Canadian Journal of Nursing Research

Revue canadienne de recherche en sciences infirmières

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INTRODUCTION

You Can Judge This Journal by Its Cover

I have often used the following analogy to convey to my students the importance of attending to both the form and the substance of their work. My spiel goes something like this: If you were in a store and you had to choose between a Lalique crystal flask and a urine bottle, you would probably choose the Lalique crystal flask. However, if there was perfume in the urine bottle you might not notice it, because of its container. On the other hand, if the Lalique crystal flask contained urine, rather than perfume, the contents would still smell of urine, regardless of the packaging. Thus both content and appearance are important.

When I assumed the editorship three years ago I promised to overhaul all aspects of the journal. During the past three years, in partnership with Dr. Mary Grossman, I have paid considerable attention to improving the quality of the contents of the journal. Respected scholars from across the country have been invited to serve as guest editors to give the journal a bonafide national face; focus themes have been introduced with each issue; the number of reviewers has been increased and the review process has been made more stringent; new sections such as Discourse, Happenings, and Designer's Corner, have been introduced and scholars have been invited to write articles on "cutting edge" issues; the quality and presentation of the manuscripts have been improved by excellent copy editors and layout professionals. In addition, we have made a concerted effort to improve the bilingual aspect.

With the publication of Volume 28, we enter a new stage in the development and evolution of the *Canadian Journal of Nursing Research*. The most obvious change is our new cover. We examined many cover designs and settled on this one because it conveyed to us what we have been striving for: quality, professionalism, elegance, and forward thinking. The design depicts the connectedness between the English and French initials of the journal. The bilingualism of the *Canadian Journal of Nursing Research* gives it its uniqueness.

We also welcome Dr. Lise Talbot, who has been appointed an associate editor responsible for developing the French content of the journal. Dr. Talbot is a professor at the Faculté de sciences infirmières of

the Université de Montréal and is a highly respected researcher. Although she has been working with us during this past year, we officially welcome her to the team with this issue.

Finally, the success of *CJNR* is in large measure due to the efforts of Jill Martis. For the past two years, Jill has been responsible for all aspects of the journal. In her quiet, low-keyed, but delightful manner, this highly competent woman has managed to keep everything together. She has played a key role in the journal's transformation. Jill Martis embodies the very features that we found in the design: quality, professionalism, elegance, and forward thinking.

With this issue, we have taken one more step toward achieving the "Lalique crystal" standard in nursing journalism. In the months and years ahead, we will continue our quest for excellence.

Laurie N. Gottlieb
Editor

INTRODUCTION

Le contenue est aussi important que le contenant

J'ai souvent utilisé cette analogie pour convaincre mes étudiants d'accorder autant d'importance à la forme qu'au fond en ce qui concerne leurs travaux. Voici à peu près ce que je leur répète : si vous vous trouvez dans un magasin et que vous devez choisir entre un flacon en cristal Lalique et une fiole pour les urines, vous choisirez probablement le flacon en cristal Lalique. Cependant, si la fiole pour les urines contient du parfum, vous risquez de ne pas le remarquer à cause du contenant. Par contre, si le flacon en cristal Lalique contient de l'urine plutôt que du parfum, le contenu aura l'odeur de l'urine malgré le contenant. Ainsi, le contenu est aussi important que le contenant.

Lorsqu'il y a trois ans j'ai pris en charge l'éditorial, j'ai promis de m'occuper de tous les aspects de la revue. Pendant ces trois années, la docteure Mary Grossman et moi nous sommes efforcées d'améliorer la qualité du contenu de la revue. Des chercheurs de premier plan provenant de tout le pays ont été nos rédacteurs invités et ont apporté à la revue le sérieux de l'image nationale; des rubriques «le point» ont été présentées dans chaque numéro; le nombre de réviseurs a augmenté et le processus de révision a introduit davantage de rigueur; de nouvelles rubriques, telles que Discussion, En bref et le Coin du concepteur ont vu le jour et les chercheurs ont été invités à écrire des articles sur des thèmes «brûlants»; la qualité et la présentation des manuscrits se sont améliorées avec l'arrivée d'excellents secrétaires de rédaction et de graphistes professionnels. De plus, nous avons concentré nos efforts sur l'amélioration du bilinguisme.

Avec la publication du numéro 28, nous entrons dans une nouvelle phase de promotion et d'évolution de la *Revue canadienne de recherche en sciences infirmières*. Notre nouvelle couverture constitue le changement le plus important. Nous avons examiné de nombreux projets de couvertures et notre choix s'est arrêté sur celle-ci car elle évoque pour nous ce pour quoi nous avons lutté : la qualité, le professionnalisme, l'élégance et la réflexion constructive. Le logo évoque la communication entre les acronymes anglais et français du nom de la revue. L'aspect bilingue de la *Revue canadienne de recherche en sciences infirmières* lui confère son caractère unique.

Nous souhaitons la bienvenue à la docteure Lise Talbot qui a été nommé rédactrice en chef adjointe responsable de la promotion du français dans la revue. La docteure Talbot est professeure à la faculté des sciences infirmières de l'Université de Montréal et également chercheuse très respectée. Bien que Lise ait travaillé avec nous pendant cette année, nous lui souhaitons officiellement avec ce numéro la bienvenue dans l'équipe.

Enfin, le succès de la RCRSI est largement dû à madame Jill Martis. Durant les deux dernières années, Jill a été responsable de tous les aspects de la revue. Calme, discrète et charmante, cette personne très compétente a réussi à tout mener à bien. Elle a joué un rôle clé dans l'évolution de la revue. Jill Martis incarne les attributs que nous retrouvons dans la conception de la revue : qualité, professionnalisme, élégance et réflexion constructive.

Avec cette nouvelle parution, nous nous sommes encore rapprochés du concept «cristal Lalique» dans le journalisme en matière de sciences infirmières. Dans les mois et les années à venir, nous continuerons notre quête vers l'excellence.

Laurie N. Gottlieb
Rédactrice en chef

Le pouvoir des mots

Oui bonjour! Kshshshshsh...Allô!..i......l.....es.....tposs.....ible.......que......
leschang....em......entsq...uis'eff.......ectue...ntlors....decon......vers..ationa...
vecles..bé......néfi......ciares...soi.....entliésà..allô.kshsh....Allô, vous m'en-
tendez! Quoi de plus irritant qu'une communication brouillée. Vous
aurez vite fait de reconstruire la phrase émise par l'auteure prise au
milieu d'un ouragan d'idées qu'elle désire vous faire partager.

La communication est un concept à la fois universel et passionnant.
C'est un concept dont les moyens varient du langage verbal à l'Internet,
de la navette à la Calypso, du braille à la vidéo. Chercheurs, ensei-
gnants, explorateurs et penseurs la critiquent et la fuient; elle revient
toujours tel un boomerang frapper à nos portes. On ne peut s'en passer
et pourtant on la laisse filer, sans s'y référer.

Pour les sciences infirmières ce mode est notre principal outil
d'intervention, d'enseignement et de recherche. Si elle n'est pas notre
leitmotiv quotidien elle est tout au moins notre levier d'intervention
auprès de nos clients (patients et étudiants). N'est-ce pas elle qui nous
permet d'entrer en relation avec nos clients, de les accompagner à
travers leurs expériences de santé? N'est-ce pas à cause d'elle que nous
pouvons transmettre nos savoirs et en évaluer les résultats?

Mais d'où vient-elle? Communiquer et communication apparais-
sent dans la langue française dans le seconde moitié du XIVe siècle avec
la signification de «participer à» du latin communicare c'est-à-dire
mettre en commun, en relation (Bateson et al., 1981). Jusqu'au XVIe
siècle communiquer et communication sont associés à communier
(processus circulaire) et communion. Par la suite le terme désigne le
partage, la transmission d'une nouvelle aussi bien que d'une maladie.
Au XVIIIe siècle, la signification de partager cède sa place à transmet-
tre uniquement (processus linéaire). On passe donc du processus circu-
laire à un processus linéaire.

Avec l'avènement des moyens sophistiqués de communication
(train, téléphone, médias) l'emphase est mise davantage sur le moyen
que sur le processus. Finalement, deux siècles plus tard, avec les écrits
du chercheur Wiener (1948), la communication retrouve son processus

circulaire où tout effet rétroagit sur la cause. Les systèmes en présence s'influencent mutuellement par la communication dont le langage.

Aujourd'hui, le Petit Larousse (1994) nous définit le concept selon trois thèmes. Il s'agit : de l'action de communiquer, d'établir une relation avec autrui ; de l'action de transmettre quelque chose à quelqu'un ; de l'action pour quelqu'un d'informer et de promouvoir son activité. Ces deux dernières définitions nous lient aux théories de la communication et la première nous ramène au processus de circularité par la théorie de la régulation des systèmes.

La communication est un comportement appris depuis la tendre enfance. La communication verbale et non verbale est empreinte de nos valeurs et de nos croyances. Elle devient aux cours des âges de la personne, l'expression de ces croyances qui se manifestent par des comportements communicatifs verbaux ou non-verbaux. C'est un moyen d'exploration des souffrances, de la maladie et de la qualité de vie des bénéficiaires des services de santé. C'est un moyen qui nous permet d'annoncer une bonne ou une mauvaise nouvelle, de choisir les mots pour dire ou ne pas dire. C'est un moyen puissant qui peut être facilitant ou contraignant pour les personnes (systèmes) en interaction. La communication ne mérite-t-elle pas des recherches sur nos croyances implicites et explicites reliées à nos comportements communicationnels ?

Peu de recherches en sciences infirmières existent sur les effets de la communication au cours des interactions infirmières. Alors que le système infirmière en présence du système individu-famille a des effets réciproques par la communication verbale et non verbale, quels effets produisent ces interventions sur les différents systèmes en présence ? Cliniciennes et chercheures (F. Duhamel, communications personnelles, 1996 ; Wright, Watson, & Bell, sous-presse) ont la conviction que certains types d'interventions verbales produisent des changements à plusieurs niveaux sur le système individuel et familial ; par ailleurs, les familles exposées à ces types d'interventions verbales semblent en solliciter davantage. Alors comment s'effectue le changement ? Est-ce le langage utilisé lors des interventions verbales, les attitudes des infirmières, le modèle utilisé, tous ces facteurs ou d'autres encore ?

La technologie actuelle peut être utile aux chercheures audacieuses qui désirent explorer les comportements langagiers au cours des interventions systémiques infirmières. Des modèles de recherche évaluative sont aussi disponibles pour regrouper intervenantes, chercheures et clients d'une manière interactive. Les analyses qualitatives et quantita-

tives découlant de ces interactions ingénieuses sauront nous livrer certains médiateurs de nos interventions et certainement, nous surprendre.

Felix qui portuit rerum cognoscere causas
Heureuses celles qui sauront débrouiller les causes secrètes des choses !

Lise R.Talbot
Rédactrice en chef adjointe

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The Power of Words

Yes, hello! Kshshshshsh...Hello!...I...tis...poss....ibleth..... atchan... gesth...atocc....urdur...ingcon...versa....tionw...ith..ourc...ients...arepro....d uced....bya....Hello? Can you hear me?..Kshkshsh. Nothing is more frustrating than scrambled communication! In the process of reconstructing the speaker's sentence you realize he/she is caught in the storm of ideas he/she is trying to impart.

Communication is a concept both universal and exhilarating. Means of communicating range from spoken language to the Internet, from the space shuttle to the Calypso, from braille to video. Researchers, teachers, explorers, and thinkers criticize it and avoid it, but communication returns like a boomerang knocking at our door. We cannot do without it, yet we rarely acknowledge it.

In nursing, communication is our principal means of intervention, education and research. Although it is not a daily leitmotif, communication is certainly our primary tool for client (patient and student) intervention. It allows us to connect with our clients and accompany them throughout their health experience. It allows us to transmit our knowledge and to evaluate the results.

But where does it come from? The words *communiquer* (to communicate) and *communication* (communication) appeared in the French language in the second half of the 14th century, meaning "participating in," from the latin *communicare*: to render common; to relate (Bateson et al., 1981). Until the 16th century, communicating and communication were associated with communion and communing (a circular process). Later, the term came to mean sharing or transmission, whether of news or of an illness. In the 18th century, the earlier meaning of sharing was replaced by transmitting (a linear process). Thus communication no longer suggesteded a circular process, but rather a linear one.

With the advent of sophisticated methods of communication (train, telephone, media), more emphasis was placed on the means than on the process itself. Finally, two centuries later, with the writings of Wiener (1948), the communication process again became circular, with all elements influencing one other. Current systems are mutually influenced by communication, including language.

The *Petit Larousse* (1994) defines the concept according to three themes: the act of communicating, of establishing a relationship with another person; the act of transmitting something to someone; and the act of informing and promoting one's activity. These last two definitions tie in with communication theories, and the first brings us back to the circular process, through the theory of regulating systems.

We learn to communicate in early childhood. Verbal and non-verbal communication are marked by our values and beliefs. Over the course of an individual's life, communication becomes the expression of these beliefs, manifested through verbal and non-verbal communicative behaviour. Communication is used to explore suffering, sickness, and the quality of life of people receiving health care. Through communication we can transmit good or bad news; we choose the words with which to tell or not to tell. It is a powerful tool that can either help or hinder human (system) interaction. The implicit and explicit beliefs relating to communicative behaviour merit further study.

Little research has been done on the effects of communication during nursing interaction. We know that the nursing system and the individual/family system influence one another through verbal and non-verbal communication, but how do these interventions affect the different systems present? Clinicians and researchers (F. Duhamel, personal communication, 1996; Wright, Watson, & Bell, in press) believe that certain types of verbal exchange produce changes at several levels in the individual or family system. Furthermore, families exposed to these kinds of verbal interventions seem increasingly able to benefit from them. What causes these changes? Is it the language used in the interventions, is it the nurses' attitudes, the model used; is it all these factors combined, or still others?

Current technology may be useful for daring researchers who wish to answer such questions; it may help them explore language behaviour in the course of systemic nursing intervention. Evaluative research models that allow the interaction of clinicians, researchers and clients are also available. The qualitative and quantitative analyses that result could be used to mediate our interventions, and they might surprise us.

Felix qui portuit rerum cognoscere causas
Happy are those who discover the hidden causes of things!

Lise R. Talbot
Associate Editor

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Focus: Culture & Gender

Constructing Culture and Gender

It is some years now since Laurie Gottlieb and I first spoke about this focus issue for the *Canadian Journal of Nursing Research,* and it is with a sense of fulfilment that I write this editorial. We had excellent submissions for the issue. Unfortunately, space did not permit all of them to be published, but there is the consolation that some will appear in subsequent issues and keep up the dialogue that I believe will result from the papers that appear here. We are especially pleased that this issue fosters an international exchange of ideas; in addition to contributions from scholars in Canada, we have an opportunity to hear from our colleagues in Australia, England, and the United States. This gives us a sense of how they are addressing the topics highlighted here.

The invited papers, Allen's Discourse and Williams's Designer's Corner piece, have set the stage for talking about culture, gender, and ways of understanding and knowing. Though written independently of the other papers in this issue, they provide conceptual linkages among them. As Allen reminds us, neither culture nor gender is an objective reality awaiting our discovery; both are socially constructed. This theme runs through the four papers. As well as tackling the topics of gender and culture, the call for papers stressed our interest in pursuing the discourse on research from a feminist perspective that attempts to examine the intersection of gender, race, and class relations. Williams, in writing about the principles of feminist ethnography, pinpoints what I see as at the core of feminist research – it "implies a political position in relation to the production of knowledge." This theme is, I think, implicit in all of the papers and explicit in others.

Papers were selected on the basis that, collectively, they will help us advance the discourse on culture and gender in nursing research, education, and nursing practice as socially constructed phenomena. Individually, they give us a window on topics that, in some instances, have received little attention but that, once introduced, open up a whole new way of understanding issues that are central to nursing. The

paper by Paterson et al., on the lived experience of male nursing students, is an example of this. This paper demonstrates an elegant way of carrying out phenomenological research. It also unmasks the ways in which what I call the "culture of nursing" is gendered, and it explicates, I think, what Allen has described as the creation of the "other" as "outsider." These constructions had consequences for students' experiences of learning to care. Chater's paper illuminates another aspect of talking about culture, and focuses on the politics inherent in doing cross-cultural research. Given that Canada, like Australia, has multiculturalism policies, the issues raised are similar to those in this country as attempts are made to do research that will inform policy and practice. Among other things, Chater draws attention to the problem of representation; seeing groups as representative obscures intragroup dynamics and renders issues such as class and gender invisible.

The papers by Varcoe and Stewart and her colleagues offer a wealth of insight into theorizing about the intersectionality of gender, race, and class. Stewart and her colleagues, in discussing smoking cessation in disadvantaged women, highlight the important conceptual distinction between biological sex differences and gender as a socially constructed category, and speak to the ways in which gender and class intersect in determining women's health behaviours. The data upon which the authors draw show the multi-layered contexts in which women's lives are enmeshed. Varcoe's paper on theorizing oppression provides the lenses through which we might begin to grasp the simultaneity of oppressions at the intersectionality of gender, class, and race relations. She explicates how theorizing oppression as simultaneity contributes to the ways in which we understand violence, and subsequently how this guides nursing research on violence against women. Varcoe extends her conceptualization to include analyses of power, agency, and resistance.

Together, these papers lay the groundwork for us to continue to address the theoretical issues so elegantly presented here. For those of us who are interested in pursuing feminist scholarship, Williams provides a rich resource to help us to conceptualize what we mean by feminist research and the principles we might draw upon. One of the challenges will be to explicate a perspective that does not privilege gender or race or class, but that will allow us to understand them as simultaneous forces. Brewer (1993) cautions that we must eschew additive analyses: race + class + gender; we must understand the embeddedness and relationality of race x class x gender; and we must develop a feminism "rooted in class, culture, gender and race in interaction as its organizing principle. Importantly," she tells us, "the theorizing about race, class and gender is historicized and contextualized" (p.16).

My dilemma, even as I write this editorial, is whether the term "feminist" is so deeply rooted in particular ways of theorizing that by using it, we continue, perhaps unwittingly, to privilege gender in our conceptualizations and analyses. Perhaps our search should now be to find a way – a new word, perhaps – that will come to terms with the intersectionality of oppressions, an understanding of which is emerging in post-colonial scholarship, as the voices that have been silenced enter, gradually, into the discourse. A further challenge will be to examine how we can use this perspective to construct nursing knowledge for praxis and practice with the vision of social justice for all people.

It has been a privilege for me to be involved in the editorial process. My special thanks to Laurie Gottlieb for giving me the opportunity to edit this issue. It was a real pleasure working with Jill Martis; I thank her for her invaluable help in facilitating the editorial process. My thanks also to the reviewers for giving generously of their time to provide insightful comments and critiques of a number of articles, and to the contributors for their patience and willingness to meet deadlines. Without their commitment this issue would not have been possible.

Joan M. Anderson
Guest Editor

Joan M. Anderson, R.N., Ph.D., is a Professor in the School of Nursing at the University of British Columbia, Vancouver.

