçue | | n | Ressources | | | Suffisance de l'aide | | Caractère satisfaisant de l'aide | | |
|--|----|-----------------------------|------------|----------|----|--------------|-----------|--------------------------|-------------------------|----------|-------------------------------------|----------|------|
| | | | oui % | non % | | famille % | amis % | service de santé % | oui % | non % | oui % | non % | X |
| NÉCESSITÉS D'AUTOSOIN DÉVELOPPEMENTALES | | | | | | | | | | | | | |
| 1. Travail | 29 | 2,10 | 72,4 | 27,6 | 21 | 28,6 | 28,6 | 66,7 | 72,2 | 23,8 | 67,1 | 42,9 | 2,62 |
| 2. Vie sociale et loisirs | 29 | 1,90 | 69,0 | 31,0 | 20 | 15,0 | 15,0 | 85,0 | 70,0 | 30,0 | 60,0 | 40,0 | 2,65 |
| 3. Relation amoureuse | 25 | 1,80 | 48,0 | 52,0 | 12 | 8,3 | 25,0 | 100,0 | 58,3 | 41,7 | 50,0 | 50,0 | 2,17 |
| 4. Rôle parental | 21 | 2,00 | 61,9 | 38,1 | 13 | 38,5 | 15,4 | 92,3 | 76,9 | 23,1 | 53,8 | 46,2 | 2,69 |
| 5. Unité familiale | 25 | 2,48 | 68,0 | 32,0 | 17 | 23,5 | 17,6 | 88,2 | 64,7 | 35,3 | 47,1 | 52,9 | 2,53 |
| 6. Famille éloignée | 20 | 1,60 | 50,0 | 50,0 | 10 | 10,0 | 0,0 | 90,0 | 60,0 | 40,0 | 60,0 | 40,0 | 2,40 |
| 7. Affirmation et réalisation de soi | 30 | 2,40 | 73,3 | 26,7 | 22 | 36,4 | 18,2 | 86,4 | 68,2 | 31,8 | 50,0 | 50,0 | 2,36 |
| 8. Situation économique | 17 | 1,06 | 0,0 | 100,0 | 0 | — | — | — | — | — | — | — | — |
| NÉCESSITÉS D'AUTOSOIN RELIÉES À L'ALTÉRATION DE LA SANTÉ | | | | | | | | | | | | | |
| 9. Bien-être physique | 28 | 2,11 | 75,0 | 2650 | 21 | 0,0 | 0,0 | 100,0 | 61,9 | 38,1 | 42,9 | 57,1 | 2,29 |
| 10. Humeur | 28 | 2,86 | 89,3 | 10,7 | 25 | 36,0 | 16,0 | 100,0 | 60,0 | 40,0 | 68,0 | 32,0 | 2,72 |
| 11. Estime de soi | 24 | 2,88 | 87,6 | 12,5 | 21 | 42,9 | 19,0 | 95,2 | 61,9 | 38,1 | 76,2 | 23,8 | 2,81 |
| 12. Connaissances sur la dépression | 26 | 2,62 | 88,5 | 11,5 | 26 | 15,4 | 7,7 | 88,6 | 47,8 | 52,2 | 26,1 | 73,9 | 2,13 |
| N : femmes ayant reconnu au moins une nécessité d'autosoin de la catégorie comme étant importante. n : femmes appartenant à N, qui disent recevoir de l'aide. Besoin d'assistance : les valeurs possibles se situaient entre « 0 » (pas du tout satisfaisant) et « 4 » (très satisfaisant). | | | | | | | | | | | | | |

***Perception des femmes traitées pour un trouble dépressif
quant à leur besoin d'assistance***

Le tableau 3 regroupe les résultats relatifs à la troisième question de recherche, soit la perception des femmes suivies pour un trouble dépressif quant à leur besoin d'assistance pour arriver à satisfaire les nécessités d'autosoin qu'elles considèrent importantes. En ce qui a trait aux nécessités d'autosoin développementales, les femmes ressentent davantage le besoin d'être aidées pour ce qui est des catégories unité familiale, affirmation et réalisation de soi. Quant aux nécessités d'autosoin liées à l'altération de leur santé, elles rapportent un plus grand besoin d'aide pour les catégories estime de soi, humeur et connaissances sur la dépression. Ces mêmes catégories correspondent à celles pour lesquelles la majorité des femmes estiment recevoir de l'aide (près de 90 %). Selon la majorité d'entre elles (entre 66,7 % et 100 %), cette aide provient principalement des professionnelles et des professionnels de la santé. Celles qui disent recevoir de l'aide des membres de leur famille, d'amis ou de collègues au travail sont considérablement moins nombreuses (entre 0 % et 42,9 %). L'aide relative à l'acquisition de connaissances sur la dépression est évaluée comme étant la moins suffisante (52,2 %). Pour l'ensemble des catégories de nécessités d'autosoin développementales, entre 40 % et 52,9 % des femmes jugent l'aide reçue insatisfaisante. En ce qui a trait aux nécessités d'autosoin reliées à l'altération de la santé, les catégories qui soulèvent le plus d'insatisfaction quant à l'aide reçue sont le bien-être physique (57,1 %) et, encore une fois, l'acquisition de connaissances sur la dépression (73,9 %).

D'autres données indiquent que près du tiers des femmes (31 %) ne se sentent pas à l'aise de demander de l'aide où que ce soit. Près de la moitié des femmes (45 %) considèrent une ou un psychiatre, ou une ou un psychologue comme l'une des deux personnes les plus en mesure de leur apporter l'aide dont elles ont besoin. Le conjoint, ou un ami ou une amie sont respectivement désignés par 15 % et 11,7 % des femmes. Par ailleurs, il ressort qu'une femme dans la même situation, un membre de la famille, une travailleuse ou un travailleur social, une infirmière ou un infirmier, une ou un médecin sont très rarement reconnus par les femmes comme faisant partie des principales ressources pouvant leur procurer une aide valable.

Discussion

Les femmes du groupe à l'étude sont significativement moins nombreuses à être mariées ou à cohabiter avec un conjoint et sont moins scolarisées que celles du groupe de comparaison. On pouvait s'attendre

à ces différences, puisque les résultats de l'Enquête Santé Québec (Ministère de la santé et des services sociaux, 1988) indiquent un taux plus élevé de détresse psychologique chez les personnes séparées ou divorcées et moins scolarisées. Effectivement, il semble que les femmes suivies pour un trouble dépressif disposent de ressources personnelles et sociales plus limitées, liées à leur niveau de scolarité plus bas et au fait qu'elles sont moins nombreuses à être mariées et à demeurer avec un conjoint. Nous ne pouvons toutefois préciser de quelle façon ces caractéristiques sont liées à la dépression. Le fait de vérifier dans quelle mesure ces variables contribuent aux résultats obtenus dépasse le cadre de cette étude.

Plusieurs nécessités d'autosoin développementales perçues comme prioritaires par ces femmes ont trait à l'affirmation et à la réalisation de soi. De plus, elles apparaissent significativement moins préoccupées par des nécessités d'autosoin associées à la relation amoureuse (éléments 24, 29, 30, 31), au rôle parental (élément 35), à la relation avec la famille éloignée (élément 42, 43) que les femmes du groupe de comparaison. Quant aux nécessités d'autosoin reliées à l'altération de la santé qu'elles reconnaissent comme prioritaires, elles concernent surtout l'humeur dépressive, l'estime de soi et la compréhension de la dépression. On pouvait s'attendre à ces résultats concernant les nécessités d'autosoin reliées à l'altération de la santé, puisqu'elles découlent directement des manifestations cliniques de la dépression. Par contre, les résultats relatifs aux nécessités d'autosoin développementales peuvent apparaître étonnants car, selon l'étude de Weissman et Paykel (1974), ce sont dans les rôles comme conjointes, mères et travailleuses que les femmes rencontrent le plus de difficultés. Plusieurs nécessités d'autosoin liées aux relations avec leurs proches auraient donc pu leur apparaître significativement plus importantes comparativement au groupe de comparaison. Il est possible que les différences sociodémographiques entre les deux groupes expliquent en partie ces résultats. Puisque les femmes suivies pour un trouble dépressif sont moins nombreuses à vivre avec un conjoint, elles peuvent apparaître moins préoccupées par une relation amoureuse ou par les relations avec la famille éloignée d'un conjoint. De même, il est possible de croire que le niveau de scolarité significativement plus élevé des femmes du groupe de comparaison ait eu une influence sur les résultats. Selon Warren et McEachren (1983), les personnes plus scolarisées auraient des connaissances et des habiletés variées leur permettant d'augmenter leur propre potentiel d'adaptation et d'être moins déprimées. Les femmes du groupe de comparaison peuvent donc être plus enclines que celles suivies pour un trouble

dépressif à reconnaître les relations interpersonnelles comme un moyen d'augmenter leur bien-être.

Les méthodes différentes de collecte de données pour les deux groupes peuvent avoir influencé les réponses obtenues, ce qui constitue une limite de cette étude. En effet, il est possible que les femmes non suivies pour un problème émotif, qui ont rempli leur questionnaire seules, dans leur milieu familial, aient été plus enclines à accorder de l'importance à la relation avec leurs proches, tandis que les femmes présentant un trouble dépressif, interrogées par une infirmière, ont pu être davantage portées à attribuer de l'importance à leurs besoins personnels concernant leur santé, à des buts orientés vers elles-mêmes. D'ailleurs, cette tendance pourrait être considérée comme un reflet des approches traditionnelles utilisées en psychiatrie, lesquelles sont essentiellement centrées sur la personne et sur ses déficits, plutôt que sur la personne en interaction avec son environnement.