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Le point : La culture et le sexe

ÉDITORIAL INVITÉ

La culture et le sexe : Des phénomènes à construire

Cela fait quelques années maintenant que Laurie Gottlieb et moi-même avons commencé à discuter du thème du présent numéro de la *Revue canadienne de recherche en sciences infirmières* et c'est avec un sentiment de contentement que je rédige cet éditorial. On nous a proposé d'excellents articles. Malheureusement, il n'y avait pas assez de place pour les publier tous ; cependant, ils pourront apparaître dans les numéros suivants et ils entretiendront le dialogue que soulèveront, j'en suis certaine, les articles publiés dans ces pages. Nous sommes tout particulièrement heureux que ce numéro favorise un échange d'idées au niveau international ; en effet, outre les contributions apportées par les chercheurs canadiens, nous avons la chance d'avoir des nouvelles de nos collègues australiens, anglais et américains. Cela nous donne une idée de la façon dont ils abordent les thèmes traités dans ces pages.

Les articles des rédacteurs invités (*Discours* de monsieur Allen et *Le Coin du concepteur* de madame Williams), ont permis de traiter de culture, des sexes et des méthodes de compréhension et d'acquisition des connaissances. Même s'ils ont été écrits indépendamment des autres articles de ce numéro, ils fournissent des liens conceptuels à ces derniers. Comme nous le rappelle monsieur Allen, ni la culture ni le sexe ne constituent de réalité objective ; ceux-ci sont déterminés socialement. Ce thème revient dans les quatre articles. Tout en traitant des sujets relatifs au sexe et à la culture, la demande de ces articles soulignait également notre intérêt pour la poursuite de la discussion sur la recherche dans une perspective féministe ; cette discussion tente d'examiner l'entrecroisement du sexe, de la race et des relations entre les classes sociales. Madame Williams, en traitant des principes de l'ethnographie féministe, met le doigt sur ce que je considère comme la pierre angulaire de la recherche féministe ; cela « suppose une position

politique par rapport à la production des connaissances ». Ce thème, je pense, est implicite dans tous les articles et explicite dans d'autres.

Les articles ont été sélectionnés dans la mesure où ils faisaient avancer la discussion sur la culture et le sexe dans la recherche en sciences infirmières, dans l'éducation et dans la pratique des soins en tant que phénomène construit socialement. Individuellement, ces articles nous procurent une ouverture sur des thèmes ayant reçu, dans certains cas, peu d'attention mais qui, une fois présentés, apportent une nouvelle méthode de compréhension pour les questions inhérentes aux sciences infirmières. L'article de madame Paterson et ses collègues, sur l'expérience vécue des étudiants de sexe masculin, en est un exemple. Il indique une méthode raffinée pour mener à bien la recherche phénoménologique. Cet article dévoile également les méthodes dans lesquelles ce que je nomme « la culture de la sollicitude » est dispensée selon le sexe et explique, d'après moi, ce que monsieur Allen décrit comme la création de « l'autre » en tant qu'« étranger ». Ces interprétations ont eu des conséquences sur les expériences des étudiants dans l'apprentissage de la sollicitude. L'article de madame Chater illustre un autre aspect de la discussion sur la culture et met l'accent sur les politiques inhérentes à la pratique de la recherche interculturelle. Étant donné que le Canada, tout comme l'Australie, a adopté une politique interculturelle, les questions soulevées sont les mêmes ici que là-bas, à savoir les tentatives pour effectuer des recherches qui donneront des informations sur les politiques et les pratiques. Entre autre chose, madame Chater attire l'attention sur le problème de la représentation ; le fait d'être représenté par des groupes éclipse les dynamiques existant à l'intérieur d'un groupe et masque certains problèmes tels ceux soulevés par les questions de classe sociale ou de sexe.

Les articles de madame Varcoe, et de madame Stewart et de ses collègues proposent une profusion d'idées sur la façon d'élaborer une théorie quant à l'entrecroisement du sexe, de la race et de la classe sociale. Madame Stewart et ses collègues, en traitant du fait de cesser de fumer chez les femmes défavorisées, illustrent l'importante distinction conceptuelle entre les différences des sexes au niveau biologique et les sexes en tant que catégorie construite au niveau social, et énoncent des méthodes selon lesquelles le sexe et la classe s'entrecroisent au moment de déterminer les attitudes en matière de santé. Les données sur lesquelles s'appuient les auteures montrent les contextes en strates

dans lesquels la vie des femmes est enchevêtrée. L'article de madame Varcoe concernant l'élaboration d'une théorie sur l'oppression fournit les lunettes à travers lesquelles on doit commencer à examiner la simultanéité des oppressions à l'entrecroisement du sexe, de la classe sociale et des relations entre les races. Elle explique comment l'élaboration de la théorie de l'oppression en tant que simultanéité contribue à nous faire comprendre la violence et par conséquent, guide la recherche en sciences infirmières dans la violence faite aux femmes. Madame Varcoe pousse sa conceptualisation plus loin, afin d'inclure les analyses du pouvoir, des agents de la violence et de la résistance à celle-ci.

Tous ces articles nous préparent le terrain pour que nous continuions à aborder les problèmes si joliment présentés dans nos pages. Pour les personnes parmi nous qui désirent poursuivre des études en matière de féminisme, madame Williams fournit des renseignements précieux pour nous aider à conceptualiser ce que nous entendons par recherche féministe et les principes que nous pouvons en tirer. Un des défis sera d'expliquer une perspective qui ne privilégie ni le sexe, ni la race ou la classe sociale mais qui nous aidera à les comprendre en tant que forces simultanées. Madame Brewer (1993) nous recommande d'éviter les analyses additives du genre : race + classe sociale + sexe ; nous devons comprendre l'enchâssement et l'interdépendance des facteurs race x classe sociale x sexe et nous devons élaborer un féminisme « ancré dans la classe sociale, la culture, le sexe et la race en interaction, comme principe d'organisation ». Il est important de souligner, nous précise-t-elle, « que l'élaboration d'une théorie sur la race, la classe sociale et le sexe est inscrite dans l'histoire et dans les contextes » (p. 16). Mon dilemme, au moment même où je rédige cet éditorial, réside dans le fait que le terme « féministe » est tellement enraciné dans les méthodes particulières d'élaboration d'une théorie que lorsque nous l'utilisons, nous continuons, peut-être sans le vouloir, à privilégier le sexe dans nos conceptualisations et nos analyses. Peut-être notre recherche devrait-elle maintenant trouver un moyen, un nouveau mot peut-être, qui viendra à bout de l'entrecroisement des oppressions, une compréhension de ce qui surgit des études post-coloniales, tandis que les voix jusqu'ici silencieuses se font peu à peu entendre dans la discussion. Un autre défi sera d'étudier comment nous pouvons utiliser cette perspective pour acquérir les connaissances en matière de sciences infirmières afin d'arriver à une praxis et à une pratique fondées sur la vision d'une justice sociale pour tous.

Cette participation à la rédaction fut pour moi un véritable privilège. Je remercie tout spécialement madame Laurie Gottlieb pour m'avoir permis de préparer ce numéro. Ce fut un vrai plaisir de tra-

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Joan M. Anderson
Rédactrice invitée

*Joan M. Anderson, R.N., Ph.D., est Professeure à l'École des sciences infir-
mières de l'Université de la Colombie britannique à Vancouver.*

Référence

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Learning to Care:
Gender Issues
for Male Nursing Students

Barbara L. Paterson, Sharon Tschikota,
Marta Crawford, Marian Saydak, Peri Venkatesh,
and Teri Aronowitz

L'article suivant est la description d'un aspect d'une recherche phénoménologique visant à examiner le vécu des étudiants en sciences infirmières tandis qu'ils apprennent à montrer leur sollicitude dans leur emploi d'infirmier. Les stratégies de collecte de données comprenaient des récits de cas particuliers et des entrevues paradigmatiques. Quatre points importants caractérisaient l'étude des données : l'analyse, la synthèse, la critique et la compréhension. On a employé ces stratégies pour établir le sens des entrevues transcrites et pour en faire l'interprétation. Les participants ont décrit l'apprentissage de la sollicitude comme une entité complexe qui inclut le sexe de l'étudiant, le malade, le professeur et l'infirmière. À mesure que les étudiants avançaient dans le programme, leur expérience des questions de sexe dans l'apprentissage de la sollicitude était façonnée par leur vécu personnel, les attentes d'un corps enseignant majoritairement féminin et du personnel infirmier, et leur meilleure compréhension des façons de montrer leur sollicitude, basées sur le fait qu'ils étaient des hommes.

The following article is a description of one aspect of a phenomenological research study designed to investigate the lived experience of male nursing students as they learned to care as nurses. Data-collection strategies included paradigm case narratives and interviews. Data analysis was characterized by four major strategies: analysis, synthesis, criticism, and understanding. These strategies were used to identify meanings of the text of transcribed interviews and to generate interpretive commentary. Learning to care was described by the participants as a complex entity that incorporates the gender of the student, the patient, the teacher, and the nurse. As students progressed through the program, their experience of gender issues in learning to care was shaped by personal experiences, the expectations of a predominantly female faculty and nursing staff, and their evolving understanding of the ways of caring that are gender-based.

Barbara L. Paterson, R.N., Ph.D., is Assistant Professor in the University of British Columbia School of Nursing, Vancouver. Sharon Tschikota, M.N., and Marta Crawford, M.N., are Lecturers in the University of Manitoba/Health Sciences Centre Baccalaureate Collaborative Program, Winnipeg. Marian Saydak, M.N., is a Lecturer in the University of Manitoba Faculty of Nursing. Peri Venkatesh, M.N., is Director of the Misericordia General Hospital School of Nursing, Winnipeg. Teri Aronowitz, M.Sc.N., is Assistant Professor in the Syracruse University College of Nursing, Syracuse, New York.

In order to untangle the meaning of caring in nursing, it is necessary to understand the social construction of caring within historical patriarchy (Macpherson, 1991). Historically, caring within the female-dominated profession of nursing has been perceived as arising from the biological and social differences that exist between men and women (Baines, Evans, & Neysmith, 1991). Nursing has its roots in the notion that women care for others because of their maternal feelings and experience (Turnipseed, 1986). Tact, gentleness, and empathy in the caregiver role of the nurse are normally attributed to "maternal instincts." Men have been perceived as not imbued with these mothering characteristics and more concerned with competition than with the ethic of caring (Baines, 1991). The belief that caring comes "naturally" to women has added to the perception that men in nursing experience difficulty relating to patients in a caring manner, and that they prefer the more technical aspects of the profession to the manifestations of compassion and caring (Dassen, Nijhuis, & Philipsen, 1990).

Streubert and O'Toole (1991) and Okrainec (1994) conclude in their review of research concerning male nursing students that most researchers have assumed that the experience of female and male nursing students is the same. They challenge researchers to investigate the lived experience of male nursing students in order that educators be able to maximize the quality of the educational experience of these students. The following article is a description of one aspect of a phenomenological research study designed to investigate the experience of male nursing students as they learned to care as nurses.

Literature Review

The research regarding male nursing students is sparse. The majority of this research was conducted 20-30 years ago. It has been criticized as focusing largely on entry-level students, employing unequal and small samples, using only one setting, and having inconsistent results (Okrainec, 1994; Streubert & O'Toole, 1991). The major findings of this research have been that (1) high school and university students consistently view nursing as requiring "female characteristics" (Aldag & Christensen, 1967; Egeland & Brown, 1988; Minnigerode, Kayser-Jones, & Garcia, 1978; Pontin, 1988); (2) male nursing students may or may not experience role strain when they attempt to reconcile their role as men with the feminine qualities inherent in nursing (Okrainec; Schoenmaker & Radosevich, 1976); (3) there are no statistically significant differences between female and male nursing students as to their experience of social isolationism and tokenism within the profession (Snavely &

Fairhurst, 1984); and (4) male nursing students have equal or higher aptitude for caring to their female counterparts (Aldag & Christensen; Becker & Sands, 1988; MacDonald, 1977; Okrainec).

One study of how nursing students learn to care as nurses was conducted by Kowsowski (1995). The 18 female nursing students who participated in this phenomenological research study indicated that they constructed their understanding of caring in nursing by building on what they had experienced as children or parents, or in other family roles. The author does not consider the gender of the participants in her discussion of the research findings. No research regarding the experience of male students as they learn to care as nurses was located. Thompson (1993) calls for the abandonment of research that emphasizes the question of whether men or women are more caring. She invites researchers to investigate how men and women differ in their experience of learning to care in order to determine what conditions are necessary for men and women to learn caring within a helping profession. Okrainec (1994) proposes that a phenomenological investigation of the lived experience of male nursing students would be an appropriate response to such a call.

Research Design

The research was a phenomenological investigation of the lived experience of male nursing students as they learned to care as nurses. It was guided by the tenets of interpretive phenomenology in the tradition of Benner (1984, 1994). The goal of interpretive phenomenology is to reveal similarities and differences in the participants' lived experience.

Sample

The 20 participants in the study were male students, ages 18 to 34, representing each year of a four-year baccalaureate nursing program. A member of the research team who did not have teaching or evaluation responsibilities for the students presented a description of the research and asked for volunteers in class at the beginning of the academic year. The number of male students enrolled in the final year of the program was small (four); therefore, the third- and fourth-year students are considered as one cell group, to protect their identity. First-year students are referred to in this report as "beginning students," second-year students as "junior students," and third- and fourth-year students as "senior students."

Setting

The setting was a multi-campus-site Canadian university undergraduate nursing program. There were 28 male students enrolled in the program in a student body of approximately 300. The beginning students in the research did not have clinical site experiences in their educational program; clinical education for students began in the second year of the program. The majority of faculty were female. Only the senior students reported that they had been taught by a male faculty member; this faculty member was a lecturer in the classroom.

Method

The premise of interpretive phenomenology is that individuals' experiences and their reflections on those experiences constitute knowledge (Boyd, 1988). The participants' stories were obtained by means of paradigm cases and interviews. Paradigms are narratives of significant events or situations in the participant's experience (Benner, 1984, 1994). An analysis of the paradigm cases offered by the male students in the research revealed their common understandings, as well as the dilemmas a male nursing student faces in learning to care as a nurse. The participants were asked to relate a story about an incident/situation in which they learned about how to care. They were given the following instructions: (a) relate a story about an incident or situation during this academic year that taught you about the nature of caring in nursing; (b) describe the context of the incident or situation (i.e., Who was there? What was happening? What was the setting like?); (c) describe the emotions you felt during and after the incident or situation; and (d) do not stop until you feel you have discussed the incident/situation as fully as possible. The participants contributed 30 paradigm narratives. All participants contributed a paradigm narrative in January of the winter term of their academic year; 10 of these students chose to offer another paradigm narrative in April of that year.

A member of the research team contacted the participants in person or by telephone to review the purpose of the study, answer the participant's questions related to the research, and introduce the plan for the paradigm interview. As recommended by Benner (1994), this pre-interview enabled the researcher to coach the participant about the nature of the narrative that was required (i.e., events, situations, feelings, and actions) in the research. Several participants commented that the pre-interview helped them to understand the purpose and design of the research, as well as to intentionally select a paradigm case.

Each participant was interviewed at a location of his choosing, for approximately one hour, about the paradigm case he related to the interviewer. The interviews were audiotaped. The interview consisted of questions designed to clarify and reflect upon the meanings and understandings inherent in the paradigm case.

Four members of the research team, three researchers and one research assistant, participated as interviewers. As it was possible that the gender of the interviewer could affect the interview process, the participants were divided equally among the two male and the two female interviewers in order that half the participants be interviewed by a man and half by a woman. In the data-analysis phase of the project, the data from the male interviewers were compared to those of the female interviewers; no differences were identified.

Data Analysis

In congruence with the tradition of interpretive phenomenology detailed by Benner (1984, 1994), data analysis was characterized by four major strategies: analysis, synthesis, criticism, and understanding. These strategies were enacted according to the framework of qualitative data analysis developed by Collaizi (1978). The first step in the data analysis was to read each transcript, to obtain an overall picture of the contents. Next, the researchers extracted significant statements relating to the experience of students as they learn to care as nurses; 356 significant statements were extracted from the 30 interview transcripts. Meanings were formulated from the significant statements and these were then organized into clusters of themes. Outliers and discrepancies between themes were identified. Table 1 provides examples of significant meanings, their formulated meanings, and the theme cluster that was derived from the formulated meanings.

Theme clusters were validated by referring to the original transcript and by distributing the theme clusters to the participants and requesting their feedback as to the accuracy of the researchers' interpretation of the lived experience of learning to care.

Research Findings

The experience of learning to care as a male nursing student was perceived by the participants to be unique to their gender. The category "caring as a male" emerged from the theme clusters "gender differences in caring," "experiencing the difference," and "being prepared for the difference." The following discussion will include a description of this

Table 1

Example of Significant Statements, Formulated Meanings, and a Theme Cluster

Significant Statements	Formulated Meanings	Theme Cluster
1. It has been my experience that the women here [the teachers and students] think that the only way to show you care for patients is to hold them and to talk about feelings. I was taught that real men don't behave that way. (22)*	1. Males are not socialized to care in the same way as females in our society.	Gender Differences in Caring
2. I feel like if I acted the way my teachers wanted me to, with all that touchy feely stuff, that I'd have to become less of a man. I'd have to act like a woman, not a man. (18)*	2. Junior students feel there is a need to divest themselves of the macho image of being a man before they can learn to care as nurses.	Gender Differences in Caring
3. And he [male nurse] was sort of a friend, a tease at times, to the patients. He would go by their wheelchairs and give them a punch on the shoulder. It was a male thing. It wasn't the same as how the female nurses cared for the patients but it was caring nonetheless.	3. Senior students have identified a male form of caring that is different from but as valuable as female caring.	Gender Differences in Caring

* Numbers indicate total number of similar statements from which meanings were formulated.

category, as well as the exhaustive description and essential structure of learning to care as a male nursing student.

Gender Differences in Caring

Beginning students. Only the junior and senior students in the study identified that male nurses may care differently from their female coun-

terparts. The beginning students downplayed gender as a factor in how they cared for others, perceiving their family and their experiences as being critical to their ability to care as a nurse. They believed that their desire to help others by enrolling in nursing education indicated that they, along with their classmates of both genders, had the caring traits of compassion, conscience, and commitment.

> It's not necessary to study how males learn [to care as nurses]. If you [males] want to go into nursing, you are obviously one of the few special people who are willing to do anything for other people.

Junior students. The junior students in the research acknowledged that they had encountered gender differences in caring in their clinical learning experiences. Their clinical learning experiences frequently entailed situations in which the manifestations of caring that had previously been invisible to them were now made visible. These experiences were often discomforting, causing them to confront their belief that "caring is caring, no matter if it's done by a man or a woman." The junior students recognized that women are socialized to care for others by openly expressing their feelings and by touching others freely. They admitted that they had to learn aspects of caring for patients that "came naturally" to their female classmates. One participant described a situation in which a female classmate was able to establish a rapport with his client although the participant himself had been unable to do so in the several preceding weeks.

> She walked into the room and kind of enveloped him in a fog of love. How she did it was outrageous. She doesn't show this otherwise. She's a pretty gruff person. But when it comes to her patients, at least this one time with my patient, it was overwhelming. I was just struck by it. She touched him. She was just sincere and she talked to the person. She didn't even know him. I think I may have thought about it [touching the client] before but I quickly ruled it out because I was just too uncertain about how to go about it. She was – I think it was just a shade below loving. You know? It wasn't a passion. It was sort of an empathetic caring. That's what it was. I think I was beyond that because I was worrying about the tasks I had to do. I couldn't spend the time to try it. Or maybe I didn't have it in me. I don't know. I think she had that kind of knack. And I think I have to learn it.

Several junior students described "feeling tense and frustrated" because, although they could identify positive outcomes of "feminine" manifestations of caring, they were unsure if and how they could adopt these ways of being with patients. They also hesitated to discuss this with female faculty, because "they are women and they take all of this for granted."