Toutefois, développer sa confiance en soi ressort de façon éloquente comme une priorité pour les femmes suivies pour un trouble dépressif. Cela peut se comprendre à la lumière du modèle explicatif de la résignation acquise et des facteurs de risques de la dépression, qui mettent en évidence l'importance pour les femmes d'avoir davantage confiance en elles-mêmes, d'acquiescer une meilleure estime d'elles-mêmes, d'exercer un plus grand contrôle sur leur environnement et sur les événements qui surviennent dans leur vie, de s'affirmer davantage. Orem (1987, 1991) soutient que la personne accomplit des actions d'autosoin qui peuvent être orientées vers soi ou vers l'extérieur. Les nécessités d'autosoin auxquelles les femmes suivies pour un trouble dépressif accordent une grande importance apparaissent essentiellement orientées vers elles-mêmes. En effet, elles semblent traduire avant tout un besoin essentiel de développer leur capacité de mieux contrôler des facteurs internes tels que leurs pensées, leurs émotions. Le rôle des femmes adultes dans notre société étant essentiellement orienté vers les besoins des autres, il est possible que les femmes ressentent, devant une diminution de leur intégrité, le besoin d'être davantage attentives à elles-mêmes.

L'élaboration de systèmes de soins infirmiers devrait tenir compte du besoin primordial des femmes d'arriver à se sentir bien avec elles-mêmes. Les nécessités d'autosoin associées à l'affirmation et à la réalisation de soi, à l'estime de soi et à l'humeur devraient être considérées essentielles dans un premier temps, prioritaires à la satisfaction des nécessités découlant des difficultés que les femmes rencontrent dans leurs relations interpersonnelles ou dans l'accomplissement des dif-

férents rôles qu'elles occupent. D'ailleurs, il est bien possible que l'augmentation des comportements affirmatifs et de la confiance en soi conduise les femmes vers des relations plus harmonieuses avec les autres (Bowman et Spadon, 1981). Les infirmières doivent développer des moyens pour aider les femmes à croire davantage en elles-mêmes. Des soins infirmiers basés sur la reconnaissance chez les personnes de leur capacité d'appropriation de soi, tels que proposés par Orem, apparaissent particulièrement appropriés dans ce contexte, en reflétant aux femmes leur responsabilité, leur capacité de prendre des décisions et de s'engager dans des actions autonomes, délibérées, pour augmenter leur bien-être.

En ce qui trait à la troisième question de recherche, il ressort que les plus grands besoins d'assistance sont ressentis pour les catégories estime de soi, humeur et connaissances sur la dépression. Ces catégories correspondent à celles pour lesquelles un plus grand nombre de femmes estiment recevoir de l'aide. Par contre, en ce qui concerne la recherche d'informations sur la dépression, plus de moitié des femmes ne reçoivent pas la quantité d'assistance désirée, et près des trois quarts se disent insatisfaites de l'aide reçue. Ceci semble traduire, de façon très positive, leur désir fondamental de se prendre elles-mêmes en charge sur le plan de leur santé. Ainsi, la dimension cognitive tient une place très importante dans la planification de l'assistance que les infirmières et les infirmiers peuvent leur procurer.

Les résultats démontrent qu'il apparaît plutôt rare que les femmes obtiennent du soutien auprès de leur réseau social. Il est donc possible qu'elles aient tendance à s'isoler et, ainsi, à se couper des renforcements positifs qu'elles pourraient se procurer auprès des leurs. Selon Lewinsohn (1974), il arrive que les personnes de l'entourage s'efforcent de soutenir la personne déprimée durant un certain temps, mais lorsque l'état dépressif persiste, des réactions négatives apparaissent chez les autres. Il s'ensuit que la personne déprimée se retire, continue à vivre de la frustration, de l'autodépréciation, de la culpabilité et du détachement. De cette façon, elle se trouverait prise dans un cercle vicieux que Lewinsohn nomme la « spirale dépressogène ». Les infirmières et les infirmiers peuvent encourager les femmes à maintenir ou à développer un réseau social efficace, à utiliser ce réseau ou d'autres ressources extérieures au milieu psychiatrique. De même, puisque la majorité des femmes perçoivent très rarement l'infirmière ou l'infirmier comme faisant partie des ressources pouvant leur procurer de l'aide, il est essentiel que les soins infirmiers offerts aux femmes et aux familles deviennent plus visibles, que des modèles d'intervention infirmière en

santé communautaire soient développés et fassent l'objet de recherches scientifiques en vue de les améliorer.

La théorie du déficit de l'autosoin (Orem, 1991) s'est avérée particulièrement pertinente pour orienter cette étude, en mettant l'accent, de façon positive, sur la reconnaissance fondamentale de la capacité d'appropriation de soi des femmes et de leur responsabilité concernant les décisions qu'elles prennent en vue de promouvoir leur bien-être. Il y aurait lieu de poursuivre d'autres études permettant de vérifier les qualités psychométriques de l'instrument utilisé dans cette étude et de l'améliorer. Étant donné l'influence possible des différences sociodémographiques entre les deux groupes sur les résultats, d'autres recherches pourraient être menées auprès de groupes comparables quant à leur statut social afin de vérifier si les mêmes conclusions émergeraient. D'autres recherches pourraient s'intéresser à l'identification des limitations qui empêchent les femmes de satisfaire leurs besoins d'autosoin afin de mieux cerner la nature des déficits d'autosoin pour lesquelles elles ont besoin d'assistance. Dans le domaine des soins infirmiers en psychiatrie, peu de recherches ont été effectuées à partir d'une conception propre à la discipline infirmière. Il s'agit d'une démarche importante pour le développement des connaissances sur des phénomènes spécifiques à la science infirmière, lesquelles doivent guider la pratique. Des recherches pourraient également être poursuivies dans le but de clarifier davantage les concepts formant la théorie du déficit de l'autosoin, qui apparaissent souvent complexes et difficiles à rendre opérationnels. Enfin, il apparaît nécessaire de développer des instruments valides et fiables pour mesurer ces concepts et de tester les propositions à la base de la théorie elle-même.

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Problem-Solving Counselling or Phone-Call Support for Outpatients with Chronic Illness: Effective for Whom?

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L'objectif de cet essai contrôlé avec répartition aléatoire des sujets était de déterminer dans quelle mesure les conseils pour la résolution de problèmes ou le soutien au téléphone qu'apportent les infirmières aux malades externes atteints de maladie chronique et mal adaptés à celle-ci sont efficaces. On a étudié 293 sujets une première fois, puis après une période d'intervention de six mois, pour examiner les variables psychosociales comme les comportements opérants, les buts dans la vie et l'adaptation psychosociale à la maladie. Les personnes que les infirmières ont soutenu au téléphone ont vu leur niveau de détresse psychologique diminuer. Cette étude a révélé que les conseils pour la résolution de problèmes augmentent l'adaptation psychosociale à la maladie chronique pour les malades externes qui vivent seuls, qui utilisent rarement leurs talents cognitifs d'adaptation ou pour résoudre les problèmes, ou qui emploient fréquemment des méthodes d'évitement. D'autre part, les personnes qui attendent peu de la vie et qui emploient rarement leurs talents d'adaptation à la résolution de problèmes ont le plus profité des conseils pour la résolution de problèmes que leur ont prodigués les infirmières. En dernier lieu, les personnes mal adaptées mais qui utilisent souvent leurs talents d'adaptation à la résolution de problèmes ont tiré un meilleur profit du soutien au téléphone.

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The purpose of this randomized controlled trial (RCT) was to determine the effectiveness of problem-solving counselling or phone-call support provided by nurses to outpatients not well adjusted to chronic illness. Subjects ($N=293$) completed measures at baseline and after the six-month period of intervention for psychosocial variables including coping behaviours, purpose in life, and psychosocial adjustment to illness. Subjects receiving phone-call support from nurses demonstrated less psychological distress. Results also suggest that problem-solving counselling improves psychosocial adjustment to chronic illness for outpatients who live alone, infrequently use problem-solving coping skills, or frequently use avoidance coping methods. As well, outpatients with a low purpose in life who show infrequent use of problem-solving coping skills appear to benefit most from problem-solving counselling provided by nurses. On the other hand, those not well adjusted who frequently use problem-solving coping seem to be served more effectively by phone-call support.

Psychological adaptation or adjustment among chronically ill outpatients (Davies, Quinlan, McKegney, & Kimball, 1973) is remarkably effective and is fundamentally independent of the patient's specific diagnosis, such as cancer (Cassileth et al., 1984; Cassileth et al., 1985) or renal failure (Livesley, 1982). Poor psychosocial adjustment to a variety of chronic diseases has been associated with life stress and social isolation (Lewis & Bloom, 1978; Ruberman, Weinblatt, Goldberg, & Chaudhary, 1984), as well as unfavourable self-concept, social relationships, and attitudes toward illness (Counte & Bielawskas, 1983; Hyman, 1975). Reduced function in job, household, and leisure roles as well as high rates of "medically illegitimate job disability" (Hyman, 1975) and mortality (Derogatis, Abelloff, & Melisaralos, 1979) have been observed among those not well adjusted to their illness.

Psychosocial adjustment is thought to be a quality-of-life measure of how individuals are dealing with the stresses of their illness. Social and cognitive variables explain between 27 and 57 percent of the variation in psychosocial adjustment to chronic illness (Broadhead et al., 1983; Evans & Northwood, 1983; Lazarus & Folkman, 1984; McFarlane, Norman, Streiner, & Roy, 1983; Moos, Cronkite, Billings, & Finney, 1984). Psychosocial adjustment is related to a combination of cognitive, coping, and perceived social support variables. Consequently, nursing interventions for outpatients with chronic illness should be designed to either promote more effective cognitions and coping behaviours or provide more social support. One or both of these types of interventions should improve psychosocial adjustment to illness, given that social support and cognition are inextricably bound. Thus, interactions between interventions, cognitions, coping behaviours, and social support need to be examined, to determine who benefits from different strategies (Browne, Byrne, Roberts, & Sword, 1994).

Background Literature

Problem-Solving Counselling

Problem-solving intervention is located within the literature on cognitive-behaviour therapy (Mahoney & Arnkoff, 1978). Cognitive-behaviour therapy is a broad term referring to psychological treatments that primarily emphasize the role cognitions play in explaining behaviour, as in the work of Ellis (1969) and Beck, Rush, Shaw, and Emery (1979). The coping framework of Lazarus and Folkman (1984) emphasizes the role of coping in explaining outcome, as does the theoretical work of Moos and Billings (1982). Problem-solving therapy combines cognition and coping in a naturally occurring problem-solving process, and is described in the work of D'Zurilla (1986), D'Zurilla and Goldfried (1971), D'Zurilla and Nezu (1982), Meichenbaum (1985), and Meichenbaum and Turk (1987). It is a type of cognitive-behaviour therapy.