The junior students concurred that female faculty and nurses communicated an expectation that nurses "should care for patients like women do, by being sensitive and demonstrative." This expectation was communicated most directly by the criteria faculty and nursing staff used to evaluate students' caring ("She told me I needed to open up more with my patients. She told me to watch her and try to be more like her.").

Two junior students stated that learning how to care for clients as they had been taught by female nurses and faculty meant they had to consciously divest themselves of their "macho image." They expressed concern that they would never be able to touch clients or to openly display emotions because they had learned all their lives that to do so was effeminate and emasculating. When asked whether he discussed this matter with his teachers, one student replied, "My teacher is a woman. She is very understanding of most things but she wouldn't be able to understand why I would be afraid of becoming feminine."

Senior students. The senior students agreed that they had developed an understanding and acceptance of both "female caring" and "male caring" in nursing by the final year of the program. One senior student said that by his final year he had developed a way of caring that was "an amalgamation of the models" he had observed in nurses of both genders. The senior students reported that they had learned from their personal attempts to emulate "female caring" and from occasional male nurse role models that they may "care in a different way" from their female counterparts. Male caring was perceived by the senior students as being "less touchy feely" and more of a friendship than female caring. The senior participants believed that this form of caring is not always recognized within the profession as "true blue" and as valuable as female caring.

> I was amazed at the relationship he [male nurse] had with his patients. He was loud at times. He told jokes. He teased them a lot. But they loved him. And you could tell he cared about them deeply. I think some of the female nurses on the unit thought he was too casual and not caring enough. I think they were wrong.

Experiencing the Difference

Rejection by patients. The junior and senior students in the study experienced times when their gender affected their ability to learn to care as a nurse. One participant referred to these occasions as times when "you are smacked in the face with the fact that you are different," such as when patients were asked by a teacher if they would agree to be cared

for by a nursing student and they refused based on the gender of the student. Although these situations came up infrequently, the participants concurred that they were distressing and caused them to "feel different" from their female classmates. They stated that their clinical teacher and the nursing staff generally attempted to comfort them when this happened by attributing the patient's behaviour to bias and misunderstanding of the male nurse role.

> I had one patient who refused to have me care for her. My teacher said that she was older and she didn't understand that there were male nurses now. The patient didn't want me to see her body when she was being bathed. My teacher's comments really didn't make me feel any better. I kept thinking that no one makes a fuss when male doctors look at you. I felt – well, the best way to put it is powerless. I would have preferred for the teacher to help me to change this patient's mind. Maybe I wouldn't have been successful but at least I would not have felt so useless.

Touching patients. The junior and senior participants agreed that they experienced "the difference" when in their junior year they wrestled with appropriate ways to touch a patient "so they don't think you're seducing them." They reported feelings of confusion, resentment, fear, and embarrassment when they made first attempts to emulate the touching that they had observed as "female caring."

> So then I put my big hand on him, the way I had seen her [a classmate] do it. There was my big hand on his [the patient's] little arm and it looked so huge and heavy. I wondered if I was hurting him. I felt so stupid. I wondered if he thought I was coming on to him. I thought about what my dad would say if he could see me. Or some of my friends. They would think I was gay or something. But I knew that I needed to touch this man to express my caring for him. I got mad at my teachers for not understanding how awkward I felt. I knew there was no way I could make them understand how I was feeling. To them, it's such a little thing. Women touch other people all the time, even when they're just talking to one another. Men don't.

The junior students also recalled feeling uncertain about touching and expressing their feelings openly. They agreed that such matters were not generally discussed by faculty.

> I don't think it's always men who feel funny about touching and stuff. I know that some of the girls in my class weren't very comfortable with it at first. But it is mostly a male thing. And the teachers never discuss it. They just think that it is good enough to give us a lecture on the importance of touching. There were so many questions that I had back then. Like, do you touch everyone the same way or should you touch men and women patients differently? Or how do you know if a

patient might not want to be touched or get the wrong idea if you touch them?

Being a visible minority. Another way in which the participants experienced a difference associated with their gender was that they "stood out in the crowd" because they were the gender minority. This visibility was at times disadvantageous because the male student's performance was "under a microscope."

> For the most part, I think we get treated better than average – not better, I guess we are recognized more. Because there are so few of us, everybody recognizes our names. In some ways, that is a disadvantage because people walk up to me and start talking to me. They know of me and I don't know who the heck they are.

The participants identified an additional concern in relation to visibility as rumours and gossip, particularly in regard to budding romance. They agreed that "rumours circulate pretty quickly" when they are observed to be spending social time (e.g., having coffee) with individual classmates, nurses, or faculty members. One student commented that "having everyone know who you are and what you are up to gets to be a pain. It feels like you have no privacy."

Being Prepared for the Difference

The students in both senior and junior groups concurred that they had felt unprepared for the gender issues that arose as they progressed through the program. They stated that they had few occasions in the program to explore what it means to be a male nurse and the gender-specific issues that arise when a man cares as a nurse. One student said that the only thing he had heard from his teachers in relation to gender issues in caring as a nurse was "don't date your patients."

Several junior students regretted that they had not worked with other male nurses and nursing students during their clinical learning experiences. One student commented, "I would just like to talk to some [male nurses] and hear about their experiences. I think they could teach me more about being a male in nursing than my female teachers can." Three senior students identified a significant paradigm as one in which they had worked with a male nurse who had shared his stories of caring as a nurse. They stated that such an experience helped them to appreciate the complexity of caring as a nurse, specifically as a male nurse.

Several of the participants stated that participating in the research project had been beneficial because it provided a forum to explore

issues in relation to care that are unique to male nursing students. They expressed a desire for additional opportunities within the educational program to continue this exploration.

> I am finding myself thinking about this subject [learning to care as a male nursing student] more than ever since I said I would be part of this study. The thing that is sad for me, though, is why we don't talk about these things in our program. I would love to hear what other students, the women as well as the men, think about these things. I would love it if a male nurse came to class and talked about his experiences being a man in a female profession. Don't get me wrong – I'm not treated badly or anything because I am a man. I just think my experience is different from the women in the class. And I never get to talk about it in my program because the teachers are all women and they don't seem to think it's important.

Exhaustive Description of Gender Issues in Learning to Care

Learning to care was described by the junior and senior participants as a complex entity incorporating the gender of the student, the patient, the teacher, and the nurse. Gender influenced the lived experience of learning to care because of the societal construction of male and female roles in caring. The students moved away from an initial understanding of caring in nursing as gender-neutral to an acceptance of the existence of male manifestations of caring. As students progressed through the program, their experience of gender issues in learning to care was shaped by personal experiences, the expectations of a predominantly female faculty and nursing staff, and their evolving understanding of the ways of caring that are gender-based. Although initial attempts to emulate female nurses and classmates were often awkward and private, with clinical experience, trial and error, and reflection, students were able to formulate their personal construction of both female and male caring in nursing.

Discussion

Condon (1992) postulates that because women have so much experience with caring they tend to dismiss it as familiar. Davies (1995) states that attempting to describe professional caring in nursing is like trying to help someone see invisible mending: much of it cannot be seen unless it is identified and clarified by a professional "insider." It is apparent that male nursing students benefit from the stories of nurses, particularly male nurses, regarding caring. It is in these stories that the students are able to discern the components and manifestations of caring in the profession.

The participants differentiated between female and male forms of caring. Their perceptions of female caring are congruent with those of authors who regard female caring as an ongoing connection with others (Benjamin, 1988; Davies, 1995; Gilligan, 1982). Their perceptions of male caring differed from the current sociological viewpoint. They saw male caring not as detachment and individuality (Chodorow, 1989; Davies), but as reciprocal friendship. The participants viewed male caring as less demonstrative than female caring but as equally connected. Perhaps the participants' socialization to the profession and the expectations of largely female faculty resulted in their acceptance, in their final year of the program, of connectedness as a critical component of professional caring.

The participants were convinced that their teachers and classmates would regard them as obtuse if they confessed to feeling awkward about what they perceived were female caring traits (e.g., touching, sentimentality). It is apparent that nurse educators should not assume that all students are comfortable with these aspects of caring. Male nursing students need to be able to openly dialogue with teachers, classmates, and nursing staff about the experience that is unique to males as they learn to care as nurses. According to the participants, it would be helpful in this regard if opportunities were provided within the curriculum for male nursing students to be taught by, and to work with, male nurses.

The research findings show that learning how to care as a nurse is often characterized by internal conflict. Researchers have investigated this conflict in terms of role strain; however, the findings of this study indicate that the conflict may relate to how persons of either gender are socialized to care, rather than to occupational roles. Villeneuve (1994) identifies several barriers to men in nursing education, including the interpretation of caring as women's work. The participants identified a significant barrier as the "separate realities" that exist between the male students and female teachers, classmates, and nurses. They perceived that their female teachers and peers expected them to care for patients as women. The junior participants, for example, believed that to be successful in nursing school they may be required to suppress their customary masculine behaviours (e.g., aggression). The senior participants, however, had recognized the value of an amalgamation of female and male characteristics of caring in the profession. Nurse educators should promote the acceptance of both feminine and masculine characteristics of caring in the curriculum (Galbraith, 1991). Additional research is required to explore the nature of "male caring" within the profession.

The participants' experiences of being different or of forming a minority in the program were significantly related not to discrimination because of gender but to a lack of awareness in the educational program of the unique needs of male students and the students' lack of preparedness for the gender issues they would encounter in nursing. The participants identified a number of gender-specific issues in the lived experience of male students as they learn to care as nurses. Many of these (e.g., how can a nurse touch a patient without his/her intentions being construed as sexual?) appear to be equally significant for female and male students. Further research might compare the lived experience of female and male students as they learn to care as nurses. The gender issues that appear to affect both male and female nursing students, as well as those that pertain only to males (e.g., being a gender minority in the profession), should be addressed as part of the curriculum for all students. This would serve to heighten the awareness of students of both genders regarding the influence of gender on caring within the profession.

Researchers (Lemin, 1982; Mynaugh, 1984; Newbold, 1984; Woodhams, 1984) have concluded that most patients would welcome care from a male nurse and that, therefore, rejection of a male nurse by a patient is not a significant problem. Although it occurred infrequently, the experience of being rejected by a patient because of gender was distressing for the male students who participated in the research study. It is apparent that nurse educators at times regard these situations as inevitable. Although patients have the right to refuse care by any student, the participants believed that negotiation may be a more appropriate response than removing the student from the clinical assignment. Further study could identify appropriate strategies to help male nursing students cope with such incidents.

Conclusion

It is understood in the prevalent models of caring that the uniqueness of the individuals involved will influence the process and outcome of the caring encounter (Condon, 1992). Gender is one aspect of the uniqueness of the individual that will affect how caring is carried out in nursing. The research findings presented here indicate that nurse educators can do much to explicate to students the effect of gender in caring relationships and to teach male students to care as nurses. What is required is an honest appraisal of how women in nursing have defined caring as women's work, as well as an acceptance of both female and male ways of caring in the profession.

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Acknowledgement

Smoking Among Disadvantaged Women: Causes and Cessation

Miriam J. Stewart, Angela Gillis, Gerry Brosky, Grace Johnston, Susan Kirkland, Gillian Leigh, Vena Persaud, Irving Rootman, Susan Jackson, and Betty Anne Pawliw-Fry

La présente étude avait pour objectif d'établir les facteurs sociaux et psychologiques liés au fait de fumer ou de cesser de fumer chez les femmes défavorisées. On a fait des entrevues individuelles et en groupe auprès de femmes défavorisées vivant dans les Provinces atlantiques. Les participantes étaient surtout pauvres, sans emploi, isolées géographiquement et composaient des familles monoparentales. Les facteurs liés au fait de fumer comprenaient la réaction face aux tensions, la solitude, l'incapacité à gérer les difficultés, une efficacité personnelle moindre, les pressions sociales et l'accoutumance. Les participantes estimaient important le soutien apporté par les pairs (c'est-à-dire les femmes vivant les mêmes situations) et les partenaires. Elles considéraient que les professionnels de la santé et les programmes classiques pour cesser de fumer ne les aidaient pas. Elles jugeaient que les centres pour femmes et les organismes pour femmes étaient les lieux adéquats pour les programmes visant à cesser de fumer. Les questions méthodologiques sont à l'étude.

This study aimed to identify social-psychological factors associated with smoking and smoking cessation among disadvantaged women. Individual and group interviews were conducted with disadvantaged women in Atlantic Canada. Participants were predominantly poor, unemployed, geographically isolated, and single parents. The factors asso-

Miriam J. Stewart, Ph.D., is a Professor in the School of Nursing at Dalhousie University, Halifax, Nova Scotia. Angela Gillis, Ph.D., is Director of the School of Nursing at St. Francis Xavier University, Antigonish, Nova Scotia. Gerry Brosky, M.D., is with the Family Medicine Department, Dalhousie University. Grace Johnston, Ph.D., is with the School of Health Services Administration, Dalhousie University. Susan Kirkland is a Ph.D. candidate in Community Health and Epidemiology, Dalhousie University. Gillian Leigh, Ph.D., is with the Psychology Department of the Cape Breton Regional Hospital in Nova Scotia. Vena Persaud, B.Sc., M.H.Sc., is with the Tobacco Research Unit, Centre for Health Promotion, University of Toronto. Irving Rootman, Ph.D., is Director of the Centre for Health Promotion, University of Toronto. Susan Jackson, M.A., is Coordinator of the Atlantic Component of the Women and Smoking Project. Betty Anne Pawliw-Fry, B.Sc., M.H.Sc., is Project Coordinator of the Women and Smoking Project, Centre for Health Promotion, University of Toronto.

ciated with smoking included coping with stresses, loneliness, powerlessness, low self-efficacy, social pressures, and addiction. Support from peers (i.e., women in similar circumstances) and partners was considered important. Health professionals and traditional cessation programs were not perceived as supportive. Participants viewed women's centres and women's agencies as appropriate deliverers of cessation programs. Methodological issues are discussed.

Women have been excluded from health research, which has resulted in a view of health predicated on a male model (Clancy & Massion, 1992; Dresser, 1992). Although in more recent years increasing attention has been given to gender as a framework for understanding women's health (Phillips, 1995), the emphasis has been placed on biological sex differences. There are, however, powerful social and political factors that influence the quality of women's health and well-being. When women are asked about their health concerns, they consistently identify violence, stress, and poverty as significant factors in well-being (Phillips; Walters, 1992). Indeed, gender is intricately connected with social, cultural, and economic factors, which may determine health and well-being. In Canada, poverty rates are higher for women than for men in every age group (National Council of Welfare, 1994). Women on average have lower incomes than men, are concentrated in lower-status occupations, and are underemployed (Health Canada, 1994). Further inequalities arise from the traditional division of labour; work in the labour force is paid, whereas work in the home is not. The "feminization of poverty" is reflected in the earning differentials that presuppose the economic dependence of women on men, and the disproportionate impact of cutbacks to public benefits on women due to their greater poverty and their responsibility for children (McLanahan, Sorensen, & Watson, 1989).

There is evidence that gender and class intersect in determining women's health behaviours such as smoking. Given that 25% of Canadian women smoke (Health Canada, 1995a), and that women start smoking younger and consume more cigarettes than their predecessors did (Davies, 1990), it is not surprising that there has been a substantial increase in the death rate of women from cancers related to smoking (National Cancer Institute of Canada, 1995, p. 20) and in other health effects such as earlier menopause, reduced fertility, and increased risk of stroke (USDHHS, 1989). Despite these health concerns, there are lower smoking cessation rates among women than among men (Coambs, Li, & Kuzlowski, 1992). Women in disadvantaged groups have higher smoking rates than other women smokers in Canada (Health Canada, 1995b); low-income women are more likely to be smokers (Health Canada, 1993a, b). Smoking has also been associated with the stress of caregiving in situations of financial hardship; young

women smoke to manage the pressures of child care (Romans, Herbison, Walton, & Mullen, 1993) and smoking among older women is linked to caring for relatives (Kirkland, 1994; Penning & Chappel, 1993). Social and geographic isolation is also associated with high levels of cigarette smoking among women (Health Canada, 1995b; Romano, Bloom, & Syme, 1991). Moreover, the difference in smoking rates between higher- and lower-educated women has increased (Millar & Stephens, 1993).

Cultural affiliation is related in more complex ways to smoking status. Preliminary data reveal that smoking prevalence is high among aboriginal women in Canada, particularly the Inuit, which may reflect the cultural significance of tobacco (Millar, 1992; Stephens, 1994); aboriginal women also receive the lowest average income in Canada. More women, in particular francophones, smoke in Quebec than in other provinces. There are lower rates of smoking, however, among many immigrant women than among Canadian-born residents (Millar & Hunter, 1990). The lowest levels of smoking were found among immigrant women of Asian origin and the highest levels among French, German, Polish, and Ukrainian immigrant women (Statistics Canada, 1994). Furthermore, immigrants are more likely than other Canadians to have quit smoking and to smoke fewer cigarettes.

Clearly, smoking is linked to poverty, unemployment, and other disadvantaged circumstances. Regrettably, however, research on the smoking behaviours of disadvantaged women and on the barriers and supports to their cessation is meagre. Accordingly, the objectives of this Canadian study were: (1) to identify the social and psychological factors that influence the smoking behaviour of disadvantaged women, and (2) to identify strategies, interventions, and agencies that foster reduced smoking levels among disadvantaged women.

Methods

Research teams at two Canadian health-promotion research centres engaged in several sequential data-collection activities during the six phases of the project. These included: (Phase 1) a comprehensive literature review; (Phase 2) a secondary data analysis of the Ontario Health Survey and the Atlantic provinces' Heart Health Surveys; (Phase 3) telephone interviews with representatives of 13 women-centred cessation programs in Manitoba, Ontario, Quebec, Nova Scotia, and Prince Edward Island; (Phase 4) focus-group interviews with 254 disadvantaged women and individual interviews with 134 disadvantaged women in 10 provinces; (Phase 5) telephone interviews with represen-

tatives of 29 non-traditional support agencies in 10 provinces; and (Phase 6) telephone interviews with 22 disadvantaged women using these non-traditional support services.

This paper will focus on the Atlantic component of the fourth and sixth phases, which involved interviews with disadvantaged women. Smoking rates are higher in the Atlantic region than elsewhere in Canada (Statistics Canada, 1991) and 74% of women smokers are moderate to heavy smokers (Nova Scotia Department of Health, 1993). Furthermore, there are higher unemployment rates, lower income levels, and lower levels of educational attainment in the Atlantic region than in the rest of Canada (Statistics Canada, 1991, 1994). The Atlantic region also differs from the rest of Canada in terms of the rural nature of all four provinces (Statistics Canada, 1993), which could contribute to social isolation. No research focuses on tobacco use among rural women (Health Canada, 1995b).

Phase 4

The three specific *objectives* of the consultations with disadvantaged women were: to record their recollections and reflections about their experiences with smoking; to elicit their opinions and beliefs about smoking cessation; and to explore the psychosocial factors associated with smoking and smoking cessation. A total of 126 women participated in the Atlantic region interviews: 84 in the nine focus groups and 42 in individual interviews. Disadvantaged women smokers over 20 years of age who were poor, unemployed and/or single parents, had low levels of formal education, and lived in rural and isolated communities were included as participants. Consistent with qualitative methodologies, the sampling was purposive.