Major reviews of counselling approaches have consistently documented the effectiveness of a brief (eight- to 10-session) cognitive-behaviour approach to treatment (D'Zurilla, 1986; D'Zurilla & Nezu, 1982; Elkin, Parloff, Hadley, & Autry, 1985; Hollon & Kendall, 1979; Mahoney & Arnkoff, 1978; Turk, Meichenbaum, & Genest, 1983). The cognitive-behaviour approach to therapy, which has been carefully described, emphasizes the role of thoughts or cognitive appraisals, self-control, coping, and problem-solving skills as crucial variables producing therapeutic change (Beck et al., 1979; Cameron & Meichenbaum, 1982; D'Zurilla, 1986; D'Zurilla & Nezu, 1982; Hollon & Kendall, 1989; Meichenbaum, 1985; Turk et al., 1983). However, in general, most studies of cognitive-behaviour therapy have been done on subjects with mental health problems such as depression (Beck et al., 1985; Elkin et al., 1985; Williams, 1984). Only a few studies with control groups have tested the effectiveness of cognitive-behaviour therapy for patients with chronic physical illnesses such as headache (Attanasio, 1987; Blanchard et al., 1985) or epilepsy (Tan & Bruni, 1986). The significant reduction in symptoms was associated with all groups including the group with less therapist contact (Attanasio, 1987). The cognitive component of the treatment appears to be the critical feature associated with longer lasting, more generalized effects (Attanasio, 1987; Bandura, 1977; Hollon & Kendall, 1979; Tan & Bruni, 1986).

In summary, cognitive-behaviour therapy and problem-solving therapy have been specifically tested in outcome studies with hospitalized psychiatric patients, substance abusers, depressed geriatric patients, and couples with marital problems (Coché & Flick, 1975; Hussain & Lawrence, 1981; Intagliatia, 1978; Jacobson, 1978). These studies have produced promising results but conclusions to date have been weakened by inadequate attention to control groups or procedures, inadequate outcome measures, and lack of follow-up evaluations to assess duration of effects.

Phone-Call Support

Instrumental or social support for chronically ill outpatients has been advocated as a method to improve coping and psychosocial adjustment to illness by Broadhead et al. (1983), who hypothesize that perceived supportiveness has a role in fostering positive health outcomes. We found no randomized control trials (RCT) examining the effectiveness of face-to-face versus over-the-phone counselling, in the published literature on psychosocial adjustment to chronic physical illness. Although their study was methodologically flawed since baseline characteristics were not comparable between experimental and control groups, Frasure-Smith and Prince (1989) found fewer deaths in a post-myocardial infarction group that received a combination of phone-call support and nurse visits than in a control group. Infante-Rivard, Krieger, Petitcherc, and Baumgarten (1988) found that elderly people used fewer medical services after hospital discharge when they received phone follow-up although their results did not reach statistical significance. In Wasson et al.'s (1992) trial, clinician-initiated phone care appeared to significantly reduce use of medical services. For the severely ill, this phone contact also appeared to improve health status and reduce mortality; however, psychosocial adjustment was not addressed in this study.

Emotional support was found to be the most common category of need in a phone-in line for people with arthritis (Masiak, Kaplan, & Heck, 1989). Such perceived support may be the common therapeutic mechanism during periods of high vulnerability to stress (Frasure-Smith & Prince, 1989). Nevertheless, numerous studies have identified the need to examine long-term effects of chronic illness and possible supportive interventions (Blakely et al., 1991; Bombardier, D'Armico, & Jordan, 1990; Braden, 1990; Buckley, Vacek, & Cooper, 1990; Burckhardt, Woods, Schultz, & Ziebarith, 1989; Drory & Florian, 1991; Jensen & Kroly, 1991; Jensen, Turner, & Romano, 1991; Pollock, Christian, &

Sands, 1990; Primomo, Yates, & Woods, 1990). Thus, study results of problem-solving therapy and phone-call support hold promise, while research using stringent methodological criteria is needed.

The purpose of this RCT was to determine the effectiveness of problem-solving counselling or phone-call support in improving psychosocial adjustment to illness, using a control group for comparison.

The following research questions were posed: Does the addition of problem-solving counselling (Group 1) or a phone-call support strategy (Group 2), both designed to augment conventional clinic health care, enhance patients' psychosocial adjustment to chronic illness, as compared with conventional clinic health care alone (Group 3)? What are the coping, socio-demographic, and purpose-in-life characteristics of patients for whom these interventions are effective?

Method

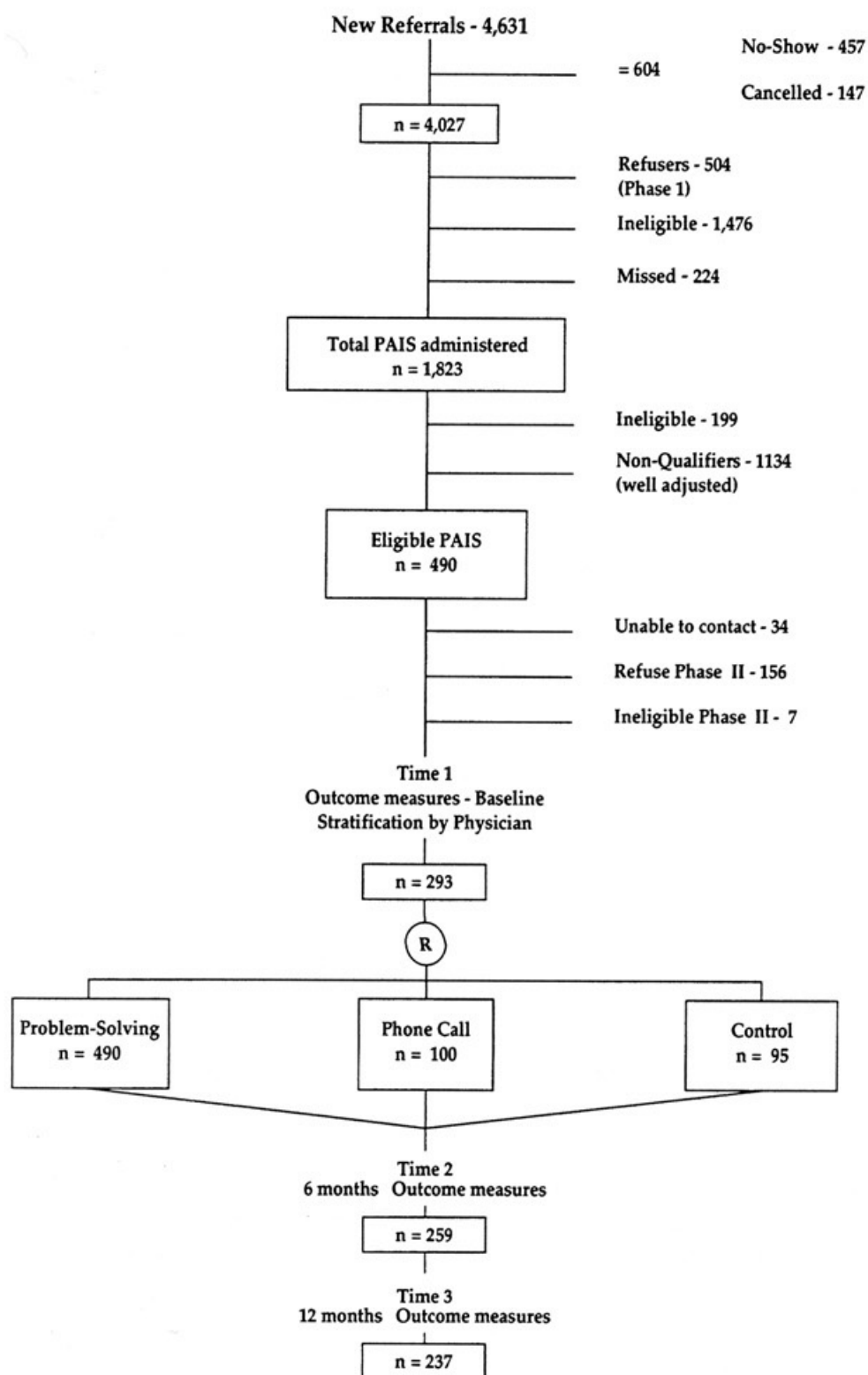
Design and Setting

This RCT was carried out in 27 outpatient specialty clinics of a southern Ontario hospital. These clinics, in a large urban tertiary care centre, serve as referral points for a broad spectrum of general disorders. The nine major clinic groupings screened were: endocrinology, internal medicine, respirology, dermatology, cardiology, occupational health, gastroenterology, neurology, and rheumatology. Subjects were stratified by physician and randomly assigned blocking after every six subjects.

Sample

Subjects were new adult referrals to physicians at the clinics participating in the study. Each had a chronic medical disorder that required ongoing medical evaluation for more than one year. These disorders included: hypertension, diabetes and other endocrine disorders, chronic lung disease, asthma, epilepsy, Parkinson's disease, Crohn's disease, ulcerative colitis, scleroderma, angina, and arthritis. Preliminary eligibility criteria were that subjects be 18 years or older and able to read, write, and understand English, and that they consent to complete the Psychosocial Adjustment to Illness Self-Report form (PAIS-SR) questionnaire. Subjects who scored low on psychosocial adjustment were subsequently asked if they would be willing to be randomly assigned visits, or phone calls, or neither from a nurse to talk about how they were coping with their illness.