The interviews were conducted in sites accessible to these women, including women's centres, family-resource centres, a public school, a library, a food-processing plant, and an apartment residence for low-income single women. Refreshments were provided and child-care costs were reimbursed. Group interviews were completed in approximately two hours, individual interviews in one hour. At each focus group, the facilitator was assisted by an observer/recorder. During the introductory portion of both the group interviews and the individual interviews, the facilitator/interviewer clarified the objectives of the study, provided a brief overview of the procedure, and assured participants that all comments were confidential and that their names would not be used in the report.

The same interview guide was used for individual and group interviews. The guide included eight questions focusing on the reasons why these women began to smoke and continued to smoke; two questions about the perceived impact of non-smoking messages in the media, in public places, etc.; eight questions on their opinions and experiences with smoking cessation or curtailment; and six questions regarding strategies, services, and support that would help them stop or reduce smoking. The questions were exploratory, open-ended, and accompanied by probes. Three examples follow.

> Now, I'd like to ask you to think back further...to the first time you smoked. What was it that got you to take those first cigarettes? What were your immediate impressions about smoking? What were the reasons you became a regular smoker? (Probes: Family? Friends? Work group? Advertising? Image? Adventure?)

> What do you like about smoking? What keeps you smoking? What does smoking do for you? (Probes: Weight control? Comfort? Relaxation? Enjoyment? Companionship? Boredom? Coping? Addiction/being hooked? Stress reduction?)

> Let's create the ideal service or support to help you become a non-smoker. Think about the things that you would find most helpful. (Probes: Where would this service or support take place? What group or organization would be most capable of doing this?)

At the conclusion of each individual and group consultation, a socio-demographic questionnaire was administered. One of the 11 items elicited the participant's current level of motivation with regard to smoking cessation. The woman was asked to choose which of four statements most closely described her cessation intentions, based on four stages of behavioural change involved in smoking cessation (Prochaska & DiClemente, 1983). All the group and individual consultations were tape-recorded and transcribed. Content analysis of themes and sub-themes in the qualitative data was conducted by the research team. The researchers identified themes and categories and attempted to achieve consensus.

Phase 6

The two *objectives* of the consultations with the women who used "non-traditional" support services (outside traditional tobacco-control organizations), such as women's centres and other organizations devoted to women in disadvantaged circumstances, were to identify interventions and strategies for smoking reduction or cessation, and to determine the role and credibility of these support services as deliverers of cessation

programs. The 12 telephone interviews in Atlantic Canada were conducted using an eight-item interview guide, encompassing open-ended and closed-ended questions. These participants (who had not been interviewed in Phase 4) were asked to talk about (1) their experiences and needs with regard to smoking cessation, (2) the appropriateness of community-based support agencies as providers of smoking-cessation programs or services, and (3) the desirability of integration of tobacco-related information within the existing programs and services of these agencies. Interview guides were mailed to all participants before the interviews, so that they could familiarize themselves with the questions and have time to consider their responses. The data analysis included content analysis of the qualitative data and frequency distributions of the quantitative data. The participants in the interviews conducted in both phases were given a summary of the findings.

Profile of Participants

The formal-education level of participants was quite low: 60% of the women indicated that they had not completed high school. The majority of participants (82%) had children and almost half (48%) were heads of single-parent families; 74% reported that they spent most of their time at home. Only one quarter of the women had paid employment, either full-time (14%) or part-time (12%). With few exceptions, those who were employed reported working in "low status" jobs, such as babysitter, garage attendant, or janitor. Some participants were in school or training (10%) or did volunteer work (15%). All participants were smokers, although some were engaged in cessation or reduction attempts. Typically, these women were heavy smokers. Most (76%) reported smoking more than 15 cigarettes a day, and 23% smoked more than one pack of cigarettes daily. Many of these women lived with other smokers, usually a partner or spouse. The vast majority (98%) of participants had lived in Canada for the past 10 years. Few belonged to multicultural groups, perhaps due to the relatively low incidence of smoking among women in the immigrant and refugee sectors. Many of the participants in New Brunswick were bilingual, although French was their first language. (Separate initiatives by Health Canada focused on francophone women, immigrant women, and aboriginal women.)

Findings

A summary of findings is presented with exemplar quotations to illustrate some themes and sub-themes.

Factors Influencing Smoking (Phase 4)

Disadvantaged women began smoking to project an image. The participants' stories about their first smoking experiences as adolescents focused on their attempts to establish an identity consistent with that of their peers, and usually at variance with the expectations of parents or other members of society. The picture changed when the participants talked about being adult smokers. In the reasons they gave for smoking, and the feelings they expressed about being smokers, the women revealed a deep ambivalence about a behaviour they knew was dangerous in the long term but which was compelling for the immediate sense of relief it brought to their daily lives. They spoke of the "hold" that smoking had on their lives. Addiction was a pervasive theme. Disadvantaged women experienced the psychological aspects of addiction and the physical manifestations of addiction and perceived that they smoked more after a cessation attempt.

> Non-smokers who have never smoked, or even ex-smokers who are faithful at it – I don't think they fully understand how hard it is, and how much cigarettes play on your mind when you are not smoking. I've never been a drug addict, but it has to be along the same line.

> I'm sorry I ever picked up that first cigarette again…I said just this one won't hurt; I'll never go back to smoking what I used to. But you're lying to yourself. You go back and you're smoking twice as much.

Due to the pressing nature of the participants' life circumstances, many were caught in a daily struggle for survival. Consequently, the long-term benefits of quitting had little relevance for them. Disadvantaged women continued to smoke to cope with the moment. Their lives were characterized by many stressors and few resources with which to respond to stressful situations. Coping mechanisms predominated in all the explanations women gave for their smoking behaviour. They smoked to cope with the stress, chaos, and crises in their lives.

> Let people in government try to live on $800 a month with two kids. See how far they get with it. Rent, heat, lights and all that. If my kid gets sick, I can't afford to go out and get medicine for him. But because I smoke, [they say], "Don't smoke any more. That's four dollars you're spending…" It's [smoking's] about the only thing that I can afford that does relax me…But I have quit in the past…and I didn't find I had a lot more money to do anything constructive with. I still couldn't go out and buy my own home.

Most women had multiple role demands that offered little space and time for themselves, and they smoked as a break from the monotonous, burdensome routine of their day. They smoked as an antidote to

boredom or inactivity, and to relieve their sense of isolation, loneliness, and limited social opportunities. These women also smoked for social and recreational reasons, because others were smoking, and they used cigarettes as a reward and for pleasure.

> My spouse died when our child was almost a year old…and I hadn't been smoking then…I went through all of that, and a year later I started smoking again! But I think it was just out of loneliness…it was just me and him…I felt lonely and it gave me something to do for the evening. It was a comfort, yes, a coping thing. I was into crafts but that was an expense to keep up…it gives me strength to cope with life.

> I don't have a man in my life. I don't have anybody telling me what to do, how to spend my money. My smoking is because I enjoy it. It's my choice to do that, and that's what I do.

Nevertheless, these disadvantaged women were ambivalent about smoking. In addition to stress management and social "benefits," participants reported seeing the detriments of smoking. They experienced the pain of social stigma and perceived a lack of control.

> I don't like the way people look down on us [smokers]. It makes people who already have low self-esteem and don't feel good about themselves, it's adding to that. It's making them feel more awful, that they don't fit in, that they don't belong.

> It's a funny feeling, you feel so bad about what you are doing to others, and yet you cannot seem to stop.

The women's discussions about smoking cessation also focused on low self-efficacy (i.e., their confidence in their personal ability to quit smoking), which they attributed to low self-esteem, previous unsuccessful attempts to quit, and multiple role demands.

> Probably the one thing that would help me [quit] would be to get my self-esteem back up…because it is not good any more like it used to be. Like I diet so many times in my life and that doesn't help, and everything else. Like I feel bad about myself. There are a lot of different situations in my life, and maybe if I could better myself in certain ways…if I could get a job…

In lives centred on parenting and caregiving, many women found it impossible to deal with the stresses of cessation in addition to trying to meet their families' expectations. A pervasive theme was the way in which children influenced women's smoking behaviour. On the one hand, children and child care were often discussed as stressors associated with smoking or resumption of smoking. On the other hand, because of concerns about the effects of second-hand smoke, children were also cited as a reason for quitting; children provoked feelings of

guilt and anxiety, which motivated cessation attempts but which also were exacerbated when these attempts failed.

> I tried to stop for two days, but I couldn't stand the kids. I couldn't stand myself.

> The proudest thing would be...not more for myself, but for my kids...if one day they say to me, Mum, I'm some proud of you because you don't smoke. To me that would be the biggest accomplishment.

Most were aware of the harmful effects of smoking on the fetus; during pregnancy many women stopped smoking, or attempted to stop or cut down.

> I was so excited at being pregnant...[I] just stopped. I didn't crave for it. I was so wrapped up in having a healthy child that I didn't want to take any risks. [Now] if I don't have it, I feel really irritable. I feel like I'm missing something.

Some women made links between smoking and weight. While this was not a prevalent theme, a number of them feared cessation because of concerns about weight gain. In contrast, a few wanted to stop smoking because they were too thin. Thus smoking for some participants was bound up with the "women's issue" of body image.

Factors Influencing Cessation (Phase 4)

Participants were unanimous in their dislike of smoking. All participants stated that they would like to be ex-smokers, and almost all had attempted to stop at least once. However, participants were variously motivated with regard to changing their smoking behaviour. The level of impact of anti-smoking messages in the media was related to the woman's Stage of Change (Prochaska, Velicer, Guadagnoli, Rossi, & DiClemente, 1991). Overall, media messages on the negative health effects of smoking had little impact on the participants' smoking behaviours. However, different stages of behavioural change were reflected in participants' reactions to anti-smoking messages. Stages 1 and 2 smokers (i.e., precontemplation and contemplation) were typically dismissive of media messages. The messages did not seem to "connect" with their own smoking behaviour. In contrast, some stages 3 and 4 smokers (i.e., preparation and action) applied the messages to their personal behaviour. Several participants who were beginning to take action (cutting down in preparation for cessation) indicated that they sometimes used media messages to strengthen their motivation.

I would probably watch it, wondering if I should turn it off…Yes, I'm listening…I feel I should quit because I don't want to be that bad! It bothers me at first, but after I forget about it I'm OK. But if I keep it in my mind, I know I should quit, get it over with…you know, I don't want to die!

The disadvantaged women studied had ambivalent feelings about smoking restrictions. Although virtually all participants acknowledged the need for restrictions and agreed that non-smokers have rights, most contended that smokers also have rights that should be protected. Smoking restrictions helped a few participants to curtail their smoking. However, the anti-smoking environment generated feelings of guilt, anger, and isolation in other participants.

Most disadvantaged subjects had low expectations of support from health professionals and health agencies. Although many had talked with their physicians, they showed an overwhelming lack of confidence in their physicians as sources of meaningful help; very few physicians had offered appropriate information, counselling, or support. Other health professionals, such as nurses, were rarely mentioned as supporters. One woman said: "My doctor wouldn't know. I called the nurse. She said she didn't know about nicotine and the doctor didn't either." These women rarely contacted health agencies such as the Lung Association or the Cancer Society for support in smoking cessation, due to their geographic isolation, their lack of awareness of these agencies' public-education function, and their scepticism.

Participants frequently mentioned lack of social support as a key barrier to smoking cessation. Lack of support from partners and immediate family posed the biggest problem. Lack of support from friends and acquaintances was also cited as a barrier:

I used to have temper fits and everything…I was a contrary person. My husband said, "You're going to have to take up smoking again. I can't live with you."

Friends? They all begged me not to quit. My girlfriend said to me, "You're some friend, telling me not to smoke." I said, "Go ahead, it doesn't bother me if you smoke." They said, "No, we don't want you with us if you don't smoke"…I had a hard time.

Participants unanimously acknowledged the positive role played by social support during cessation attempts.

My father, he's a reformed smoker, he's my hero. Every time I quit smoking, his praise was good. He never put me down for smoking, but whenever I would go and tell him I hadn't had a cigarette in a few days his praise made me feel better.

The question of how to provide social support for smoking cessation was prominent in discussions with these women. In their view, self-help mutual-aid groups and dyads could help disadvantaged women to cease or curtail smoking. The role of peer support groups in facilitating smoking cessation was a central theme in responses by almost all of the 126 participants. They were interested in mutual-aid groups in which peers would assume leadership and determine the program content. Some women indicated that although they would not choose to be part of a peer support group they would welcome the support of a peer "buddy."

> Encouraging me, being with the women, knowing they're trying the same thing you're trying…they got the same problems and same kind of symptoms…same kind of feelings you're going through.

> I'm too much of a loner for a group. I'm a homebody. I just like to visit family and friends. But to have a friend that would be giving up with me, I'd like that. When I'm craving for a cigarette I'll call her…let's go for a walk, or something. Take your mind off it.

Social support was seen as an adjunct to, rather than a replacement for, personal motivation. Most of these disadvantaged women believed that personal determination and will-power are essential elements of cessation success.

> I think it's important to have support from your family. But I think it's an individual thing. It all depends on how much you want it. How strong you are. Like I can't expect my family or friends to stop smoking or cut down or not smoke around me.

It is noteworthy that similar themes emerged in the individual and group interviews with 260 other disadvantaged women, in central and western Canada.

Provision of Cessation Programs by Support Agencies (Phase 6)

The women who used "non-traditional support" agencies such as women's centres trusted these agencies, seeing them as appropriate potential deliverers of accessible cessation programs and services. One woman said, "I've gained a wealth of information going there. We help each other; it's changed my life around." Participants indicated that they would use agency-based smoking cessation programs if these were offered and accessible. They favoured a wide range of comprehensive programs that address the multidimensional aspects of their lives and reflect their different needs at different times. Participants identified diverse cessation supports, including programs, information

seminars, and referrals to professionals, as appropriate if offered with existing agency services. Like the women interviewed in Phase 4, most (82%) wanted support groups and emphasized the benefits of experiential knowledge of peers: "If [speakers] haven't smoked before, I wouldn't get much out of them."

Participants had firm ideas about the types of cessation support and delivery modes that would be appropriate for those who access the services of community agencies focused on disadvantaged women. Printed materials (pamphlets, brochures) on cessation were not rated highly by these participants – although pamphlets were one of the cessation supports most frequently offered by the agencies, according to interviews with agency representatives during Phase 5. Most women recommended that information on health risks for both smokers and non-smokers (i.e., second-hand smoke) be made available. Several participants suggested that information on the relationship between smoking and other women's issues (e.g., body image, self-esteem, child-rearing) be incorporated into existing programs and services.

Discussion

Most participants in the Atlantic region were recruited through women's centres and other community-based organizations that serve women. The ease with which recruitment was accomplished indicates that women's networks support this type of research. The women's organizations appear to serve different clientele; for example, two centres located in low-income housing projects gave us access to poor and hard-to-reach, formerly homeless women. This approach to recruitment attracted a diversity of disadvantaged women – single parents, and the poor, the unemployed, the uneducated, and the geographically isolated. Recruitment through women's organizations also provided an environment that was familiar to these disadvantaged women, thereby increasing their willingness to participate.

In combination, the individual interview and the focus group elicited data that encompassed and penetrated the key issues faced by these women. The individual interview featured intensive discussions; the interviewer was able to keep the conversation on track, pursue ideas, probe for detail, and encourage a coherent and comprehensive response to the research questions. Many women found it easier to talk about sensitive issues, such as stress and smoking, in one-on-one consultations. Although focus-group data provided a less in-depth and coherent account of the social and psychological factors associated with this health behaviour, the discussion was rich in breadth. Participants

responded to each other's comments and expanded on ideas. The group gave both participants and researchers a panoramic view of disadvantaged women's experiences, knowledge, attitudes, and feelings.

Consistent with one principle of participatory and feminist research – that research should benefit participants – almost all women indicated that the consultations had been a positive experience for them. They found that the consultations were stimulating and challenging, provided a welcome outing, offered an opportunity for expression, acknowledged their expertise, heightened their desire to quit smoking, and raised hopes for cessation support. However, this kind of personal reflection and sharing of perspectives can have a consciousness-raising effect, which can be painful as well as educative. For disadvantaged women who experience smoking as a profoundly controlling addiction, such reflection might generate stronger feelings of powerlessness. The interviewers were sensitive to this possibility.

Conventional research on women's smoking emphasizes individual factors such as lifestyle, attitudes and knowledge, and the immediate social environment including family and friends. In contrast, a feminist approach examines broad societal and structural issues such as low-status jobs (Graham, 1989; Greaves, 1990b; Health Canada, 1995b). Because smoking may be a response to gender and class inequalities (Daykin, 1993; Graham, 1989; Greaves, 1990a), a structuralist explanation that considers the social determinants of individual behaviour (Reutter, 1995) is appropriate. In our study, participants' smoking was inextricably linked with the inequities and obstacles in their lives.

Barriers to quitting smoking were closely related to the social and economic realities of these women's lives, such as isolated environments and inadequate work and educational opportunities. For example, most participants had not finished high school. These women are at particular risk because education level predicts cessation success for women more than for men (Freund, D'Agostina, Belanger, Kannel, & Stokes, 1992).

The disadvantaged women in this study smoked to cope with the chaos and crises in their lives. Economically disadvantaged persons are more likely to be exposed to environmental stressors (CPHA, 1993; Williams, 1990), and persons with high levels of stress are more likely to smoke (Romano et al., 1991). Health-inhibiting behaviours, such as smoking, are adopted by the poor to manage the stress induced by diminished access to resources (Reutter, 1995). Women also smoke to cope with other gender-related stresses (Graham, 1987; Greaves, 1993). For example, Graham (1989) found that cigarette smoking was a way

for low-income mothers to cope with the stresses and isolation encountered in caring for their young children. Furthermore, motherhood can limit women's ability to complete cessation programs (Jensen & Coambs, 1994). Participants also smoked to relieve their child-care and household routines and for pleasure. British studies reveal that women smoked not only as part of their daily routine and to provide a "time out" (Graham, 1993), but because it was the only luxury available on low incomes (Graham, 1987).

Over half of the participants were single parents; this group of women smokers has been neglected in research (Health Canada, 1995b). Women who smoke are more likely than non-smoking women to be caregivers, with or without a partner (Graham & Blackburn, 1990; Milham & Davis, 1991). Participants' smoking behaviour was linked to their loneliness and isolation. Other women have reported that smoking helps them cope with loneliness and lack of social support (Massie, 1993). Lower-income women are less involved with relatives and are more isolated than middle-class women (Oakley & Rajan, 1991). In fact, low-income groups report smaller social networks and less social support (Millar & Stephens, 1993; Manga, 1993). Financial stresses, in the absence of sufficient social support, are detrimental to well-being (Viinamaki, Koskela, Niskanan, & Arnkill, 1993).

Smoking is also an integral component of certain social situations such as visiting friends or communicating with partners (Graham & Blackburn, 1990). Many participants reported that they had smoking spouses and partners who were non-supportive of their cessation attempts. Women who quit smoking are more likely to have non-smoking partners (Wakefield, Gillies, Graham, Madeley, & Symonds, 1993) and supportive partners/spouses (Schoenbach et al., 1992). Participants believed that social support would help them to cut down or cease smoking. Lower rates of smoking relapse have been associated with the positive influences of social support (Carmody, 1990; Gruder et al., 1993).

Many disadvantaged women are in positions of powerlessness. These participants connected their smoking to lack of control of their environment, believed that smoking cessation requires will power, and reported low self-esteem and self-efficacy. Continued smoking has been linked to low self-esteem (Greaves, 1990b) and to low self-efficacy (Schoenbach et al., 1992). The poor may experience powerlessness and a low sense of control, mastery of their environment, and self-esteem (Ross & Mirowsky, 1989; Wallerstein, 1992; Williams & House, 1991). Support, particularly from peers, can empower people (Labonté, 1993)

and enhance self-efficacy and self-esteem (Gottlieb & Selby, 1989; Katz, 1993). It is not surprising that these participants wanted support from peers in mutual-aid groups and dyads. Women are more likely than men to participate in self-help mutual-aid groups and support groups (Gottlieb & Peters, 1991); men emphasize the importance of self-help programs in smoking cessation, whereas women seek social support (Greaves, 1990a). There are other gender differences in women's experiences with social support. Reciprocity in relationships (e.g., in peer-support groups) influences women's more than men's support satisfaction (Antonucci & Akiyama, 1987), and women benefit more from supportive interactions (Shumaker & Hill, 1991).

In contrast to participants' positive view of their peers, most did not perceive professionals as supportive. Health professionals who believe that smoking-cessation advice or programs are ineffective (Wakefield et al., 1993), or who offer insensitive or judgemental advice (Bryce & Enkin, 1984), will not have an encouraging impact on cessation. Although professionals are typically valued for the informational support they provide (Dakof & Taylor, 1990), the socialization of health professionals as "expert" providers can inhibit empathy and collaboration with consumers (Stewart, Banks, Crossman, & Poel, 1994). Furthermore, the gaps in economic status and education between disadvantaged women and health professionals pose barriers to trust.

Consistent with their experiences with the formal health-care system, these disadvantaged women did not make use of traditional cessation programs. During our interviews with representatives of women's cessation programs in Phase 3, we discovered that few cessation programs were appropriate for, or available to, disadvantaged women in Canada. Most programs and resources for smoking cessation do not consider gender differences and germane issues (Gritz, 1991; Health Canada, 1995b). In fact, the participants in our study favoured having information on women's issues incorporated into programs and services. Cessation programs should also include discussions of stresses related to class, such as the inequalities inherent in being poor women (Greaves, 1990a), should focus on empowerment strategies (Daykin, 1993), and should be delivered through women's organizations (Health Canada, 1993b). Certainly, the disadvantaged women in this study, who used women's centres and other women's organizations, viewed them as credible potential deliverers of cessation support. However, the representatives of these agencies (Phase 5) reported that they operated on limited funds and with limited staff, and that stable resources would be required before they could launch such programs.

Conclusion

Disadvantaged women's smoking was found to be inextricably linked with the social context and stresses of their lives. Comprehensive smoking cessation programs should focus on their social, economic, and cultural environment, rather than on their health behaviour alone, and should be accessible in terms of cost, culture, location, literacy, and child care. Interventions should mobilize support from family and friends, encompass support from peers and health professionals, and foster efficacy, empowerment, and esteem. In this context, disadvantaged women should be offered the opportunity to participate as partners in the design and evaluation of cessation programs that address their priority concerns and in policy changes pertaining to social and health programs.

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Theorizing Oppression: Implications for Nursing Research on Violence Against Women

Colleen Varcoe

La façon dont l'oppression est théorisée est très importante pour la recherche en sciences infirmières, en général et pour la recherche en sciences infirmières sur la violence faite aux femmes, en particulier. La violence n'est pas le comportement aberrant de certains hommes ni le simple problème de l'oppression d'un sexe. Elle est plutôt un problème social complexe, pénétrant, qui surgit et qui se nourrit de multiples lieux d'oppression, y compris la race, la classe sociale et le sexe. La conceptualisation de la violence qui néglige l'analyse du pouvoir, de l'oppression, de l'agent de la violence et de la résistance pourrait servir à soutenir et à maintenir la violence. Ainsi, l'utilisation de cette conceptualisation dans la recherche en sciences infirmières peut mettre celle-ci au même niveau que des structures perpétuant la violence et l'oppression. Les théories sur la violence, fondées sur des analyses complexes du pouvoir et de l'oppression, mettent l'accent sur les causes sociales de la violence. Elles exigent l'analyse du racisme, du sexisme et de la classe sociale, et elles établissent comme objectif de recherche la façon dont les gens, les institutions et l'état ripostent à l'oppression. L'analyse de l'oppression comme phénomène de simultanéité guide la recherche en sciences infirmières dans la violence faite aux femmes vers un changement social; elle est possible au-delà de la question de la violence et peut aider les sciences infirmières à participer à l'élimination des causes sociales des problèmes de santé.

The way in which oppression is theorized is critical to nursing research in general and nursing research on violence against women in particular. Violence is not just the aberrant behaviour of some men, or a simple issue of gender oppression; rather, it is a complex, pervasive social problem that arises from and is sustained by multiple sites of oppression, including race, class, and gender. Conceptualizations of violence that neglect analyses of power, oppression, agency, and resistance may serve to support and sustain violence; thus their use in nursing research can align nursing with structures that perpetuate violence and oppression. Theories of violence that are informed by complex analyses of power and oppression focus inquiry on the social causes of violence; require analysis of racism, sexism, and classism; and establish, as a goal of research, the countering of oppression by individuals, institutions, and the state. Analyzing oppression as simultaneity guides nursing research into violence against women toward social change, is applicable beyond the issue of violence, and can help nursing contribute to the eradication of the social causes of health problems.

Initially I thought of violence in intimate relationships as an issue of gender. After all, violence within relationships is committed primarily

Colleen Varcoe, R.N., M.Ed., M.S.N., Ph.D.(c), is a doctoral candidate in the University of British Columbia School of Nursing.

by men against women. However, as I studied the issue and began related research, I discovered that racism and classism, in addition to negative attitudes toward women, pervade common understandings of violence in theory and research, and characterize many of the responses of health-care professionals to women who have been battered. I began to examine theories of gender oppression and found that I could not theorize gender separately from other sites of oppression, and turned to the notion of oppression as arising from multiple sites simultaneously: oppression as simultaneity.

The way that violence is theorized is critical to nursing because, as will be shown, the theoretical perspective chosen either can align nursing with the status quo or can challenge the social foundations of violence and thus effect change. Secondly, theoretical perspectives must be explicit in nursing, to permit systematic and critical interpretation of research from other disciplines. Finally, the choice of theoretical perspective has significant implications for methodological choices.

The way in which oppression is theorized is also crucial, because nursing serves a diverse clientele who experience oppression at multiple sites such as race, age, gender, class, sexual orientation, religion, etc. Also, clients of nursing commonly experience oppression as a result of illness and disability. Nursing's traditional commitment to advocacy and ethical practice relies on an understanding of power and inequity, and hence of oppression.

The purpose of this paper is to explore the ways in which theories of violence are informed by analyses of power and oppression, as well as to consider how theorizing oppression as simultaneity contributes to understandings of violence and provides direction for nursing research. Most importantly, I hope that examining theories of oppression in relation to this substantive area will demonstrate the utility of seeing oppression as simultaneity and stimulate further analysis. The significance of theorizing violence and oppression will be discussed in relation to nursing research, and I will argue that conceptualizations of violence devoid of analyses of power and oppression serve to support and sustain violence, and thus cannot contribute to its eradication.

Conceptualizing Violence

At present there appear to be two central problems in conceptualizing violence. First, three distinct views have been used and have given rise to contradictory explanations of violence and directions for practice. Second, within those three views, power and oppression have been

under-theorized. Under-theorizing power and oppression has limited each of the perspectives and, I believe, created barriers to their integration.

Theorists from across disciplines have attempted to understand violence by focusing on and seeking causal explanation for violence within individuals, within couples or dyads, and within society. Bograd (1988) and Gelles and Loseke (1993) label these three predominant "lenses" the psychological lens, the sociological lens, and the feminist lens, referring not to specific disciplines, but rather to the focus of inquiry and presumed causality of violence.

Initial attempts to make sense of violence against women sought to explain violence by focusing on the individual. These approaches emphasized the psychology of the victim, and, more recently, the psychology of the perpetrator. The focus on the characteristics of victims led to victim-blaming theories of violence such as the theory of learned helplessness, which "merely labels as a peculiarity...what is in fact a reasonable response to an unreasonable situation" – thus diverting attention from the situation to the victim (Wardell, Gillespie, & Leffler, 1983, p. 76). More recent attention on the psychology of the perpetrator has shifted the locus of causes of violence to the psychopathology of the perpetrator, but leaves power and gender relations unexamined. The focus on the individual popularized by the media perpetuates, Dobash and Dobash (1992) argue, "unsubstantiated yet damaging theories about the problem, its victims, perpetrators and solutions, [notions that] implicitly assume that this is strictly an individual problem suffered by deviants needing psychiatric care rather than a social problem in need of wider remedies" (p. 32). Bograd (1988) criticizes the focus on psychology of the individual for suggesting that violence is an aberrancy of a few husbands (rather than the usual pattern of most men), excuses men, implicates women, and concludes that the characteristics of abused women are the *causes* rather than the consequences of abuse. Causal explanations of violence within the psychology of the individual tend to leave power and gender relations unexamined and consider violence in isolation from the social and historical contexts in which it occurs.

The second set of perspectives on violence focuses on dyads or families, and seeks explanations of the causes of violence in social relations within couples and families. These perspectives, which are used in most research on violence (Silva, 1994), tend to be gender-neutral, to treat power inequities as only one factor among many, and to explain violence as resulting from external stresses and breakdown of the family,

rather than as a part of most normally functioning families (Bograd, 1988; Stanko, 1988). Straus and Gelles have carried out perhaps the most influential work on relations within dyads. Straus and Gelles (1986) conceptualized violence as a conflict between parties and, using the Conflict Tactics Scale (CTS), found equivalent violent behaviour among men and women. Yllö (1993), Dobash and Dobash (1988), Silva, and others have critiqued the perspective underlying the CTS because it does not critique power or gender relations. As does the focus on individuals, a focus on dyads or families limits analysis of the influence of the social context.

The third set of perspectives, labelled "feminist," tends to explain violence as arising from the social context and contributes an analysis of the influence of gender and power to theorizing violence (Yllö, 1993). Gelles (1993) and others (e.g., Dutton, 1994; Letellier, 1994) argue that feminism uses a single variable (patriarchy) to explain the existence of wife abuse, and use evidence of men who are not violent and evidence of violence in same-sex relationships to argue that patriarchal ideology does not account for male violence. However, this is a very narrow view of feminism (see hooks, 1984) and, as countered by Yllö, reflects a very narrow conceptualization of patriarchy. As Renzetti (1994) and others have noted, feminists are not concerned exclusively with gender.

Tensions and conflicts between these various perspectives have led to very different explanations of violence, and therefore to very different approaches to decreasing violence. The battle between these varying theoretical perspectives continues to be waged, and violence theorists are now calling for integrated models (e.g., Dutton, 1994; Miller, 1994; Renzetti, 1994; Tolman & Bennett, 1990). However, the approaches to such integration are contentious, and, I believe, seriously constrained by the limited ways in which power and oppression have been theorized in relation to violence.

Power, Oppression, Resistance, and Perspectives on Violence

Analyses of power are generally not found in work that focuses on the psychology of individuals, which results in an implicit assumption of equality between individuals. Perspectives that examine violence within dyads or families view power as one of many factors in violence, and the view of power used is usually one in which there are two equally opposing forces. From feminist perspectives, power inequalities are assumed to exist, and they are central to how violence is theorized. However, power may not be explicitly theorized, or it may be theorized in a variety of ways within each of these perspectives.

Three conceptualizations of power initially proposed by Lukes (1974) and applied and refined by Gaventa (1980) highlight the limitations of the various ways in which violence has been conceptualized. The first is a traditional view of power as a contest between two opposing forces in which the "winner" usually has the greatest resources (intellectual, material, personal, experiential). This view is based on the assumption that all individuals and groups have equal opportunity to express dissent. It assumes that non-participation is the fault of the non-participant, a consequence of apathy or lack of experience or skill. Powerlessness is explained as lack of knowledge, communication skills, political expertise, or clout (Dykema, 1985) – in other words, a deficit on the part of the least powerful. This conceptualization of power is congruent with and supports views that focus on the individual and that see the differences between abused and non-abused women as the causes of violence. This view of power is also compatible with dyadic perspectives on violence, as exemplified by the seminal work of Straus and Gelles (Gelles & Straus, 1988; Straus & Gelles, 1986), in which violence is a conflict between two equal and opposing parties. Using this view of power, issues of oppression and resistance do not arise; since the parties are equal, women are assumed to be autonomous agents, and research questions such as "why does she stay?" are justifiable.

The second conceptualization of power suggests that some people are excluded from contesting their lack of power. A set of dominant beliefs, attitudes, values, institutional rituals, and practices operates to benefit certain people or groups. Those who benefit are supported in defending their position; those who do not benefit are stifled before they are heard or are simply excluded from decision-making. This view of power is implicit in most feminist conceptualizations of violence, which regard the power inequalities fundamental to wife abuse as deeply gendered, arising from multiple sources of oppression, and fostered by the state (see, for example, Hoff, 1992; Kjervik, 1992; MacKinnon, 1993). Hooks (1984) argues that the state has not acted significantly to end violence against women in their homes because it prefers violence in the family to violence against the state. The devaluing and oppression of women in society is seen as fundamental to violence against women. Because women are excluded from contesting their weak positions, resistance is limited and the agency of women is constrained. From this view of power, the research question becomes "what keeps her here?" and is directed towards the structures of society and the state.

In the third conceptualization, power relationships are maintained because the very wants and needs of the dominated are shaped by

more powerful others. Gaventa (1980) believes this phenomenon occurs (1) as a psychological adaptation to powerlessness, (2) from a lack of opportunity to develop political consciousness, and (3) from inconsistent belief patterns among the dominated. This view of power also underlies many feminist understandings of violence, leading to much more complex analyses of the experiences of women who are abused (e.g., Hoff, 1990; Wuest & Merritt-Gray, 1994). Unlike views of power that give rise to theories such as learned helplessness, this view of power explains women's behaviours as adaptations to powerlessness and domination rather than as psychological deficiencies, and sees domination arising not only from the person inflicting abuse, but from an entire system that tolerates, accepts, and perpetuates abuse. It follows that feminists have argued that research on violence must be concerned more with oppression than with victimization (e.g., Kjervik, 1992; McBride 1992; Yllö, 1993). However, at the basis of criticisms of the narrow concern with gender offered by feminism (Dutton, 1994; Gelles, 1993; Letellier, 1994) is a very real problem with the ways in which oppression has been theorized by some feminists.

Before we turn to problems with feminist theories of oppression, a brief summary of Foucault's perspective on power (1978, 1980) is offered to contrast with the three dimensions described above. Foucault sees power as intrinsic to all social relations. He does not see power as a commodity, as something to be held or owned. Rather, Foucault theorizes power as existing only in action, as being enacted in all relationships. He does not view power as centralized within formal institutions such as the state, or as descending "top-down." Rather, power comes "from the bottom up." Because power is enacted in all social relations, all relations of power include resistance, and power is positive and productive as well as negative and repressive. Foucault sees power relations as intentional, but not in the sense of being enacted consciously as the result of a choice or decision of an individual. Rather, local tactics are connected to one another, forming comprehensive systems. "The logic is perfectly clear, the aims decipherable, and yet no one is there to have invented them, and few can be said to have formulated them" (1978, p. 95). Finally, Foucault sees power as most effective when it is insidious or disguised.

If this view of power is used to understand conceptualizations of violence, then power is thought to be enacted in all social relations, and analyses of power are required with regard to the individual, the dyad, and the society. Because power always includes resistance, analyses of resistance are simultaneous with analyses of power. From Foucault's perspective, explanations of violence arising from the state are not

sufficient, and domination is theorized as arising from the whole network of social relations rather than only from powerful individuals or institutions. In addition, there is no rational intentionality to explain violence. Rather, intentionality may be understood at the local or individual level, but is not clear at the collective level, thus the "state" cannot "prefer" violence. Following Foucault, oppression and resistance are theorized to occur simultaneously throughout all social relations and, to return to feminist views on oppression, not just at the interface between genders.

Feminist theorizing shifted the discourse on oppression from class as the central source (which arose from Marxism) to a concern with gender as the central source of oppression (e.g., Acker, Barry, & Esseveld, 1983; Eistenstein, 1977; Harding, 1987). This shift, born of white, middle-class, Western feminism, drew attention to gender-based oppression. However, the placing of gender at the centre of feminist theorizing implies, erroneously, that gender is the central defining feature of a woman and "reflect(s) the dominant tendency in western patriarchal minds to mystify a woman's reality by insisting that gender is the sole determinant of woman's fate" (hooks, 1984, p. 14). This focus on gender rests on essentialized notions of "woman" and "patriarchy" (Walby, 1992); that is to say, woman is conceived of as a biologically or socially defined "essence," and patriarchy as a monolithic entity (see Alcoff, 1988; Collins, 1989). Treating gender as a category distinct from race and class also essentializes these categories.

Feminists such as Brewer (1993), Collins (1986), Mohanty (1992), Ng (1993), and Smith (1990) (with notable leadership from black feminists) have contested the centrality of gender oppression, essentialist conceptions of gender, and the subordination of the experiences of race and class. Following these critiques, feminists have theorized oppression as arising from multiple sites, most expressly including race, class, and gender. The critiques of uni-causal models of oppression have resulted in pleas for radical pluralism. However, accounting for the intersection of endless sources of oppression presents significant challenges to the meaningful analysis of oppression (Bordo, 1994; Phillips, 1992). Simultaneously, poststructuralist critique has questioned the utility of analytic categories such as race, class, and gender, and has declared such categories to be too internally diverse to be useful (Walby, 1992). These challenges have served to destabilize feminist theory and threaten the very categories by which oppression can be understood and challenged (Bordo; Hoff, 1994; Phillips; Smith). The proposed alternative is to focus on oppression as arising simultaneously from multi-

ple interacting sites, without abandoning the analytic categories of oppression in related sites such as race, class, and gender.

Oppression as Simultaneity

Viewing oppression simultaneity, sites such as race, class, and gender are seen to interact in a complex manner and the effects are formative and multiplicative, rather than additive; multiple sites of oppression interact to reinforce and amplify oppression. Thus to be an aboriginal woman restricts material options, and poverty amplifies racism, and so on. This approach displaces the feminist discourse that attempts to hold gender at its centre, thereby subordinating the experiences of race, class, and sexuality, and favours a feminist theory that starts from a consideration of how race, class, or sexuality determines the positioning of a subject (Visweswaran, 1994).

A discourse of oppression as simultaneity suggests a shift in the starting point of research from particular *sites* of oppression to the *experiences of oppression*. Therefore, the categories for analysis become experiences of racism rather than race, sexism rather than gender, heterosexism rather than sexual orientation, and experiences of poverty or wealth rather than class. Such an approach is more meaningful and less likely to essentialize individuals according to colour, gender, sexual orientation, and so on.

Experience must, however, be problematized. Allen (1996) and Scott (1991) argue that experience is often held as an incontestable and irreducible form of evidence. Treating experience as unquestioned evidence is problematic because it precludes critical examination of how experience is produced and how experience produces subjects. Rather than contest historical, socially constructed categories such as "Native Indian," "lesbian," and "woman," treating experience in this manner tends to reproduce such categories as though they are "real." Scott calls for attention to be placed on processes that position individuals and produce their experiences, a view in which it is "not individuals who have experience, but subjects who are constituted through experience" (p. 779). Experience is no longer the evidence for what is known, but rather experience is that about which knowledge is produced. Scott would treat all categories of analysis (such as race, class, and gender) as "contextual, contested and contingent," but she cautions that "this does not mean that one dismisses the *effects* of such concepts and identities, nor that one does not explain behavior in terms of their operations" (p. 793).