Figure 1 Trial Flow Chart



Procedures

All subjects with chronic illness referred to the outpatient clinics ($N=4,027$) were asked for informed consent and then approached to complete the screening PAIS questionnaire. If the PAIS score indicated fair-to-poor adjustment (>34 for the total score or score >9 on the psychological distress subscale), indicating that the subject was not adjusting well to illness (Derogatis & Lopez, 1983), the subject was asked for additional consent, Baseline measures were taken, and the subject was randomized to one of three arms of the trial: problem-solving individualized counselling (Group 1), phone-call support (Group 2), or conventional medical care alone (Group 3). Of those screened ($n=1,823$), 490 eligible, not well-adjusted subjects were selected for the trial. Some 156 refused, 34 were not located, and seven were unable to participate. Thus 293 entered the trial (Figure 1). Baseline and two follow-up measurements were done at six and 12 months after patients entered the study. Baseline measures were done only after the subject had agreed to randomization. This helped ensure fewer differences in types of subjects in groups since all three groups of subjects agreed to receive counselling if so randomized. It was thought that in order to test if the therapy was effective, it should last six months. After the six months of intervention 9-13% of subjects were lost from each group, and another 6-9% were lost to the 12-month follow-up. Thus 81% of those originally randomized completed the final outcome measurements at one year after enrolment.

Nurse assignment. Nurses were master's-prepared, experienced counsellors who were educated in problem-solving intervention with meetings and workshops and had copies and the use of a Problem Solving Therapy Manual (Meichenbaum, 1992). Throughout the study, weekly group sessions, with all four nurses present as well as two senior nurse investigators, were used to generate and verify formulations about patient's circumstances and about goals and strategies for care. Through these group discussions and by review of nurses' notes, two investigators verified that the interventions were being carried out according to the protocol.

Phone calls were observed for timing and verbal responses by the nurses. Nurses' notes were monitored for content by another investigator and by the research associate. The study nurses kept notes on topics discussed and length of time of each phone call. Nurses provided only supportive comments during the phone calls made to Group 2 subjects and a sample of the comments during calls was verified by the research associate.

The same group of nurses provided both the problem-solving intervention, one to 10 hours of arranged individual meetings (Group 1), and the one to eight five-minute phone calls to subjects in order to avoid the bias associated with the personality of the therapist. Subjects were randomly assigned to counselling or phone-call support. Nurses were assigned to one or two clinics and assigned subjects based on case load. Each intervention followed a script. Each nurse who met or phoned her subjects over a six-month period kept notes of all sessions. The family physicians of all subjects were notified of the patient's participation in the trial but not of the patient's group assignment.

Study Groups

Problem-solving counselling sessions (Group 1). The problem-solving sessions were added to conventional outpatient clinic care for patients ($n=98$) allocated to Group 1. The Model of Problem Solving Therapy for Adults (D'Zurilla, 1986; D'Zurilla & Nezu, 1982), which updates D'Zurilla and Goldfried's (1971) widely used Model of Problem Solving, is recommended by Meichenbaum (1985, 1987). The model consists of stages during a sequence of sessions designed to meet the following goals: (a) Problem Orientation: to nurture identification and recognition of problems, as well as strengths, thus fostering a shift from negative emotions and thoughts (e.g., feelings of helplessness, hopelessness, and demoralization) that hinder problem-solving to a positive sense of resourcefulness; (b) Problem Definition and Formulation: to help identify realistic goals or desired outcomes for problem-solving; (c) Generation of Alternatives: to help generate and evaluate a wide range of alternative courses of action (both direct coping efforts for aspects that can be changed and emotionally palliative coping efforts for aspects that cannot) while developing and using social supports; (d) Decision-Making: to help evaluate the possible consequences of available alternative solutions and select the most effective and feasible ones for the short and long term, personally and socially; (e) Solution Implementation, Verification, and Relapse Prevention: to help assess the efficacy or outcome of the chosen solutions, take credit for changes, identify high-risk situations, and handle relapses or setbacks (Meichenbaum, 1992).

While effective problem-solving seems to follow a temporal sequence, there is interplay among the various stages relating to reappraisal of the problem and of the effectiveness of various solutions (Cameron & Meichenbaum, 1982; Meichenbaum, 1985). Since subjects in this trial did not actively seek this psychosocial help for their prob-

lems, in living with their illness or otherwise, an unobtrusive approach to the initial assessment was warranted. Nurses were taught to open the first meeting with an explanation of the purpose of this study: to learn about how people cope with illness. Then nurses explored symptoms associated with the patient's illness. This exploration included inquiries about physical symptoms, difficulties in daily living, and problematic emotions, their own and those of others, resulting from the illness and affecting their daily life.

During the one- or two-session problem-solving inquiry, the nurse observed thematic areas of deficiency in problem-solving that pervade multiple contexts (symptoms, emotions, illness, daily living related to family, job). The nurse formulated these observations and negotiated with the patient until agreement was reached regarding the central or underlying issue in appraisal, coping behaviour, or other steps of problem-solving. Then, goals regarding appraisal, problem-solving, or coping behaviour were set and prioritized. Behavioural tasks for goal accomplishment were arranged and follow-up sessions were scheduled to evaluate progress. The number and spacing of meetings were tailored to individual needs.

Of 98 subjects randomized to receive therapeutic problem-solving therapy, 96 had at least one hour-long visit with the research nurse. Twenty-four visits with subjects included another family member. Subjects were rated according to their goal-attainment (problem-solving) ability by their nurse counsellor. Of the 96 subjects, 5% were deemed to be worse off after the problem-solving therapy, and 28% showed no improvement; however, 44% and 23% showed some or great improvement in meeting their mutually identified goals. The most frequently identified concerns or goals expressed related to family or significant others. Ten sessions were planned for each individual, but nurses and subjects sometimes agreed to fewer or, infrequently, more sessions. The number of sessions ranged from one to 14. The mean number of sessions was 4.6 and the mean number of minutes per session was 64. On the whole, 89% of the subjects completed two or more sessions. Those dropping out before Time 2 (six-month measures) had an average of 3.5 sessions.

Phone-call support (Group 2). Nurses from the same pool contacted patients in Group 2 ($n=100$) by telephone using a standardized contact sequence: every two weeks for two months, then once a month for four months, for a total of one to eight brief, five-minute phone calls. The subject and the nurse mutually agreed on the total number of calls. Each call started with the question "How are you doing?" The nurses

were instructed to actively listen without probing, offering supportive and encouraging comments. Nurses were instructed not to use problem-solving techniques and were provided with scripts for supportive care only. When discussing health concerns, the nurses asked the subject what they would normally do, and supported the response, if appropriate. This was considered to be a supportive intervention that did not require subjects to learn and practise problem-solving techniques.

Only three subjects in Group 2 received fewer than two phone calls. Summary sheets of phone calls classified issues or concerns raised by the patient. These issues and concerns were recorded using the coding system adapted from Stam, Blutz, and Pittman (1986). Those mentioned most often by the subjects during calls related to treatment or physical-somatic complaints. Subjects received an average of 5.06 calls lasting an average of 6.83 minutes per call. On average, 2.30 calls for each subject were missed after three attempts, usually because the subject could not be reached at the pre-arranged time.

Conventional clinic care (Group 3). Subjects ($n=95$) randomized to this group received no supportive phone calls and had no problem-solving sessions with the research nurses. These subjects continued with their conventional clinic care as deemed appropriate by their attending physicians.

Measures

Self-report questionnaires were mailed to the subjects and returned to the research office (also by mail). Personal information collected included age, sex, marital status, whether living alone, whether Canadian-born, level of education, and employment status. Outpatient clinic charts were consulted for time elapsed since diagnosis, and for primary diagnosis which was coded according to the classification codes of the Royal College of General Practitioners (1984).

Psychosocial adjustment to illness (PAIS-SR) was the outcome of primary interest in this study. Weissman's (1981) review of instruments measuring psychosocial adjustment cited the PAIS as the only appropriate measure for a physically disadvantaged group. Morrow, Chiarello, and Derogatis (1978) and Derogatis and Lopez (1983) developed the PAIS-SR to measure psychosocial adjustment, including intrapsychic processes, as well as interactions between the individual and other people and institutions in their sociocultural environment. Derogatis and Lopez (1983) report an internal consistency ($\alpha=.81$) and

interrater reliability ($r=.86$), as well as good construct validity. This 46-item self-report assesses adjustment to a current medical illness in seven domains (health-care orientation, vocational environment, domestic environment, sexual relationships, extended family relationship, social relationships, and psychological distress). Each item is rated on a four-point scale, with a raw score of 35 to 51 representing fair adjustment to illness and greater than 51 representing poor adjustment (Arpin, Fitch, Browne, & Corey, 1990; Browne, Arpin, Corey, Fitch, & Gafni, 1990; Derogatis & Lopez, 1983).

The Eastern Co-operative Oncology Group (ECOG) Performance Status Scale is a subjective assessment of how an illness affects ability to function (Skeel, 1982). This simplified version of the Karnofsky Performance Status Scale (KPS) (Karnofsky, Abelman, Craser, & Birchenal, 1948) has five levels of functioning, to provide a global rating of physical performance status or activity level. The scale was used to enable comparison of the treatment and control groups on physical performance. The rating "1" indicates "fully active," while "5" indicates inactivity. Formal reports of reliability and validity were not found.

Coping was measured using the Indices of Coping Response (Moos et al., 1984), an instrument that focuses on cognitive and behavioural coping responses following a stressful event. Different coping behaviours are thought to mediate a stressor such as a physical illness. Respondents rate their frequency of use of 33 different coping responses on four-point scales. Responses are categorized into three methods of coping: active cognitive, active behavioural, and avoidance; and five foci of coping: problem-solving, logical analysis, emotional discharge, affective regulation, and information-seeking. Previous reports of internal consistency ($\alpha=.51$ to $.74$) and satisfactory construct validity are Moos and Billings (1982) and Moos et al. (1984). In our study sample, internal consistency was fair to good for the subscales (Cronbach's $\alpha=.69, .75, .43, .57, .59, .58, .58, .44$).

The 33-item Meaning of Illness questionnaire (Browne et al., 1988) uses seven-point items to measure whether the respondent has a positive or negative view of various aspects of the illness, such as severity, expectedness, controllability, hopelessness, uncertainty, and the degree to which the illness event interferes with commitments (Haan, 1982). Test-retest reliability was given as $.60$ to $.77$ (Arpin et al., 1990) and internal consistency was good (Cronbach's $\alpha=.73, .75, .70, .60, .40$) in the five subscales for our study sample. It was thought that meaning given to illness was an important protective resource used when facing a stressor such as physical illness.