Thus experiences of everyday oppression are suggested as a beginning for analysis, with the analytic categories of power relations being used to link these experiences to the social structural constraints of institutions and political economy. A focus on the ways in which experiences of racism (for example) influence individuals avoids treating race as something that individuals "are," and moves beyond dichotomies such as black/white, male/female. This approach avoids simple oppositional views of power; therefore, congruent with Foucault's views of power, oppression and resistance are seen to coexist simultaneously along multiple sites. This discourse of oppression fosters emancipation by altering the goal of research, changing the way in which the oppression of subjects of research is theorized, altering the way in which the researcher locates her/himself, and reframing research questions.

The way that oppression is conceptualized is critical to the theories about violence that are used to guide research. If gender is the sole source of oppression, then wife abuse is seen as arising from relations between men and women, and theories that locate the causes of violence within the individual and family are sufficient. However, a view of oppression as simultaneity demands a view of violence as also arising from the social context. Such a perspective is clearly congruent with the feminist focus on the context of violence (Bograd, 1988; Dobash & Dobash, 1988; Hoff, 1992; Yllö, 1993). Further, this view of violence as arising from multiple sites of oppression permits and requires an analysis of racism, classism, heterosexism, ageism, and other experiences of oppression in research related to violence. This is particularly critical to nursing research on violence against women, given the role of racism, classism, and sexism in responses by health professionals to women who have been abused (Barbee, 1992; Dobash & Dobash, 1992; Hampton & Newberger, 1988). Wife abuse no longer can be seen as a woman's (or a women's) problem, but rather becomes a problem of social proportions that requires intervention not only with individuals who experience and perpetuate violence, but with other social relations that permit and sustain violence. Thus the research questions must be reframed to include the context of oppression from which violence arises, and the goals of research must be broadened to include social change and emancipation. The researcher no longer merely locates her/himself in what has been called an increasingly sterile manoeuvre (Visweswaran, 1994); rather, the experiences of oppression and resistance of both the researcher and the researched must be theorized.

Viewing oppression as simultaneity is congruent with a Foucaldian perspective on power. Foucault (1978, 1980) asserts that relations of

power are not external to other types of relations, such as economic processes, knowledge relationships, or sexual relationships, but, rather, are integral to these relations. Sites of oppression such as class, race, and gender are "major dominations," which are hegemonic effects sustained by all of the multiple relations of force at the local level (1978, p. 94).

The ideas of oppression, power, and gender are intertwined and are fundamental to the theorization of violence. Violence has been seen as caused by variously individual pathology, family dysfunction, or the social context. Although it is acknowledged to occur between genders, power and oppression have not been central, and gender is not theorized in these terms. The focus of research is predominantly on the individual or the family and on the causes of violence arising from individuals and families. Although power and oppression are central to feminist theories of violence, when power is viewed from the "top down" attention is drawn away from the agency of the individual. Viewing power as enacted within all social relations requires analyses of power within all perspectives and offers the opportunity to link these apparently divergent views of violence. Moving beyond uni-causal models of oppression shifts the discourse from violence as gender oppression to violence as simultaneously arising from racism, classism, and other sites of oppression. Additionally, viewing power as enacted in all social relations directs the discourse away from exclusively individual, dyadic, or ecological models of violence and towards an understanding of power and violence as occurring within a network of power relations throughout the social fabric.

Conceptualizing Violence in Nursing Research

Without the critical distinction between the aims of the science of nursing, which concern generalization, and the aims of the art of nursing, which involve individualization (Johnson, 1991), the nursing philosophy of individual uniqueness, which may be appropriate to nursing in everyday application (Thorne, 1991), tends to uncritically guide nursing theory and research. Nursing theories tend to focus on the individual and conceptualize the individual as interacting with, yet distinct from, the environment. Nursing theories also tend to conceptualize the environment as an influence on the individual and as a context of health rather than as a cause of health and illness and as a target for intervention (Chopoorian, 1986; Kleffel, 1991). Similarly, family theories used in nursing tend to focus on isolated family systems or units, with little regard for the relationship between family and society. The indi-

vidual orientation within nursing theory appears to fit comfortably with theories of violence that focus on the individual. These theoretical perspectives foster views of violence that identify the individual as the source of the problem (whether that individual is the abuser or the abused) and the target for intervention. Furthermore, the medical model continues to dominate health care and thus supports nursing in "medicalizing" violence, focusing on the pathology of the individual, and offering interventions aimed at improving the "health" of individuals rather than strategies aimed at altering relations that create and sustain violence.

There is a small but growing body of nursing research into violence against women. Nursing research has helped us to understand violence in a variety of ways and has made an especially significant contribution in highlighting the prevalence and significance of abuse during pregnancy. Nursing research has tended to focus on the individual, and consequently, as noted by Campbell (1993), "nursing research has been more concerned with responses to and characteristics of violence than causes" (p. 503). Despite claims that nursing has tended to use feminist and critical-theory perspectives in research on violence (Campbell, 1992), most nursing research has not been explicitly feminist, and has not used theories of violence in which critique of power relations and oppression are central or in which violence is seen as arising from the social context. For example, Straus and Gelles's Conflict Tactics Scale (CTS) is often used in nursing research without reference to the extensive feminist critiques of that instrument. In addition, research is often used to prescribe clinical approaches that focus exclusively on the individual woman. While adding to our knowledge about violence, such research does not challenge the social structures that make violence possible.

Nurse researchers who have been explicit in their use of feminist theories of violence have attended to power relations and the social context and produced work that provides direction for action beyond the individual woman. For example, in her ethnographic study of battered women in their formal social networks, Hoff (1990, 1992) focuses on the sociocultural context of violence and explicitly considers power relations and oppression. She identifies the need for public awareness, consciousness-raising regarding the role of women and redefinition of oppressive social structures, the redirection of policy and human-service providers to hold assailants rather than victims accountable for violence, and the need for nurses to combine social action with crisis-intervention strategies. Wuest and Merritt-Gray (1994) were also explicit in their use of a feminist approach, and studied the social vio-

lence done to women as they attempted to leave abusive relationships. They identify the implications for social policy and programs, and for the attitudes of nurses and other service providers who become frustrated with women who return to or cannot leave abusive relationships.

Nurses are also beginning to study oppression in relation to violence. For example, Campbell, Pliska, Taylor, and Sheridan (1994) report battered women's perceptions of racism and classism on the part of hospital emergency personnel. However, for the most part nurse researchers either have not considered or have not critically examined issues of race and class in relation to violence. For example, Trucker (1992) reports that she interviewed women who were of a certain race, social class, and treatment experience (presumably made possible by race and class), but fails to specify the women's class or race (or whether ethnicity varied) and fails to include these categories in her analysis. McFarlane (1993) sought to understand the different ethnic patterns of abuse between African-American women, Hispanic women, and white women, presumably because of the limitations of previous studies. However, her study includes no discussion of the basis on which women were assigned to these non-parallel categories, no discussion of class differences between the women, no attention to the cultural appropriateness of the screening used, no discussion of the likelihood of affirmative answers, no discussion of the ethnicity of the researcher, and no suggestion that there would be positive consequences for those women who disclosed abuse. These shortcomings raise serious doubts about her conclusion that the "frequency and severity of abuse was appreciably worse for white women" (McFarlane, p. 357). Given that the race of a woman may be a particularly critical factor in the decision to disclose abuse (Dobash & Dobash, 1992), the differences in findings may solely be a function of reporting decisions by the women. Finally, Limandri and Tilden (1993) identify the prohibitive cost of care for a battered woman whose daughter required assessment for abuse, but fail to mention the economic impact of the hospitalization they recommended for an abusive man. While this may reflect an implicit understanding of the intersection between class and gender, Limandri and Tilden do not make this part of their ethical analysis. Although these studies do not include analyses of oppression arising from gender, race, and class, they demonstrate a growing awareness of oppression in nursing and emphasize the importance of such analyses for future work.

These examples highlight some of the differences in research goals, strategies, and outcomes that follow from various views of violence. The way in which violence is theorized influences the questions that are

asked, the values that are held, the data-collection methods that are used, the uses that are made of data, and the relationship between the researcher and the researched (Bograd, 1988). We have seen that various research questions are appropriate from various perspectives. If violence is theorized as arising from multiple sources of oppression and power is conceptualized as intrinsic to all social relations, then the causes of, and therefore the solutions to, violence are seen as diffused throughout the structure of society rather than being only in the hands (or heads) of victims or abusers. If violence is theorized as arising from multiple sources of oppression, then nurse researchers must account for the multiple sources simultaneously. If research is guided by the idea that all social relations are imbued with power relations, then an understanding of violence will require analysis of the network of power relations throughout the entire social fabric. Researchers in nursing will be led to examine the power relations between nurses and women who are battered, as well as between nurses and others within the social context. If resistance and agency are thought to coexist in all power relations, then women who are battered are not merely positioned multiply as victims, but are considered subjects with agency operating within a network of power relations that limits their choices, but does not eliminate them. Therefore, the potential for nurses to oppress as well as to be oppressed is examined along with their potential to resist the power of others. If categories of analysis shift to experiences of oppression, then categories such as "black," "white," and "Hispanic" are replaced by categories of experiences of oppression and resistance arising from skin colour, language, poverty, etc. Finally, the goal of research and the purposes that the research serves are not limited to interventions with women. If violence is theorized as arising from multiple sources of oppression, then the goal of research includes countering oppression in one's own relations and in all social relations.

Nursing research informed by violence theorized in this manner would necessarily address all power relations within the social context. For example, research on identifying women who are abused would question the power relations between nurses and clients at multiple sites, including race, class, gender, age, and sexual orientation. What heterosexist and sexist assumptions are operating if nurses ask women, but not men, if violence is an issue in their lives? In what ways could white nurses asking non-white women about violence compound experiences of racism? Such research would also address the conditions under which nurses practise. What are the priorities in nursing work, who sets these priorities, and how do these relations influence nurses'

ability to respond in a meaningful manner to women who have been abused?

The very size of the problem and the deep social roots of violence against women create major challenges for nursing. Knowledge cannot be developed, interventions cannot be designed, implemented, and evaluated through research in isolation from the social structures in which violence is fostered. The effectiveness of nursing is seriously constrained by the very social structures that create and permit violence in the first place. Nurse researchers can choose to theorize violence from approaches that accept these constraints as given, and focus investigation on individual perpetrators and victims. This position will foster our alliance with dominant medical and institutional views. Alternatively, nurse researchers can choose to theorize violence in a manner that accounts for and challenges the roots of violence in our social institutions. If nursing research is to contribute to the eradication of violence, rather than to the counting of women who are abused and the number of injuries that are sustained, and to the mere patching up of injuries, then we must confront oppression at all sites, examine power relations, and seek to transform the social structures that foster violence. Theorizing violence from a complex analysis of power and oppression is a prerequisite to ending violence. Theorizing oppression as simultaneity is essential if nursing is to contribute to the eradication of the social causes of health problems.

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Acknowledgements

Brief

Dilemmas of Difference and the Politics of Comparison: Cross-Cultural Research on Dementia

Keri Chater

L'article traite de quelques-unes des questions théoriques et méthodologiques apparues lors de la recherche inter-culturelle de l'auteure consacrée à la démence. Son souci principal est la difficulté de représentation au sein des groupes culturels. L'article sous-tend que, tandis que la représentation induit une perception d'homogénéité du groupe, elle estompe ainsi les différences en son sein. Il est parfois opportun d'employer cette méthode pour faire avancer la cause du groupe en question. L'auteure propose une façon de présenter les résultats qui, tout en atteignant les objectifs de la recherche, ne compromet ni les participants ni le chercheur. Cette recherce montre l'arbre de décisions qu'elle a suivi durant la réalisations de son étude.

This paper examines some of the theoretical and methodological issues that were raised when I undertook cross-cultural research on dementia. The main concern addressed in this paper is the difficulty of representation within cultural groups. The paper contends that whilst representation can lead to perceived homogenization of a group, thus blurring intragroup differences, it is at times expedient to use this method in order to further the cause of that group. This paper proposes a way of presenting findings that, whilst meeting the aims of the research, compromises neither the participants nor the researcher. This paper also represents part of the decision trail the author left while carrying out the research.

Introduction

Recently I was asked by the Chief Executive Officer of a major public-care facility for the aged to prepare a report on understandings of dementia from various cultural perspectives. Thus began a preliminary foray into the cultural beliefs of dementia found among Mediterranean, Asian, and Arabic communities. The aim of the project was to formu-

Keri Chater, R.N., B.A., M.N., is a doctoral student at La Trobe University in Melbourne, Australia.

Requests for reprints should be directed to Keri Chater, School of Nursing, La Trobe University, St. Helliers St., Abbotsford 3067, Victoria, Australia.

late recommendations for enhancing the "cultural sensitivity" of nursing care at the facility.

This request was premised on an understanding that the work would be stereotypical. It was acknowledged that the project would uncover only "flavours" of cultural understandings of dementia. However, it was argued that this would be appropriate to the trans-cultural nursing practice already established at the facility.

I used a qualitative method for my data collection and conducted interviews with nine bilingual employees. My reason for choosing these particular people for the project was that they almost all worked with older people who spoke the same language as they did. In this regard I felt that these employees would have an insight into the cultural background of the people with whom they were working and thus would be able to articulate various cultural understandings of dementia.

Although the process of data collection posed no problems and the participants were all very willing to share their understandings of dementia, it became apparent that theoretical and methodological dilemmas had to be addressed. The remainder of this paper will first examine some of the dilemmas I discovered whilst undertaking cross-cultural research, then propose a way in which to manage data in order to best help resolve those dilemmas.

The Slippery Concept of Culture

The first difficulty I encountered when I undertook the project was how to manage the huge concept called *culture*. Australia is very proud of its multiculturalism and its concomitant policies that try to ensure equity and equal access for all Australians. It is acknowledged, however, that there are real political and philosophical problems in trying to define culture, because of the inherent complexity and multiplicity of meanings of the term (Wallerstein, 1990). Clearly, however, an operational definition of the concept of culture is a prerequisite to its having the potential to inform policy development or research.

In Australia, policy reflects the notion that different language groupings connote different cultural groupings. People who speak Italian, for example, would be perceived as belonging to the Italian community and sharing the values of that community. Conversely, people who are seen as not part of the Italian community do not speak Italian and therefore do not share the values of that community. So it can be argued that concepts of language, culture, and community can be used interchangeably.

I argued that basic concepts such as caring and health were culturally specific and socially constructed, and that they can vary with each cultural group. I also argued that dementia had only recently been constructed as a biomedical condition within the Anglo-Celtic culture (Hernandez, 1991; Lyman, 1989). The normative nature of such basic concepts, however, means that often the issue that they are culturally constructed is rendered invisible (Ferguson, 1990), and this can be very powerful for the dominant or host culture.

Employing the above notions of culture, I assumed that the participants – because of their language – belonged to a particular community and therefore had an insight into the beliefs and values of that community. I also assumed that the participants would have an understanding of the Anglo-Celtic construction of dementia as a pathological manifestation.

The Problem of Representation

I then encountered another problem. Whilst I (and the funding body) realized that the research would be stereotypical, I had not envisaged the power of the proviso of almost all the participants that whilst they would share their understandings of dementia constructed out of their own cultural experiences, I was not to interpret their comments as representational. This posed theoretical problems in terms of the definition of culture I had used and methodological problems in terms of how I would write up my findings.

Once we see groups as representative, particularly because there is a shared language, then the complex intragroup dynamics tend to be blurred and obscured (Higgenbotham, 1992), masking difference, rendering issues such as class and gender invisible, and ignoring power relations. Moreover, homogeneity lends itself to essentialism, which represents "the community" as sealed, static, integrated, and enduring.

The participants and I agreed that seeing their contribution to the research as representative would suggest homogeneity, and thus render invisible certain aspects of that community. Given that the aim was to improve health-care delivery to people of non-English-speaking backgrounds, the challenge was to find a method of data analysis that could lend itself to informing nursing care whilst not falling into the trap of false representation.

Highlighting the problem was the fact that representations of cultural groups lend themselves to cross-cultural comparisons, which can be seen as compounding the issue of homogeneity and which can also

run the risk of being labelled racist and thus political. Additionally, making comparisons of stereotypical representations seems a somewhat fruitless exercise. Pearson (1987) sums up this dilemma:

> To ignore differences is seen by some as egalitarian, treating all people the same, but by others as evidence of colour blindness. To emphasize difference within a racist ideology is to reinforce and emphasize notions of alienness, whilst within an anti-racist perspective, recognition of difference is a prerequisite for a positive and sensitive awareness, a welcome departure from ethnocentrism. (p. 44)

This expresses exactly the dilemma faced by me, as the researcher, and by those who participated. Cultural research can lead to a greater understanding of cultural differences; however, it can also lend itself to cross-cultural comparison. This comparison, as the data analysis was to suggest, has the potential to reinforce negative, racist stereotypes.

Another problem that became apparent was that the participants, all of whom worked in health or welfare using their bilingual skills, wanted more funding, improved access, and cultural equity for the groups with whom they worked. Clearly, it became politically expedient for participants in this research to offer as much cultural information as possible in the hope that the research recommendations would benefit older people from non-English-speaking backgrounds. Therefore, while it is culturally insensitive and inappropriate to represent groups in a way that assumes homogeneity, it is politically expedient, given finite health-care resources, for the participants to speak in representational tones if they perceive a benefit.

The Politics of Comparison

Considering the potential for conflict between highlighting difference and the politics of comparison, the researcher can find herself in a very powerful and thus political position. Given that cross-cultural comparisons can lend themselves to racist interpretations, the researcher must make some very clear, principled and ethical, methodological decisions about data interpretation.

I realized that my data represented some powerful beliefs and emotions. Clearly, dementia was a very evocative subject for all people in this research. However, the cultural constructions of dementia varied considerably across the sample of people interviewed. Dementia was variously articulated as "dotage," "madness," "payback," "craziness," and "second childhood." Those who spoke of dementia in a negative

sense articulated a complex web of emotions and actions that manifested in various notions of shame.

Another notion that demonstrated cultural specificity was that of caring. For some groups, "caring" was the hands-on, day-to-day physical care carried out almost exclusively by women. Others stated that the men do the caring. When I delved into this subject it became obvious that caring by men was synonymous with making decisions on behalf of another, such as a parent making a decision on behalf of a child. When the participants were questioned further, they stated that the women do the hands-on work but did not articulate this as "caring."

The two above examples, outlining conflicting cultural constructions of dementia and caring, point to the potential for difficulties inherent in cross-cultural comparative research. Where there exists the possibility of perceiving something in a negative light – for example, dementia as madness associated with shame and stigma – the researcher must address the issue in a way that does not reinforce old stereotypes or create new ones.

Towards a Pragmatic Approach

A possible solution to my methodological problem was discovered in a rereading of my original aims and objectives. The principal aim of the project was to recommend ways to enhance culturally sensitive nursing care. To do so I would have to look for common themes or convergences in the data, which could be possible sites of service provision. Differences would not need to be highlighted; thus the possibility of harmful comparison would be reduced.

I arranged my findings under two broad headings: "benign" and "malign" constructions of dementia. As is normal in qualitative research, I included quotes from the transcripts to help to clarify the findings. However, I omitted the source of the quote. The reader therefore had no knowledge of the cultural origins of the speaker and thus could not attribute either benign or malign constructions of dementia to any one group of people. The decision to present data in this way was supported by the finding that all groups, however they constructed dementia, experienced great difficulty in relinquishing care of their loved one.

In choosing to arrange my data in this way I realized that one aspect of rigour in qualitative research, that of external validity, would be compromised. However, although the reader would not be able to

identify the speaker, data was presented in such a way that the speaker could immediately identify his or her own comments. This notion of subjects being able to find themselves in a final report enhances the credibility of the research. Credibility is also enhanced if the reader can identify real issues raised in the report and follow the decision trail made by the researcher (Koch, 1994).

By approaching the research findings in this way, I deliberately chose to forsake reader interest in the specific details of the findings for a more general overview. In making this decision I realized that I would not be able to use a large amount of the data that I had collected. However, I felt that I could still fulfil the aims of the project, maintaining some of the aspects of rigour involved in qualitative research yet knowing that I was not personally compromised and that I had not compromised the integrity of the participants in any way.

Conclusion

This paper has presented of some of the dilemmas I encountered when I set out to do cross-cultural research on dementia. The major difficulty for me has been how to acknowledge difference while at the same time being aware of the politics of comparison. This work has shown that findings do not have to be written up in a comparative way. Nurse researchers can find alternative ways to present findings.

The research process is an inherently political one. All research is culturally specific (King, 1994). We must therefore acknowledge methodology and process as cultural constructions, with all their implications for cultural regulation and control. It is thus imperative that the research agenda acknowledge the political nature of the research, particularly if, as I have demonstrated, the research is cross-cultural.

The outcomes of this project highlight the inadequacy of the operational definition of culture with which I started and which guides policy. It has become obvious that if culture is seen as synonymous with language then the way to break down cross-cultural barriers is to use interpreters. A possible outcome of such an argument is that a language problem has the potential to be interpreted as a cultural problem. The conclusion to such an argument is that a person's culture is to blame for any misunderstanding.

Finally, I suggest that there exists a hegemonic culture to which both I as the researcher and all the participants alluded. Although all participants did express particular cultural views of dementia, they simultaneously acknowledged the Anglo-Celtic view as the dominant

view, and the view that attracted government funding. It was therefore expedient for them to participate in the research process – so that their communities would benefit from funding.

This paper hints at just some of the ideological and conceptual difficulties that confront any person wishing to undertake cross-cultural research. I have proposed one way of writing up research findings that is sensitive to the wishes of the participants whilst simultaneously fulfilling the aims of the funding body. The challenge in cross-cultural research lies in acknowledging the fact that research is political, and then using data in a way that can produce benefits whilst not compromising the cultural integrity of the participants.

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Acknowledgement

Designer's Corner

The Politics of Feminist Ethnography

Anne Williams

To preface *ethnography* with the word *feminist* is to point out that ethnography (in feminist interviewing, survey research, or other "feminist" research approaches) cannot be conceived of as simply method or technique. Rather, *feminist ethnography* implies a political position in relation to the production of knowledge, which has come to be associated with certain principles.

Feminists invite people to understand and know the world in ways other than through the rigid, unilinear approaches of conventional social science (Smith, 1988). Secondly, feminist researchers are committed to ways of knowing that avoid subordinating their subjects (Ramazanoglu, 1992). Thirdly, feminist writers acknowledge the importance of conveying the complexities of people's lives (Stanley & Wise, 1993). Indeed, how these complexities are understood, by those experiencing them, lies at the heart of knowledge production (Stanley, 1990, 1991).

Designing feminist ethnography (or other feminist research) is not, therefore, simply a matter of following a set of either positivistic or interpretivist conventions in relation to sampling, data collection, and data analysis in order to establish the validity of the knowledge produced (although I would not want to diminish the importance of this "technical" aspect of the research). It is also, and most importantly, a political matter: how principles are put into practice, and for what purposes. In this paper I shall consider issues that arise from putting principles into ethnographic practice, bearing in mind that not all feminists would feel bound by each principle I have cited and that there is great diversity in the approaches taken by feminist ethnographers (Williams, 1993).

Anne Williams, R.G.N., R.M., B.A., M.A., Ph.D., is Senior Lecturer in the School of Nursing at the University of Manchester, England.

Ways of Understanding and Knowing

Social scientists have tended to draw boundaries between the world of scientific theorizing and the world of everyday life (e.g., Berger & Luckmann, 1973; Garfinkel, 1967; Shutz, 1973), often concentrating on the former. And we should not assume that ethnography is necessarily a challenge to the emphasis of conventional social science on ideas about objectivity, neutrality, and the construction of a hierarchy of knowledge. Radical ethnographers (e.g., Clifford & Marcus, 1986; Geertz, 1988; Rabinow, 1977; Said, 1978) have questioned the extent to which an ethnographic text reflects the reality of a field of study, and they usefully demonstrate that ethnographic writing, in constructing "the other" (meaning research subjects), also constructs the ethnographer's "self" or "selves." However, what they have failed to recognize is that in the process they also construct distinct boundaries between researcher and researched that emphasize the differences between, on the one hand, analytic or professional knowledge and theorizing, and, on the other hand, lay knowledge and everyday theorizing (see Williams, 1991, for a fuller discussion of this point).

Feminist challenges to conventional ways of understanding and knowing range from what Harding (1993) describes as spontaneous feminist empiricism to feminist-standpoint theory. Empiricists "think that insufficient care and rigour in following existing methods and norms is the cause of sexist and androcentric results in research" (p. 52), and they aim to improve the rigour in existing research methods. Standpoint theorists, as exemplified by feminists such as Smith (1988), "propose and formulate a sociology from the standpoint of women and follow through its implications for research" (p. 1). This latter approach offers a strong critique of so-called radical alternatives to orthodox ways of knowing the world.

Smith is concerned with preserving the presence of subjects in research, as knowers and actors (1988, p. 105). She writes that "the development of a feminist method has to go beyond our interviewing practices and our research relationships in order to explore methods of thinking that will organise our enquiry," and she calls for ways of writing our texts that preserve the presence of actual subjects (p. 111).

Smith goes on to demonstrate how such research might be designed, and she includes in her discussion the example of how an ethnography might be designed from her own experience as a single parent. This ethnography, she says, would be part of a complex of women's experiences (a number of ethnographies), which when pieced

together would provide an analysis of the organization and relations of "women at work as mothers in relation to children's schooling" (1988, p. 202). In so doing, Smith breaks down the boundaries constructed by orthodox and more radical ethnographers between, on the one hand, analytic or professional academic knowledge, and, on the other hand, lay knowledge (chapters 4 and 5).

Avoiding the Subordination of Subjects

While the focus on a women's perspective is a clear challenge to conventional boundaries set between researcher and researched and between professional and lay knowledges, it has brought the criticism that feminist research is ethnocentric. Harding (1993) responds to this criticism by making the point that those who claim to have produced "universally valid beliefs – principles of ethics, of human nature, epistemologies and philosophies of science – are ethnocentric"(p. 60). Ethnocentrism is a function of the dominant class, which sets the standards (p. 60). The implication is that standpoint theory, insofar as it conceives itself to be historical and changing, is not ethnocentric.

This may be so, but Stanley and Wise (1993, p. 7) write that there is a contradiction in feminist social science:

> On the one hand feminist social science proclaimed its egalitarian impulse, but on the other it seemingly welcomed a very traditional and elitist notion of "us," the theorising and researching elite (feminists), and "them," the experiencing researched (women).

Moreover, they argue that feminists have assumed

> the existence of a single and unitary "Women" and ignored – or rather silenced – those who were not white, middle class, heterosexual, first world, able bodied, young... (Stanley & Wise 1993, p. 3)

Ahmad (1993) addresses such silencing in relation to the exclusion of black women by U.K. feminist health-care researchers. Ahmad uses the word *black* in its political sense, and he makes the point that exclusion of the experiences of black women fosters an "intellectual apartheid" (p. 27) insofar as the health needs of minority groups are interpreted by a white elite. The message conveyed by black feminist and other writers is that the experiences of minority groups should be reinterpreted through black perpectives. However, this approach is not problem-free, as Wheeler (1994) shows in relation to the in-depth interviews she conducted in her study of the mental health of women recently discharged from hospital. Wheeler points out instances "when being a black researcher is not enough"(p. 55). She notes that while she

could empathize with those she was researching, she could offer little practical help to the people actually participating in the research. While she took a political-action research stand and was able to lobby for changes in the provision of mental-health services for black women, she felt "powerless" to help individuals who had shown her kindness during the course of the research (p. 56).

Wheeler's words reflect the irony of power in researcher-researched relationships. On the one hand, researchers set research agendas and they have the skills to persuade policy-makers of the significance of their research. On the other hand, they are never simply researchers. Their engagement with the people they encounter in research is complex. Researchers may also be women – black women, white women, sometimes nurses – all of whom, in common with their "subjects," are constrained by socioeconomic factors and what they can actually do to help the people who participate in their projects.

Acknowledging Complexities

Acknowledging and conveying the complexities of people's lives presents a challenge. Crenshaw (1994, pp. 39-52) observes that it is difficult to analyse the multidimensionality of black women's experiences within a single-axis analysis. She is referring to the absence of patriarchy and gender in anti-racist analyses and to the absence of race in feminist analyses. In a similar vein, Maynard (1994) observes that "whiteness is not seen as a racial identity" and that it is thus not problematized (p. 21). She writes:

> It is important to look at the taken-for-granted everydayness of white privilege, as well as the circumstances in which it is more directly expressed. Also significant in this context is the process of unravelling what the term "white" actually means, for it is by no means a homogeneous category. (p. 21)

Analyses that take complexity into account can be applied across researcher-researched boundaries. Wheeler (1994) goes some way towards attempting this. The account of her relationships with her interviewees suggests the various ways in which researchers encounter their subjects. Wheeler encountered the black women she interviewed as a researcher, as a woman, and – importantly – as a black woman. Conventionally, these aspects of self (if a researcher's self is acknowledged at all) are subsumed under the category "researcher."

A sense of complexity in written accounts can be communicated in works that focus on the textual analyses of ethnographies. Smith (1988),

who in the research cited earlier is aware of her role as mother as well as researcher, acknowledges her similarities with those she encounters as well as their differences. Her recognition that she does not relate to the subjects of her research as simply researcher to researched (but also, in this case, as woman to woman and mother to mother) underlines the complexity of research encounters; she portrays the women she encounters as having an active and equally complex presence in the research.

Stanley (1987, 1990, 1991) is also concerned to show that women who are the subject of her research are "active," in the sense that they share with her the ability to theorize about their lives. It is not simply that Stanley theorizes as an academic while the women she encounters theorize as lay people. In certain circumstances this may be the case, but not always. In my own ethnographic research (Williams, 1990, 1991) I have found that those I encounter as "subjects" (but who are colleagues insofar as I am a nurse as well as an ethnographer) share with me the ability to theorize about nursing and other aspects of their lives. Indeed I can never be certain that those I encounter as "subjects" do not include ethnographers doing an ethnography in which I am "subject" (1990, p. 46).

It is tempting to focus on the common experiences of women at the expense of recognizing differences and diversity. Maynard (1994) calls for an exploration of how unity and difference in relation to women's lives are implied in and experienced through each other (p. 21). Certainly taking both unity and difference into account in feminist ethnographic practice allows for a departure from "unilinear" (Smith, 1988) or "single axis" (Crenshaw, 1994) modes of analysis, which tend to subordinate views of and experiences of minority groups and thus to create a hierarchy of experiences and knowledge.

For example, within the field of women's health there is a call for justice in the provision of health care. However, justice is experienced differently, according to whether one is a black woman or a white woman (Anderson, 1991; Anderson, Blue, Holbrook, & Ng, 1993; Bryan, Dadzie, & Scafe, 1988; Davis, 1984, 1988). And even these categories are not homogeneous. Further factors add to the complexity of women's experiences of health, among them age, class, employment status, and geography. These and other socioeconomic factors that affect how women experience health care (Anderson) must be taken into account in ethnographic practice (and indeed in nursing practice), so that the experiences of a minority are not subordinated to those of the majority

and silenced, or relegated to the bottom of a hierarchy of knowledge about women's health needs.

Conclusion

I took as my starting point principles drawn from the work of feminist ethnographers and other writers in order to consider how they might be put into practice – in short, to elucidate the politics of feminist ethnography.

I have offered only a glimpse of the challenge of putting principles into practice. Clearly, there are diverse ways of implementing these principles, for feminist ethnography is far from a homogeneous enterprise. There are also problems. For example, from one perspective I might accept the fact that knowing the world in ways other than those offered by conventional social science avoids subordinating research subjects. However, while I am concerned that my ethnographic practice should not favour scientific knowledge over lay knowledge, I could argue that the women in my research would be best served by "scientific" research that presents the "facts" of, for example, discriminatory practices in access to health care (see Jayaratne, 1983; Kelly, 1978, for similar arguments).

However, from my experiences as a nurse and as an ethnographer, I know something of the complexities of women's lives and women's health needs, and strive for analyses that take very seriously the understandings of both the researcher and the researched. I seek to design research that allows for the exploration of differences while recognizing the importance of similarities of experience, and I seek to produce knowledge that conveys something of the complexities of life and health needs as understood by those experiencing them.

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Discourse

Knowledge, Politics, Culture, and Gender: A Discourse Perspective

David G. Allen

In this short analysis, I want to discuss (a) a view of cultures and bodies as created within discourses and (b) the potential relationship between that creation and oppression. My main point is that the categories of "culture" and "gender" and their instances (Hmong, woman) are not theory neutral "descriptors" but theory-laden constructs inseparable from systems of injustice. We need to be very careful how we use them. Space constraints mean I'll only be able to indicate, not provide, supportive arguments.

Neither "culture" nor "gender" is an "object": there is no such "thing" as a culture. Nor are they independent variables. There is no such thing as a gender that is not already cultured. One is never a "man" and then an "Irish" man; one is an Irishman. To be an African American woman is not to be one thing, nor is it to be the same thing as a Chinese American woman. It's not possible to subtract African Americanness and Chineseness and end up with a generic "woman." Nor are there any cultures which are not already gendered. This is particularly obvious in cultures which use gendered articles ("el," "la"). But feminist scholarship has increasingly demonstrated the "gendered" nature of cultural positions such as "person" or "citizen" (Pateman, 1989; Young, 1990).

I'll start my discussion with culture because it has been less "naturalized" than "gender" (i.e., culture is not assumed to be organized around non-cultural, "natural," or "biological" reality such as "the body").

David G. Allen, R.N., Ph.D., is Professor and Chair of the Department of Psychosocial and Community Health at the University of Washington, Seattle, Washington.

Cultures and cultural differences are not "discovered," they are *constructed* in the process of doing something else (Clifford & Marcus, 1986). A salient example is the current struggle over "American" or "family" values. This is not a struggle to "recover" or "decontaminate" a "lost" culture. It is a struggle to create one. And the struggle itself is as much a part of the culture that is created as the values around which the culture is organized. Ours is the sort of culture that has conflicts about what "counts" as "truly American" (McLaren, 1995). Culture is thus "written" (or spoken or imaged), created through these discursive acts. (By "discursive" I mean a series of conversations or texts that are organized around a similar topic or discursive object. Thus there are liberal, conservative, Russian, and Palestinian conversations that construct – differently – American culture. In this sense, "American culture" is a discursive object – the object of multiple discourses.)

These discourses within which a particular culture is constructed arise from different perspectives and have different purposes. Consequently, the representation of the culture varies. A frequent goal of the process is creating cultural identity as a means to a political end (e.g., unifying divergent perspectives; clarifying who has access to certain resources; creating a positive identity for group members) (Mohanty, 1992). Other goals include creating generalizations that facilitate talking or working across "differences." These are the goals that we see most often in the nursing literature as people attempt to identify meanings that are generally held by, say, Thai people, and have contributed to misunderstandings or conflict when care is provided by European Americans.

There are several problems, and many strengths, in such analyses of "cultural differences." But my focus is on conceptual and epistemological concerns. Conceptually, such analyses tend, of course, to be stereotypes or over-generalizations. They also tend to be ahistorical. They are "essentialist" in that they tend to portray each cultural position as a homogeneous set of relatively fixed characteristics (necessary and sufficient conditions for correctly characterizing a particular cultural configuration as "Thai"). This becomes most problematic when it is then applied as a taxonomy to individuals: "He's not really Thai."

More importantly, in the U.S. nursing literature they are almost always defined against an implicit "norm" that is European American (West, 1990). Description is always implicit comparison: one is saying, in effect, that the "X is *like* Y or *unlike* Z." And description is always perspectival (Rorty, 1979). What is described depends on the position from which it is viewed. What might be background (or unimportant)

from one perspective is foreground (or salient) from another. Since there is an infinite number of possible viewpoints, there is no such thing as a "complete" description. Thus the comparative and perspectival nature of discourses about any particular culture is inescapable. This should not be interpreted as meaning such discourses are always "biased." "Bias" and "perspective" are synonymous *only* within an objectivist, foundationalist metaphysic that supposes some "god's eye" view that sees everything from nowhere in particular is possible. A perspective *may* be biased because it ignores counter-evidence it would normally accept but it certainly need not be (Bernstein, 1988).

The perspectival nature of discourse about a culture is only problematic when it is obscured or denied within a narrative style that is objectivist or "scientific" in the neopositivist sense. Such objectivist discourses almost always fail to acknowledge that the "background" against which features are being "picked out" is the writer's own cultural context and particular purposes (Chandler, Davidson, & Harootunian, 1994). One can imagine that a "transcultural nurse" in China might pick out quite different features in describing Thai culture from an American nurse working in a shelter for abused women. And the features of Inuit culture that might be relevant from the perspective of planning childbirth services may be different from those that are relevant for planning substance-abuse services. These different discourses would construct different "Inuit cultures." This is not a problem. The problem is in not being explicit about the "standpoint" from which one is "writing" Thai or Inuit culture.

The problem of not being explicit becomes more serious when the writer is from a cultural position that has exploited or colonized the culture being written about. Please note that this is not an attribution about individuals, but about cultural positioning. I have not individually (at least not intentionally) participated in the colonization of Guatemala. But the United States (following Spain) certainly has. So if I study Guatemala, I do so carrying with me cultural assumptions that are not merely *different* from, but potentially *exploitive* of, Guatemalan culture. Consequently, there is considerable turmoil about whether the anthropological project, born of European colonial interests, can ever serve the interests of a colonized people (Bhabha, 1994; Marchand & Parpart, 1995; Patai, 1991; Stacey, 1991). There are, of course, similar concerns about European Americans studying African Americans or men studying women (Collins, 1990).

The epistemological problem is that these understandings of culture are based on an unexamined philosophical realism that assumes

a culture is a "thing" that pre-exists its description and that ethnographers are simply "mirroring" (more or less well) the cultural entity. However, "culture is not a static object of analysis but a multiplicity of negotiated realities within historically contextualized (and contested) communicative processes" (Salazar, 1991, p. 98). Interestingly, at least in U.S. nursing literature, many of these researchers hold self-avowed "constructionist" perspectives while writing as if the culture they are "representing" is an objective phenomenon. Thus they tend to under-theorize the framework from within which they are "describing" the culture.

A key point is that writing culture is a definitional act and, as such, always creates an "other, " an "outsider," a "not us." This "other," then, is *defined* in relationship to the first position; this sets up a binary (us/them) in which the first term is privileged (i.e., in a descriptive sense it "sets the terms") and is often hierarchically located as superior, preferential, etc. (Said, 1978).