The Purpose-in-Life questionnaire is an attitude scale constructed from the orientation of logotherapy, a system of Frankl's (1965, 1969) existential therapy. It quantifies one's primary motivation to find meaning and purpose in human existence. If one fails to find sufficient meaning and purpose to give one's life a sense of unique identity, "existential vacuum" is experienced. This is a 20-item questionnaire on a seven-point scale. A total score under 92 indicates a definite lack of purpose in life, a score of 92-112 indicates indecisiveness, and over 112 indicates a clear sense of purpose. Split half reliability ($r=.81$), test-retest reliability (.68-.83), and criterion validity (.38-.47) have been reported (Crumbaugh, 1969). Our study sample yielded good internal consistency (Cronbach's $\alpha=.92$).

Social supports have been shown to have both buffering and direct beneficial effects on diverse health-related outcomes, including use of health care services, general morbidity, and a variety of psychologic states (Broadhead et al., 1988). The Duke social-support questionnaire measures functional elements of social supports using two factors, a five-item confidant support and a three-item affective support. Confidant support reflects primarily a confidant relationship in which important matters in life are discussed and shared. Affective support reflects a more emotional form of support or caring. Test-retest reliability was reported as .66 (Broadhead, Gehlback, deGruy, & Kaplan, 1988). In our sample, internal consistency was good for the two subscales (Cronbach's $\alpha=.82$ and .79) and a factor analysis with our dataset yielded the same two factors with eigenvalues of 4.0 and 1.1.

The clinicians' (clinic physician or nurse) subjective judgement of disease severity was recorded on a seven-point scale to provide a global measure applicable across types of disease. A rating of "1" indicated not severe, "7" very severe. It was considered neither reliable nor necessarily valid, however, since a broad measure of severity for a diverse range of chronic illnesses was needed, it was included in the study.

A measure of perceived change in life and health (developed by two of the investigators) was given immediately after the intervention in Groups 1 and 2. Subjects were asked to complete a four-item scale measuring their change from six months previously, in (a) satisfaction with life, (b) life overall, (c) state of health, and (d) coping and adjustment to health. Questions were scored from 1 to 7 (much worse to much better). Validity of this questionnaire was evaluated by examining correlations with PAIS scores ($r=.43$ to .44). Subjects in Group 1 and Group 2 were also asked to indicate whether the nursing intervention they received was helpful, not helpful, or neither.

Analysis

Subject representativeness and group comparability at Baseline were assessed using analysis of variance (ANOVA) and chi-square statistical tests. The effectiveness of interventions was evaluated using repeated-measures ANOVA for the Baseline, six-month follow-up, and 12-month follow-up. Since interactions for time were significant, change scores in psychosocial adjustment from Baseline to Time 2 (when the intervention occurred) were used in analysis of variance when examining interactions in more detail.

Results

Representativeness

Of 4,027 clinic attendees (Figure 1), 504 refused to participate in the study screening and 224 were missed by screeners; however, most were ineligible ($n=1,476$), because, for example, they did not have a chronic illness ($n=413$). The three groups of participating subjects were similar to the three groups of non-participating subjects (refused, unable to be contacted, and died or too ill) in level of psychosocial adjustment to illness ($F_{5,484}=.28, p=.92$). Dropouts (12% by Time 2; 19% by Time 3) were compared with those remaining in the study. At Time 2, dropouts were comparable except they were younger on average (47 vs. 39 years). By Time 3, dropouts were younger and had more unanswered questions about health care at Baseline.

Prevalence of Poor Psychosocial Adjustment

Screened subjects were well (66%), fairly well (20%), or poorly (14%) adjusted. Highest levels of poor adjustment were for subscales: Psychological Distress (feeling angry, sad, depressed) and Health Care Orientation (having many unanswered questions about the illness and its treatment).

Comparability of Study Groups

Subjects randomized to one of three study groups were comparable in age (44-48 years), education (grades 12-13), time elapsed since diagnosis (six-eight years), moderate severity of illness, sex (30-40% males), employment (48-63% employed), whether Canadian-born (72-78%), level of disability (22-26% fully active), marital status (64-74% married), and living alone (10-18%), and were comparable in the proportions of subjects from each diagnostic grouping. There were no statistically sig-

nificant differences in any sociodemographic or psychosocial Baseline variables of the three study groups. PAIS scores at Baseline were comparable across Groups 1, 2, and 3 ($F_{2,256}=.34, p=.71$).

Effectiveness of Interventions

Psychosocial main effects. Table 1 indicates the mean scores on PAIS and PAIS subscales, and compares mean changes from Baseline to Time 2 (when the intervention occurred). The higher the change score, the greater the improvement. There were main-effect differences among groups on the psychological distress subscale of the PAIS ($F=4.07, p=.02$), the phone support group demonstrating the greatest improvement. Single-item global measures also indicated that the two intervention groups experienced greater (a) satisfaction with life ($\chi^2=21.6, p<.001$), (b) improvement in life overall ($\chi^2=15.3, p<.01$), and (c) improved coping and adjustment to health ($\chi^2=12.2, p<.01$). Thus there was a statistically significantly larger proportion of patients satisfied with life overall in the problem-solving counselling (60%) and phone-support (69%) groups versus the control group (40%). In addition, only 3% (Group 1) and 7% (Group 2) rated the interventions as not helpful.

Analysis of interaction effects: treatment assignment by psychosocial factors. To determine the effect of counselling and phone-support interventions on the dependent variable psychosocial adjustment to illness, repeated measures ANOVA using theoretically postulated important independent variables such as living alone status and coping factors, and purpose in life were carried out examining the interactive effects of group allocation, intervention, and time (two follow-up measures) on the dependent variable, psychosocial adjustment. Since time of measure interacts with other factors, the latter were examined more fully over one time period, the six months of the intervention using ANOVA with PAIS change scores from Baseline to Time 2 as the dependent variable. Because statistically significant interaction effects were found, statements about effects of treatment are qualified based on interacting variables. Discussions of main effects of treatment are meaningless when interactions are present (Kleinbaum & Kupper, 1978). The presence of interactions indicates that certain characteristics (factors) moderate the treatment effect.

1. Sociodemographic characteristic interaction. The interactive effects of the following sociodemographic characteristics, in relation to study group and change in psychosocial adjustment as the dependent variable (Baseline to Time 2), were investigated: age, sex, living status,

Table 1

Comparison of Mean Changes in Outcome Scores among Counselling, Phone-Call Support, and Conventional-Care Groups (Time 1-2) (n=259)

| Mean Score | Counselling | | | | Phone-Call | | | | Conventional | | | | | |
|---------------------------|-------------|--------|----------------|--------|------------|--------|----------------|--------|--------------|--------|----------------|--------|------|-----|
| | Time 1 | Time 2 | \bar{x} Diff | SD | Time 1 | Time 2 | \bar{x} Diff | SD | Time 1 | Time 2 | \bar{x} Diff | SD | F | P |
| Total PAIS | 50.19 | 42.72 | 7.47 | (17.8) | 50.26 | 42.44 | 7.82 | (17.1) | 49.10 | 44.72 | 4.37 | (14.2) | 1.12 | .33 |
| Health-Care Orientation | 8.41 | 7.54 | .87 | (4.0) | 8.79 | 7.74 | 1.05 | (3.7) | 8.28 | 8.45 | -.17 | (3.4) | 2.63 | .07 |
| Vocational Environment | 7.22 | 6.29 | .93 | (3.7) | 7.17 | 6.30 | .87 | (3.7) | 7.10 | 6.17 | .93 | (3.5) | .01 | .99 |
| Domestic Environment | 7.43 | 6.33 | 1.10 | (3.9) | 7.78 | 6.48 | 1.30 | (3.2) | 7.73 | 6.73 | 1.00 | (3.3) | .16 | .85 |
| Sexual Relations | 5.35 | 4.54 | .81 | (2.8) | 5.37 | 4.47 | .90 | (3.3) | 5.46 | 5.17 | .29 | (3.5) | .88 | .42 |
| Extended Family Relations | 3.11 | 2.66 | .45 | (3.1) | 2.55 | 2.54 | .01 | (2.6) | 2.58 | 2.36 | .22 | (2.3) | .59 | .56 |
| Social Relations | 8.22 | 6.52 | 1.70 | (4.1) | 7.54 | 6.52 | 1.02 | (5.1) | 7.89 | 6.46 | 1.43 | (4.4) | .48 | .62 |
| Psychological Distress | 10.46 | 8.84 | 1.62 | (4.9) | 11.06 | 8.39 | 2.67 | (4.7) | 10.06 | 9.39 | .67 | (4.0) | 4.07 | .02 |

education, whether Canadian-born, time elapsed since diagnosis, activity level, and severity of illness. Living status was the only sociodemographic variable to interact with effect of treatment in determining change in psychosocial adjustment. Among those who lived alone, the patients assigned to receive problem-solving counselling showed the greatest improvement in adjustment ($F_{2,247}=3.2, p=.04$).

2. Coping methods interactions. Two coping factors, problem-solving coping and avoidance coping, were a priori hypothesized to be characteristics that might predict differences in effectiveness of treatment. Table 2 indicates the statistically significant interaction effects for problem-solving coping, avoidance coping, and study group ($F_{2,247}=3.8, p=.02$). These interactions identified subgroups of subjects who had improved psychosocial adjustment in different intervention groups in relation to their use of these coping methods at Baseline.

Table 2

Analysis of Variance: Interaction of Problem-Solving and Avoidance Coping Variables with Study Groups for Improved Total PAIS Scores Time 1-2

| Variables | MS | Df | F | p |
|---|--------|-----|------|-----|
| Group | 303.9 | 2 | 1.19 | .33 |
| Problem-Solving Coping | 2077.8 | 1 | 8.18 | .01 |
| Avoidance Coping | 173.3 | 1 | .68 | .42 |
| Group*Problem-Solving Coping | 432.4 | 2 | 1.70 | .20 |
| Group*Avoidance Coping | 820.2 | 2 | 3.23 | .04 |
| Problem-Solving*Avoidance Coping | 1.26 | 1 | .50 | .49 |
| Group*Problem-Solving*Avoidance Coping | 973.5 | 2 | 3.83 | .02 |
| Residual | 253.92 | 247 | | |
| R ² = .1060 Total F _{11,247} =2.66, p=.003 | | | | |

Figure 2 suggests that the problem-solving intervention was effective for subjects who at Baseline were infrequently using problem-solving coping methods but were using avoidance as a means of coping. Problem-solving counselling appeared to help these subjects to improve their psychosocial adjustment by Time 2, as indicated by improvement in overall PAIS scores. By contrast, among subjects who

infrequently used avoidance coping and frequently used problem-solving coping, those receiving the phone-call strategy showed the most improvement. Subjects who infrequently used both problem-solving coping and avoidance did equally well with phone calls and conventional care. By Time 3, interactions were no longer significant, probably since the intervention had ended six months previously.

Figure 2

Improvements in PAIS (Time 1-2) Related to Use of Problem-Solving and Avoidance Coping at Baseline and Study Groups

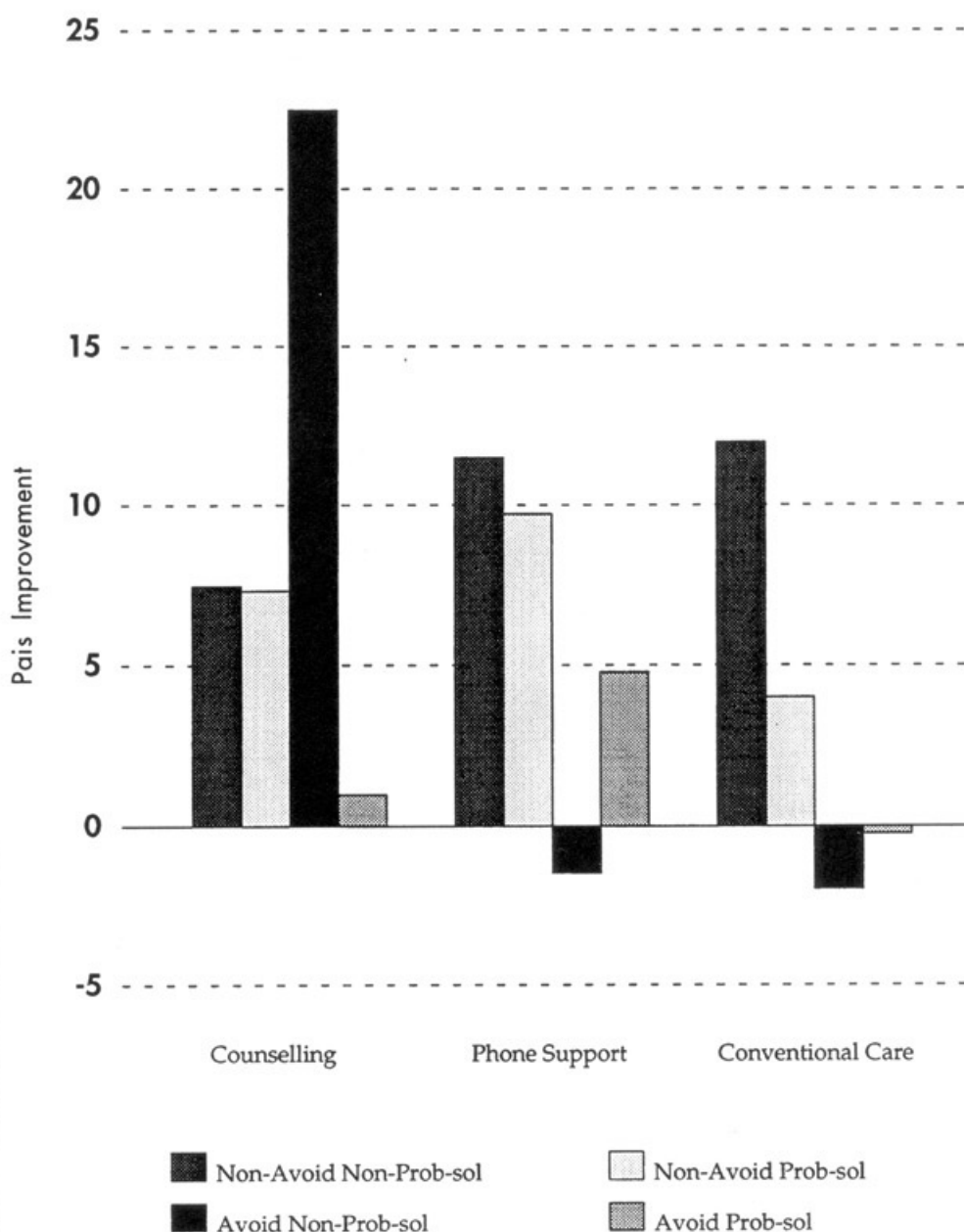
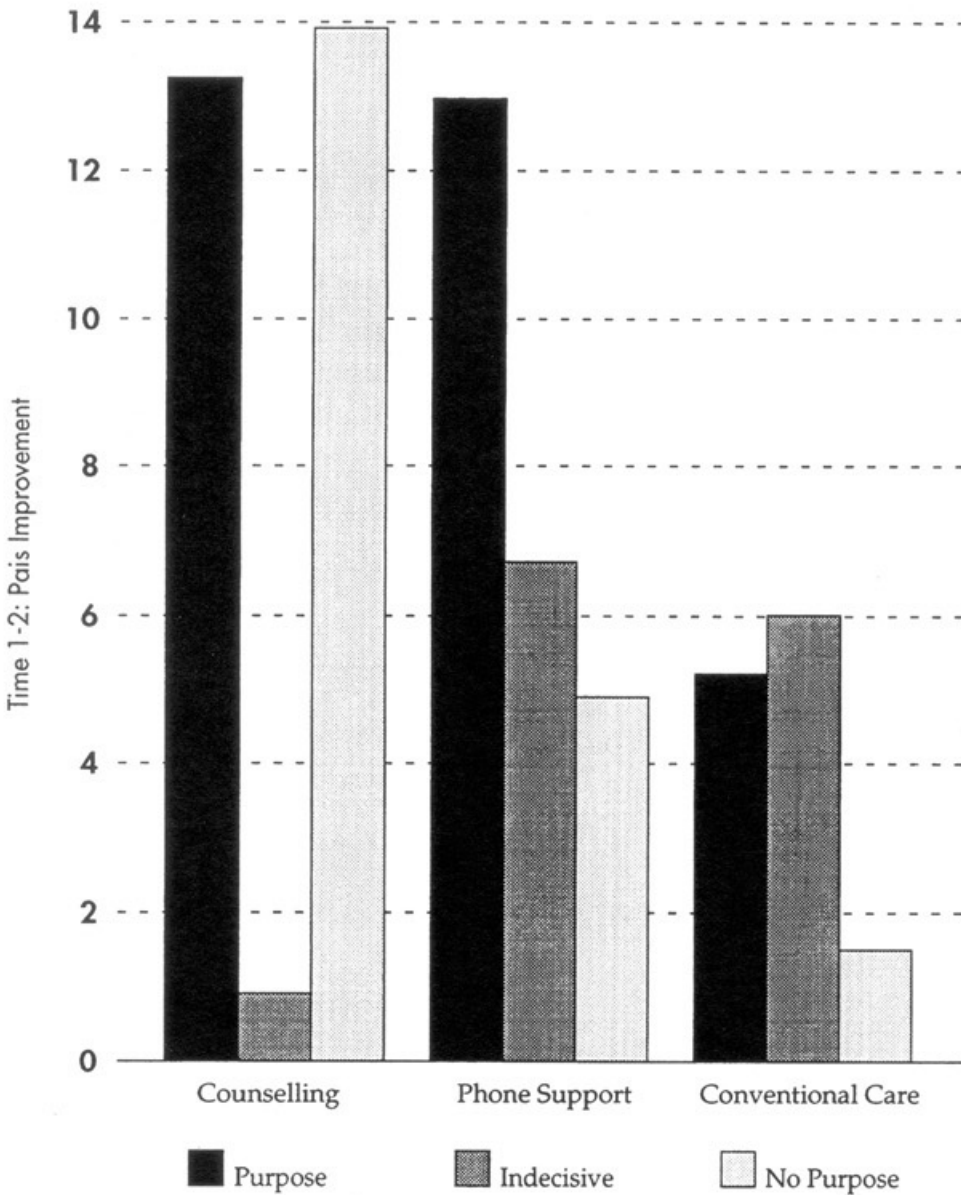


Figure 3

Improvements in Psychosocial Adjustment Related to the Clients' Purpose in Life at Baseline, and Study Groups



3. Purpose-in-life scale. Post hoc analysis of variance using other non-a priori hypothesized variables demonstrated differences in treatment effect related to categorizing patients according to purpose in life. Purpose-in-life scores were categorized as low, indecisive, or high (Crumbaugh, 1969). Using ANOVA to examine these interactions, there is a statistically significant effect of category (low, indecisive, high) of

purpose in life and treatment group for mean improvement (change) in PAIS scores Baseline to Time 2 ($F_{4,243}=2.9, p=.02$). Figure 3 shows the improvements in psychosocial adjustment for each category of purpose in life and study group. On average, subjects allocated to problem-solving counselling (Group 1) who showed high or low purpose in life had improved psychosocial adjustment scores. Subjects who received phone support (Group 2) improved their psychosocial adjustment if they had high purpose in life at Baseline. In contrast, individuals who received problem-solving counselling and who scored in the indecisive range on the purpose-in-life instrument demonstrated little change in adjustment following counselling and did worse than those in the conventional-care group. The resistance to change in this group of indecisive people cancelled out the gains made by other categories of purpose in life when study group scores were averaged, thus indicating the lack of statistical significance for main effects.

4. Coping methods by purpose-in-life interactions. When categorizing patients by purpose-in-life scores and problem-solving coping scores, analysis of variance also indicated that subgroups of subjects with variations of these characteristics also varied in response to treatments (three-way interaction: $F_{4,234}=2.45; p=.047$). The greatest difference among groups was in subjects with little purpose in life and poor problem-solving skills. Problem-solving counselling appeared to help these subjects to make statistically significant improvements in psychosocial adjustment to illness, in comparison to phone-call support and conventional care (Groups 2 and 3), which helped very little. Furthermore, subjects who indicated they used many problem-solving skills and were indecisive in purpose in life at Baseline, and who received problem-solving counselling or phone-call support, demonstrated little change in their PAIS adjustment score compared with those receiving conventional clinic care.

Secondary Outcome Measures

Table 3 shows the differences in mean change scores for study groups in purpose in life, social support, meaning given illness, and coping behaviours, from Baseline to Time 2, just after the interventions occurred. There were statistically significant differences between study groups in two Meaning-of-Illness subscales, Stressfulness and Attitude, and the subscales of the Indices of Coping Response cognitive coping behaviours. Patients receiving counselling or phone support showed increased meaning-of-illness scores, indicating that their meaning given illness became less stressful, more manageable,

Table 3

Comparison of Mean Changes (Baseline to Time 2) of Purpose in Life, Social Support, Meaning of Illness, and Coping Behaviour Scores among 3 Study Groups

| Mean Score | Counselling | | | | Phone-Call | | | | Conventional | | | | | |
|--------------------------------|-------------|--------|----------------|--------|------------|--------|----------------|--------|--------------|--------|----------------|--------|------|-----|
| | Time 1 | Time 2 | \bar{x} Diff | SD | Time 1 | Time 2 | \bar{x} Diff | SD | Time 1 | Time 2 | \bar{x} Diff | SD | F | P |
| Purpose in Life (n=248) | 98.81 | 98.83 | .02 | (14.4) | 100.86 | 100.03 | -.83 | (13.0) | 99.31 | 98.61 | -.70 | (13.5) | .10 | .91 |
| Social Support | | | | | | | | | | | | | | |
| Confidant | 16.87 | 17.40 | .53 | (4.6) | 16.57 | 16.87 | .30 | (4.3) | 17.87 | 17.39 | -.48 | (4.5) | 1.17 | .31 |
| Affective | 11.58 | 11.54 | .05 | (2.6) | 11.76 | 11.16 | .60 | (3.1) | 11.45 | 11.49 | -.04 | (2.7) | 1.28 | .28 |
| Meaning of Illness | | | | | | | | | | | | | | |
| Little Impact | 2.41 | 2.71 | .30 | (1.6) | 2.60 | 3.08 | .48 | (1.4) | 2.46 | 2.77 | .31 | (1.7) | .35 | .71 |
| No Loss, Threat | 2.31 | 2.46 | .15 | (1.4) | 2.52 | 2.89 | .37 | (1.4) | 2.39 | 2.47 | .11 | (1.4) | .87 | .42 |
| Little Stress | 2.67 | 3.03 | .36 | (1.2) | 2.73 | 3.10 | .38 | (1.2) | 2.93 | 2.86 | -.07 | (1.1) | 3.93 | .02 |
| Positive Attitude | 3.88 | 3.93 | .05 | (1.0) | 3.88 | 3.92 | .05 | (1.2) | 4.06 | 3.72 | -.34 | (0.9) | 3.88 | .02 |
| Not Vulnerable | 3.98 | 4.07 | .09 | (1.3) | 3.78 | 3.69 | -.09 | (1.3) | 3.83 | 3.72 | -.11 | (1.3) | .62 | .54 |
| Coping Behaviours | | | | | | | | | | | | | | |
| Cognitive (n=255) | 17.94 | 19.19 | 1.25 | (5.0) | 17.53 | 17.93 | .40 | (5.3) | 17.88 | 17.26 | -.62 | (4.4) | 3.09 | .04 |
| Behavioural | 21.78 | 20.38 | -1.40 | (5.8) | 23.31 | 21.99 | -1.32 | (6.0) | 21.58 | 19.37 | -2.21 | (5.8) | .59 | .56 |
| Avoidance | 6.42 | 5.39 | -1.03 | (3.0) | 6.94 | 6.20 | -.74 | (3.3) | 6.02 | 5.70 | -.32 | (2.9) | 1.18 | .31 |
| Logical Analysis | 6.98 | 7.09 | .11 | (2.3) | 6.79 | 6.89 | .10 | (3.1) | 6.92 | 6.70 | -.22 | (2.6) | .41 | .67 |
| Information-Seeking | 11.89 | 11.65 | -.24 | (3.2) | 13.40 | 11.90 | -1.50 | (3.8) | 12.22 | 11.13 | -1.09 | (3.7) | 2.84 | .06 |
| Problem-Solving | 8.89 | 8.47 | -.42 | (3.1) | 8.57 | 8.58 | .01 | (3.0) | 8.58 | 7.76 | -.82 | (2.8) | 1.66 | .19 |
| Affective Regulation | 9.21 | 9.03 | -.17 | (3.7) | 9.72 | 9.87 | .15 | (3.7) | 8.93 | 8.72 | -.21 | (3.5) | .26 | .19 |
| Emotional Discharge | 5.06 | 4.36 | -.70 | (2.4) | 5.30 | 4.92 | -.38 | (2.8) | 4.61 | 4.09 | -.52 | (2.2) | .35 | .70 |

and more challenging as compared with the deterioration in meaning of illness observed over time in patients receiving conventional care only. Patients in the counselling group showed an increase in cognitive coping behaviours compared to the other subjects. At follow-up, they more often saw the positive side of the situation, considered alternatives, reassured themselves, or simply accepted their situation. These results need to be viewed with caution due to multiple statistical testing.

Discussion

Certain limitations were apparent in our study. The ethics committee did not permit us to tape sessions between subject and nurse, and thus verification of counselling was mainly made by examining records and through meetings of nurses and supervisors. The fact that mean scores on cognitive coping methods increased with counselling also helped verify that the intervention had occurred, since problem-solving counselling specifically encourages the use of cognitive coping methods. Some of the subscales on our measure of coping were low in internal consistency (Cronbach's $\alpha < .70$). Nurses providing the interventions rated the amount of problem-solving and were obviously not blinded to the patient's assignment group.

Theories have postulated that mediators or buffers may produce the differential individual response to similar stressful circumstances such as chronic illness. Thus one assumes that interventions to improve these buffers would in turn affect quality of life, adjustment to or response to the stressor. The results of this study extend our ideas in stress and coping research one step further, by showing that interventions can be helpful for persons with certain social, cognitive, or coping characteristics; that is, certain interventions enhance the coping variables which buffer the effects of stress. Interventions thought to increase problem-solving behaviours, lend social support, or foster purpose in life will be effective only for a person who needs to develop these characteristics. Others with problem-solving abilities will derive little or no benefit from such interventions and may improve without it. Of utmost importance for research is that these identifying, buffering characteristics be delimited through evaluation of interactions or analysis of subgroups. Thus for nurses in clinical practice, interventions should vary according to the characteristics of the patient.

When no curative health-care interventions are available to obliterate a stressor (as is the case with many chronic illnesses) psychosocial adjustment to illness can be improved by targeting those people most

likely to benefit from either counselling or phone support. The findings of this study support health-promotion strategies and psychosocial approaches by nurses to augment medical care in outpatient clinics. For optimal effectiveness, psychosocial approaches must be matched to the patient's coping, cognitive, and social support characteristics.

Conclusion

Results suggest that nurses can assist poorly adjusted, chronically ill outpatients by providing individual problem-solving counselling and telephone support, in addition to the patients' conventional clinic care. A number of characteristics of these outpatients can be used to select an appropriate mode of treatment. The nursing intervention should match the coping or support strategies already being used by the patient. For instance, a person's coping behaviours, living support, and category of purpose in life can identify who could potentially benefit from counselling or phone support. Nurses can identify the characteristics through short questionnaires, and nursing interventions can then be tailored.

Of additional importance is that phone-call support helped many chronically ill outpatients with poor psychosocial adjustment, by improving their level of psychological distress. Subjects indicated they had less anger, depression, guilt, and anxiety after phone-call support had been initiated by the nurse.

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Book Review

Legacy: History of Nursing Education at the University of British Columbia, 1919-1994.

Glennis Zilm & Ethel Warbinek.

Vancouver: University of British Columbia Press, 1994. 336 pp.

Illustrated. ISBN 0-88865-234-8.

Reviewed by Natalie Riegler

The Canadian nursing profession has a past of which it can be proud. Glennis Zilm and Ethel Warbinek have written a people-oriented book, reminding us of the struggles and accomplishments of leaders, as they developed nursing education within the university, and of graduates, who provided nursing service in the health care system. They are to be commended on this important addition to nursing history.

The authors, who are graduates of the nursing program at the University of British Columbia (UBC), give us an overview of the school's seventy-five years. The essence of their text is in its title. The nursing education program was directed by six notable women, each of whom is the subject of one of the eight chapters: Ethel Johns (1919-1925), Mabel Gray (1925-1941), Evelyn Mallory (1941-1967), Beth McCann (1967-1971), Muriel Uprichard (1971-1977), and Marilyn Willman (1977-1993). The legacy that they have bequeathed to their graduates is the "courage and creativity" to meet the needs of the community and the nursing profession. Their stories, beginning with the first chapter which highlights the "climate for change" leading to the formation of the UBC department of nursing in 1919, are set within the social context of the time. Lest readers think this is only about British Columbia, the book gives ample proof that the directors and graduates had careers across Canada and internationally.

Each of the six women made a unique contribution to the school. Johns guided its new program "into being." Gray instituted a program for students too young to be admitted to hospital schools. The first baccalaureate-prepared director, Mallory, initiated the "scientifically based, problem-solving approach to nursing." McCann, who had a

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master's degree in nursing, implemented the master's degree program. Dr. Uprichard, though not a nurse, argued for a curriculum based on a nursing model and brought to fruition the UBC model for nursing: the nurse as nurturer, helping people to cope with their loss of wellness. Finally, Dr. Willman, a nurse, brought stability and order while managing the school's financial difficulties. During her time, the school began its doctorate program.

Along with primary and secondary documents, photographs, and interviews, Zilm and Warbinek include vignettes of the graduates. The alumnae are too numerous to mention here, but some, who have gained national and international recognition, will be familiar: Margaret Kerr, a former editor of *Canadian Nurse*; Lyle Creelman, who became Chief Nursing Officer in the World Health Organization; Dr. Jacqueline Chapman, a noted nurse researcher at the University of Toronto; and Dr. Alice Baumgart, Dean of Nursing at Queen's University in Kingston. The UBC School of Nursing can be proud of its record and this book.

Because the volume contains a lot of information, readers may approach its content in several ways. As an overview, students will find many topics needing further research. Those interested in leadership may select the chapter relevant to each director or use the index to locate the graduates. Others wanting to follow the evolution of the school can extract the pertinent information chronologically, from cover to cover. This book should be in every nursing school's library.

Erratum

In Volume 27, No. 2, the English version of the first paragraph of the summer editorial, **Family Nursing in Tertiary Care: History or the Promise of Things to Come?** by Mary Grossman, was printed in an incomplete fashion. The following is the paragraph as it ought to have appeared. We regret the error.

In the past decade, nursing has been developing the necessary knowledge and expertise to move from nursing the patient-within-a-family context to nursing the family. Just as family nursing is coming of age for the second time in this century (the turn of the century being the first), a revolutionary approach to health care services is sweeping the country, resulting in a radical restructuring of health services. In the future, tertiary care settings will house only the acutely ill, and more monies will be reallocated to ambulatory services, community health clinics, and extended care facilities. Whereas primary health care holds considerable promise for family nursing in the community, the same cannot be said for tertiary care settings.

Call for Papers

Symptom Management

Summer 1996 (vol.28, no.2)

Manuscripts are invited that address management of symptoms. Symptoms may include, but are not limited to, pain, discomfort, nausea, anxiety, depression, and confusion. We seek a wide range of patient populations, symptoms, and management strategies. Preference will be given to completed research reports.

Guest Editor: Dr. Celeste Johnston

Submission Deadline: January 15, 1996

Outcomes & Measurement

Fall 1996 (vol. 28, no.3)

Manuscripts are invited that address a wide range of issues involved in measurement of outcomes. Preference will be given to measures of effectiveness and efficiency as well as mediating variables that are: (1) amenable to change following practice or service interventions; and/or (2) applicable to disadvantaged, culturally diverse, or age- or gender-specific populations.

Guest Editors: Dr. Gina Browne,

Prof. Jacqueline Roberts, Dr. Robin Weir

Submission Deadline: March 15, 1996

Chronicity

Winter 1996 (vol. 28, no.4)

This issue is intended to make a contribution to the rapidly expanding body of nursing knowledge on chronicity. Topics with potential for enhancing the effectiveness of nursing intervention are of particular interest. Qualitative and quantitative research reports and state-of-the-science reviews about people and families living with chronic health conditions are invited.

Guest Editor: Dr. Sharon Ogden Burke

Submission Deadline: June 15, 1996

Please send manuscripts to:

The Editor

Canadian Journal of Nursing Research

McGill University School of Nursing

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Articles à publier

La gestion des symptômes

Été 1996 (vol.28, no.2)

Nous vous invitons à soumettre vos manuscrits sur le traitement des symptômes. Ceux-ci comprendront, sans s'y limiter, la douleur, l'inconfort, la nausée, l'anxiété, la dépression et la confusion mentale. Nous désirons étudier un large éventail de symptômes, de stratégies de traitement et de types de malades. Les rapports de recherche complets auront la priorité.

Rédactrice invitée: D^{re} Celeste Johnston

Date limite pour les soumissions: le 15 janvier 1996

Les résultats et leur mesure

Automne 1996 (vol.28, no.3)

Les articles porteront sur un vaste éventail de questions traitant de la façon d'évaluer les résultats. On donnera la préférence aux mesures de l'efficacité et de l'efficience, de même qu'aux variables médiatrices qui: a) permettent de modifier les pratiques qui s'ensuivent ou les interventions au niveau du service, et b) peuvent être utilisées sur des populations particulières, à savoir les personnes défavorisées, les gens de diverses cultures ou d'âge ou de sexe différent.

Rédactrice invitée : D^{re} Gina Browne,

Professeure Jacqueline Roberts, D^{re} Robin Weir

Date limite pour les soumissions: le 15 mars 1996

La chronicité

Hiver 1996 (vol.28, no.4)

Ce numéro se veut une contribution à l'ensemble des connaissances en sciences infirmières, qui se cessent de se développer, sur la chronicité. Les sujets présentant le plus d'intérêt sont ceux qui permettront éventuellement d'améliorer l'efficacité des soins infirmiers. On demande des rapport de recherche qualitative et quantitative, et des études sur l'état des sciences concernant les personnes et les familles aux prises avec des maladies chroniques.

Rédactrice invitée : D^{re} Sharon Ogden Burke

Date limite pour les soumissions: le 15 juin 1996

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For further information, please contact:

Associate Director, Graduate Program, School of Nursing,
or Director, School of Health Services Administration,
Dalhousie University, Halifax, Nova Scotia B3H 3J5.



Dalhousie University

SCHOOL OF NURSING TENURE-TRACK POSITION IN WOMEN'S HEALTH AND CHILDBEARING FAMILIES

Applications are invited for a full-time tenure-track position with rank and salary appropriate to qualifications and experience. The School offers programs of study at the undergraduate and master's levels, and is located within a large metropolitan university with excellent affiliated clinical practice and research facilities.

A funded joint appointment is available with the newly amalgamated Grace Maternity/Izaak Walton Killam Hospitals, focusing on leadership in clinical nursing research in women's health and childbearing families. Academic responsibilities will be with the graduate program and with an innovative collaborative project to offer BSc(N) courses with a clinical focus in perinatal nursing via distance education for post-RN students.

Minimum academic preparation and qualifications include a master's degree in nursing and an earned doctorate in nursing or related discipline; eligibility for Registered Nurses Association of Nova Scotia registration; significant teaching experience; and evidence of a well-developed area of practice and research in the care of women's health and childbearing families.

In accordance with Canadian Immigration requirements, this advertisement is directed to Canadian citizens and permanent residents. Dalhousie University is an Employment Equity/Affirmative Action Employer. The University encourages applications from qualified women, Aboriginal peoples, racially visible persons, and persons with disabilities.

Interested and qualified persons should submit a cover letter, an updated curriculum vitae, a copy of their current registration, and the names of three referees, including most recent employer, to the Director's Office, Dalhousie University, School of Nursing, Halifax, Nova Scotia B3H 3J5.

Position will begin as soon as possible.



University of Toronto Faculty of Nursing Faculty Positions in Community Health

The Faculty of Nursing at the University of Toronto invites applications for two tenure-stream positions in community health nursing, one at an assistant professor level and the other at a more senior level, either associate or full professor. These Faculty members will contribute to the undergraduate (BScN) and graduate (MN, MSc, PhD) programs of the Faculty. They will be expected to develop their research in collaboration with researchers and clinical nurse specialists in the teaching hospitals and the teaching health units with which the Faculty is closely associated. Cross-appointments to appropriate agencies will accompany these positions.

Qualifications include: a doctoral degree in nursing or a related science, a master's degree in nursing, interest and expertise in teaching at the undergraduate and graduate levels, publication in peer reviewed journals, a strong commitment to research, and the ability to work collaboratively with community health nurses, nurse researchers, and researchers from other disciplines.

Please send your curriculum vitae, letter of application, and names of two referees to:

Dr. Dorothy Pringle, Dean
Faculty of Nursing
University of Toronto
50 St. George Street
Toronto, Ontario, Canada
M5S 1A1

Appointment Date: July 1, 1996

Salary: Commensurate with qualifications and experience

Application Deadline: January 31, 1996

In accordance with its employment equity policy, the University of Toronto encourages applications from qualified men and women, members of visible minorities, aboriginal peoples, and persons with disabilities.

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 8 1/2 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.

References: The references are listed in alphabetical order, double spaced and placed immediately following text. Author names and journal citations must be spelled out in full.

Tables and Figures: Tables and figures should only appear when absolutely necessary. They must be self explanatory and summarize relevant information without duplicating the content of the text. Each table must include a short title, omit abbreviations and be typed on a separate page. Figures must be in camera-ready form.

Review process and publication information: *The Canadian Journal of Nursing Research* is a peer-reviewed journal. Manuscripts are submitted to two reviewers for blind review. The first author will be notified following the review process which takes 12 weeks to complete.

Electronic copy: Authors must provide satisfactory electronic files of the accepted final version of the manuscript.

Renseignements à l'intention des auteurs

La revue canadienne de recherche en sciences infirmières paraît quatre fois par année. Son mandat est de publier la recherche en sciences infirmières qui développe les connaissances de base dans la discipline et qui analyse la mise en pratique de ces connaissances. La revue accepte aussi des articles de recherche reliés à l'enseignement, l'histoire, et accueille des articles ayant trait à la méthodologie, la théorie, et l'analyse qui promouvoit le développement des sciences infirmières. Les soumissions de lettres et de commentaires sur des articles publiés sont aussi encouragées.

Modalités : Veuillez envoyer trois exemplaires de votre article dactylographié à double interligne sur des feuilles de papier de 216 mm x 279 mm. Il est entendu que les articles soumis n'ont pas été simultanément présentés à d'autres revues. Veuillez inclure avec votre article une déclaration de propriété et de cession de droit d'auteur.

Manuscripts

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For further information please contact:

School of Nursing
Graduate Programs
3506 University Street
Montreal, QC, H3A 2A7
Telephone: 514-398-4147
Fax: 514-398-8455

The Canadian Journal of Nursing Research
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La Revue canadienne de recherche en sciences infirmières constitue au Canada une tribune pour la publication d'articles savants et de recherche concernant les sciences infirmières et la santé. Nous vous invitons, vous et votre organisme, à vous abonner à la revue.

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