Another, empirical and political, problem with such descriptions is that in the nursing literature they tend to be nationalistic. Ethnic/cultural locations very often "happen" to be written within vocabularies of nationalist boundaries. My own examples (e.g., Chinese, Thai, etc.) have done this. Almost all current "nations" are, of course, colonialist creations. Even those that have had successful anticolonialist revolutions often stay mired in the binaries of nationalistic identities that are the mirror image of the colonialist project they attempted to purge (Said, 1993).

To conclude about culture: my two main points are that (1) culture is created, not discovered, and (2) when the standpoint from which it is created is inadequately articulated, the result is likely to participate in various forms of colonialist appropriations.

Gender

The discourse around gender is somewhat easier to address, because the term "gender" was created to detach the social construction of sexual identities from the "real" biological differences of sex. There are three points I'd like to emphasize with respect to gender: (1) genders are not binary: any time we sort folks into two kinds (male/female, masculine/feminine, men/women) we are really talking sex, not gender; (2) the "body" is as much a cultural construction as "gender"; and (3) gender is always cultured.

My discussion of gender is linked to my discussion of culture in several ways. I can capture my main theme by saying "demographic categories" are theory-laden, not simply "descriptive," and they are not politically neutral (Mohanty, 1991). Thus I believe we need to be much more theoretically self-conscious about how we employ these categories in our theory, research, and practice (Allen, Allman, & Powers, 1991). Whenever one uses a social category that is *also* employed as a mechanism of social injustice, one is in danger of reproducing the conditions that perpetuate injustice. For example, the U.S. culture employs categories such as "gender" or "race" to privilege or restrict access to important cultural resources and opportunities (e.g., jobs, salaries, cultural authority, mortgages, housing). These categories operate ideologically in the sense that they become internalized into ways we think about other people (e.g., what we "expect") and ourselves (e.g., what we desire, our self-concepts). Consequently, when one thinks of *oneself* as a "man," one thinks in terms that are complicit with (but also escape, go beyond) sexism. When I identify my students or research participants as "women" or "African American" or "American Indian" I am using a social theory that these are "basic units of analysis."

And they are. But one reason they are is society itself uses them to structure opportunity and privilege. Often, however, people think "gender" is "basic" because it is grounded in a biological reality. This marks "gender" (and "race") as a different sort of demographic marker from "culture" or "ethnicity," because it presumes the former are "secured" by the natural order of things while the latter are secured by history and society.

I believe this conceptualization of gender is misleading in ways that are analogous to the way thinking of culture as a "thing" is misleading. In the short space I have here, I can briefly trace but one line of argument to suggest the concerns I have and a way out of them. I suggest we think of bodies (e.g., sex) as social objects, *not* "natural" (pre-social, "real").

Three lines of reasoning can help free us from this biologism. First, whatever else bodies are, they are discursive objects in exactly the same sense that cultures are (Jacobus, Keller, & Shuttleworth, 1990; Smith, 1990; Turner, 1984) . We have numerous cultural conversations that construct the "body" in multiple ways. Biological conversations are only one set, although they are culturally privileged. There are fashion, fitness, penal, educational, and a host of other cultural discourses about bodies (Coward, 1985). But I'll stay with the biological because it has

the most ideological hold on us, since we think it's not our conversation, but nature's own.

Second, biological taxonomies are theoretical, conventional, pragmatic ordering systems. They are internally inconsistent and historically and theoretically variable (Diprose & Ferrel, 1991; Lewontin,1994; Martin, 1994). Think, for example, about the assumptions behind assuming that "skin" marks off a "body" from its "environment," despite the fact this border is transitory (since we shed it regularly), permeable, and arbitrary (why not set the border in thermal terms?). Skin is a practical boundary only for certain purposes; for others it is irrelevant. Virtually no internally consistent biological taxonomic system, for example, sorts human bodies into only two sexes. Chromosomes don't. There are XXY, XYY, and a host of variations. Possession or non-possession of uteral tissue does not. External genitalia do not. And social taxonomies are even more multiple and overlapping (hence we wonder if gays or quiche-eaters are "real men") (Jaggar & Bordo, 1989).

Third, the body is always already cultural and historical (Oudshoorn, 1994; Turner, 1984). The differentiating of bodies increasingly starts before birth through technological identification of sex that immediately creates a different context for male and female fetuses. Once a child is born, social shaping of its body increases in intensity. Thinking this way requires us to take "seriously the ways in which diet, environment and the typical activities of a body may vary historically and create its capacities, its desires and its actual material form...the typical spheres of movement of men and women and their respective activities construct and recreate particular kinds of body to perform particular kinds of task" (Gatens, 1992, p. 130). There are no bodies (or organs) that are not already shaped by their cultural context.

To summarize, our descriptions of "culture" and "gender" are always perspectival social constructions. They always depend upon a host of theoretical assumptions and not upon some guarantee of correspondence to a "real" world independent of our conversations about it. And since these demographic categories are always already taken up by, created in, systems of injustice, we need to be extraordinarily careful not to supply further support for these systems by unintentionally reproducing ideological discourses under assumptions of descriptive neutrality.

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A Struggle for Equality: Resistance to Commissioning of Male Nurses in the Canadian Military, 1952-1967

Dean Care, David Gregory, John English, and Peri Venkatesh

On a effectué une recherche d'un point de vue historique dans le but d'explorer et de décrire les forces d'opposition à l'emploi d'infirmiers et à leur obtention du grade d'officier dans la division des soins infirmiers des forces armées canadiennes. Avant 1967, seules les infirmières pouvaient s'engager dans la division des soins infirmiers de l'armée canadienne. Il fallut une lutte d'un quart de siècle, menée par la Registered Nurses Association of Ontario (RNAO), le Comité des infirmiers (CI) de la RNAO et l'Association des infirmières et infirmiers du Canada (AIIC) pour modifier cette politique discriminatoire de l'armée. Grâce à l'unité qu'ont manifesté le CI, la RNAO et l'AIIC, la lutte pour l'égalité en faveur des infirmiers canadiens a abouti. L'étude montre également qu'il faut aller au-delà des perspectives matriarcales de l'histoire concernant les soins infirmiers pour comprendre plus globalement l'évolution de la profession au Canada.

Historical research was conducted to explore and describe the forces of resistance that prevented male registered nurses from being employed and conferred officer status in the Nursing Division of the Canadian military. Prior to 1967, only female nurses were permitted to join the Nursing Division. A 25-year struggle by the Registered Nurses Association of Ontario (RNAO), its Male Nurses Committee (MNC), and the Canadian Nurses Association (CNA) was required to change this discriminatory policy. The struggle for equality on behalf of Canadian male nurses was successfully resolved because of the united stand taken by the MNC, the RNAO, and the CNA. The study also demonstrates the need to move beyond matriarchal history perspectives in nursing to more completely understand the evolution of the profession in Canada.

Historical exotica, such as the Crusades, often serve as the focus for discussions about the history of men in nursing (Larsen & George, 1992). The relevancy of this history for the Canadian context is remote; accounts of men in nursing are briefly mentioned in the literature

Dean Care, R.N., Ed.D., is Coordinator, Educational Services, St. Boniface General Hospital, Winnipeg, Manitoba. David Gregory, R.N., Ph.D., is Associate Professor in the Faculty of Nursing, University of Manitoba, Winnipeg. John English, R.N., M.H.Sc., is Associate Professor in the Department of Nursing and Health Studies, Brandon University, Brandon, Manitoba. Peri Venkatesh, R.N., M.N., is Assistant Vice-President, Education Services, Misericordia General Hospital, Winnipeg, Manitoba.

(Larsen & George; MacPhail, 1991; Okrainec, 1990), but historical research on Canadian men in nursing is virtually nonexistent. Rigorous investigation will help us more fully understand the history of men in nursing and the evolution of the profession in Canada. In this paper, the authors report on a systematic inquiry into male nursing in the Canadian military between the years 1952 and 1967.

During the period 1945-1965, Canadian men and women generally assumed social roles and pursued careers based on gender. For example, engineering and medicine were virtually male bastions, while nursing was overwhelmingly the domain of women. In 1951, only 138 registered nurses in Canada, or 0.33%, were men (Canadian Nurses Association, 1960). By 1966, the number of male nurses had marginally increased, to 372, or 0.45% of all Canadian nurses (MacPhail, 1991). Systemic societal barriers to occupational gender equity were evident during this post-war period; men and women who attempted to challenge occupational mores often met with resistance.

The following examples illustrate the resistance to accepting men in nursing during the 1950s and 1960s. This resistance was apparent both within and outside the profession. A study by Robson (cited in Okrainec, 1990) showed that out of 170 Canadian schools of nursing only 25, or 14.7%, accepted male applicants during the early 1960s. Robson suggested that men were refused admission because schools lacked appropriate residential accommodations. However, resistance to men in nursing must be seen in the context within which the nursing profession was situated. Evidence suggests that the few men admitted as students were often excluded from particular areas of nursing, such as obstetrics.[1] Male nursing students, by virtue of their presence, challenged gender-based roles. Limitations were placed on their learning experiences, however, and they were not permitted to function as fully fledged nursing students.

Practice restrictions were also imposed on male nurses. Prior to 1969, men were not permitted to register as nurses with the Association of Nurses of the Province of Quebec (Desjardins, 1971). When the Association endeavoured, in 1946, to have men legally admitted to the profession the move was blocked in the Quebec Upper House, one senator commenting that it was "immoral" to have men working under the supervision of female nurses in hospitals.[2] It was not until December 1969 that Bill 89 ("An Act to amend the Nurses Act") received assent by the National Assembly of Quebec. The amendment permitted male nurses to register as full members in the provincial nursing association for the first time since its inception in 1920. Nursing

care in Quebec was traditionally provided by female religious orders. The influence of these orders, combined with legislation reflecting societal views on gender-appropriate roles, had effectively kept men out of nursing for 49 years.

The Canadian military was also affected. Before 1967, male registered nurses could not join the Nursing Division of the Canadian Armed Forces. Attempts to challenge this policy serve as a case study in the struggle to achieve equality within the nursing profession and are the focus of this historical investigation.

Resistance to Males:
The Nursing Division of the Canadian Armed Forces

Within the Nursing Division, female registered nurses were given nursing officer status, while male registered nurses worked as non-commissioned officers – as X-ray technicians, medics, or in other allied health-care positions. An applicant to the Nursing Division had to "be a registered nurse and a current member of a provincial registered nurses' association. Male nurses [were] not eligible for enrollment in this branch."[3] The only military career option available to them was in the Medical Administration Branch, where they could work towards a commission as registered nurses. Male nurses holding officer status in this branch, however, were not "nursing officers"; they served as administrators rather than practising nurses.

The authors explored efforts made by the Male Nurses Committee (MNC) of the Registered Nurses Association of Ontario (RNAO), as well as the Canadian Nurses Association (CNA), to change this discriminatory policy. The purpose of our study was to investigate the forces of resistance that prevented male nurses from achieving commissioned officer status in the Canadian military prior to 1967. Two research questions guided this study:

1. How was resistance toward male registered nurses in the Canadian military manifested during the years 1952-1967?
2. What actions were taken by the MNC of the RNAO and by the CNA to overcome this resistance?

Primary and secondary archival materials[4,5,6,7,8,9] and an interview with a key informant[10] served to bring to life the involvement of the CNA, the RNAO, and the MNC in this issue. The struggle for equality in the Nursing Division unfolded in three distinct time periods spanning 25 years and was characterized by an ebb and flow in movement toward resolution of this issue.

Male Nurses and the Military: The Issue Surfaces in 1942, 1952-1953

In 1942 the RNAO began to bring about a policy change in the Department of National Defence whereby only female registered nurses were commissioned in the Nursing Division of the Canadian Armed Forces.[11] This issue first appeared in the Executive Committee minutes of the CNA dated June 2, 1952. Members of the Executive Committee discussed the fact that "Medical Services refus[ed] to enroll male registered nurses as nursing officers" (p. 6). Some Committee members who had served overseas during World War II stated that there were many cases in which the services of a male nurse was required. Alice Wright put forward the following motion:

> THAT the In-Service Medical Committee, Department of National Defence, be asked to reconsider present policy in respect to male registered nurses, and that the request be implemented in the most effective manner possible.[12]

It was decided that a delegation of former nursing sisters would present this request, in person, to the In-Service Medical Committee. However, Marjorie Russell, Edith Dick, and Gladys Sharpe, the delegates, were unable to secure a meeting with officials of the defence department. No explanation was given in subsequent minutes to account for the delegation's lack of progress.

Agnes Macleod, CNA Representative on the Department of Defence Medical and Dental Services Advisory Board, was then requested to seek the advice of the Chair of the Board on how to "deal with this matter and report back to the National Office." Miss Macleod agreed to do so; however, the outcome of her efforts is not known. There does not appear to be any mention of this issue within the CNA until 1966, when the RNAO put forth a resolution at a CNA annual general meeting requesting that Canadian nurses exert pressure to bring about a change in the discriminatory policy of the Department of National Defence.

The Male Nurses Committee of the RNAO: 1956-1963

On April 14, 1956, the RNAO Board of Directors approved the formation of a Male Nurses Committee (MNC). Albert Wedgery was elected its first Chair. The Committee dealt with many issues related to male nurses (e.g., recruitment of men into the profession, different educational content for male and female nursing students, and use of only feminine pronouns in the RNAO by-laws and its publications[13]). It also sought to reverse the military policy preventing male nurses from

becoming commissioned officers in the Nursing Division of the Canadian Armed Forces.

The MNC received a letter from Corporal John Bell, a registered nurse with the Royal Canadian Army Medical Core (RCAMC), inquiring about the status of male registered nurses in the Armed Forces. It is interesting that Corporal Bell approached the MNC rather then the military, possibly to protect himself from repercussions such as censorship. After discussion by members of the MNC it was moved

> That the committee recommend that the RNAO Board of Directors request the CNA to make representation to the proper authorities regarding male registered nurses in the armed services having equal rank with female nurses; and, That they be assigned duties for which their training has fitted them.[14]

No RNAO records were located to account for how this MNC motion was implemented by the RNAO Board of Directors. Mr. Wedgery reported that correspondence from Florence Walker (Executive Secretary, RNAO), Pearl Stiver (General Secretary, CNA), and Brigadier Tremblay suggested that the armed services employed male nurses to the best advantage of the military. Mr. Wedgery stated that while he understood this position he did not agree with it.[15] At the next meeting of the MNC (September 12, 1959), the issue was reviewed again and tabled until a later date.

Eight months later, Flight Officer John Scholes, Royal Canadian Air Force, Medical Administration Branch, attended an MNC meeting and addressed the issue of status of registered male nurses in the Nursing Division. It was Flying Officer Scholes's opinion that

> the continuance of the policy handed down from the Director General of Medical Services, Canadian Armed Forces, was a slur on the nursing profession in that both male and female nurses enjoy equal recognition in ordinary nursing employment. The present utilization of registered male nurses in the Armed Forces not only shows professional discrimination but also fails to assign male nurses to duties for which they have been trained.[16]

A registered nurse and a commissioned officer in the Administration Branch, Flying Officer Scholes was concerned that qualified men were working at a non-professional level in the military while full advantage was not being taken of their training. He suggested that the time was right to press for change, given the following: the amalgamation of Medical Services in the Armed Forces was in a transition stage, a new Director General of the Canadian Forces Medical Services had recently been appointed, and there appeared to be sufficient support among

medical personnel to justify a review of the matter at the federal level. At this same meeting, members of the MNC put forth the following motion:

> That the Board of Directors [RNAO] request the Canadian Nurses Association to arrange a joint interview between the four Matrons-In-Chief of the Canadian Forces Medical Services and representatives of the Male Nurses Committee to explore further the matter of commissioning registered male nurses in the Armed Forces.[17]

In February 1961 the MNC received a letter from Miss Walker, RNAO Executive Secretary, regarding this motion. RNAO and CNA agreed that arrangements for this interview would be made at a later date. "It was the committee's [the MNC's] general feeling that something concrete had been accomplished and the results so far were encouraging."[18] However, this optimism was short-lived, as a letter dated April 13, 1961, to Miss Stiver (CNA) from T. B. McLean, Surgeon Rear Admiral, Surgeon General, Canadian Forces, communicated the military's perspective on this issue. It appears that his letter usurped the planned meeting with the Matrons-In-Chief. It contained the following points:

- the impracticality of opening the issue of commissions for male nurses at this stage in the integration of the Medical Services

- the existence of opportunities for male nurses as administrative medical officers in the RCAMC

- any interested candidates would not be involved directly in nursing duties.[19]

The MNC was not satisfied with this response, as the military did not provide clear reasons why male nurses could not be assigned the nursing duties for which they had been prepared.

At the April 1961 annual meeting of the RNAO, a resolution was passed that the issue be placed in the hands of the RNAO Board of Directors to "follow through as they see fit." Mr. Wedgery, who was now Secretary of the MNC, attended an RNAO Executive Committee meeting on June 14, 1961. He later reported that since this matter concerned all male nurses in Canada, the Executive Committee placed it on the agenda of the Executive Secretaries and Registrars meeting to be held in Ottawa in September 1961. "By determining the viewpoint of the other provincial nursing associations and attempting to gain dominion-wide support in this problem, it was felt that the RNAO would have a stronger argument to present to the federal authorities."[20]

Not only were these formal channels used, the MNC minutes revealed, but clandestine political activity occurred around this issue as

well. "Intercepted" private correspondence[21] was shared with members of the MNC at a meeting held on June 21, 1961, although identity of the male nurse who secured the correspondence was not divulged at the meeting.

1. A letter from Mr. Hazen Argue, National Leader of the CCF Party, to Mr. Pierre Sevigny, Associate Minister of National Defence, made reference to the desirability of awarding commissioned rank to male nurses, thus putting them on the same level as Nursing Sisters.

2. A letter from Mr. Gaston Levesque, Executive Assistant to the Minister of National Defence, in reply to Mr. Argue's letter. This letter stated the government's April 1961 decision to continue to restrict the Nursing Branch of the Armed Forces to female nurses. The factors cited were: influence on morale, the flexibility of employing unmarried Nursing Sisters, and the minimal cost of military training for Nursing Sisters. These factors were listed as determining the decision to continue to maintain a female nursing section.

3. A letter from W. H. Pope, Executive Assistant to Mr. Argue, replied to Mr. Sevigny and raised the following points: (a) some jobs in the nursing profession could be more suitably performed by men yet require the skill and training of a registered nurse, (b) the discontinuance of the present maintenance of registered male nurses in the subordinate status of medical orderlies or assistants, (c) while nursing sisters are not obliged to exercise powers of command over service personnel, they have all the prerogatives of rank accredited to male officers.[22]

Upon consideration of the above correspondence, members of the MNC put forth another motion requesting that the RNAO Executive Committee, through the CNA, take immediate steps to discuss this issue with the Minister of National Defence. They recommended that a member of the MNC be present at these discussions.

At the October 4, 1961, meeting of the MNC it was revealed that the meeting of the CNA Executive Secretaries and Registrars had not taken place as expected in September. However, the MNC pointed out that support would be sought at the CNA Executive Committee meeting in February 1962. At this same October 1961 meeting, a further item of correspondence "had been put at the Committee's disposal."[23] A letter from Gaston Levesque, Executive Assistant, Department of National Defence, in reply to a letter from W.H. Pope, Executive Assistant, House of Commons, identified points "noted as being significant in estimating the degree of resistance to any change in present regulations." The essence of these points was: (a) male nurses have opportunities for commissions in Medical Administration or in any branch they

choose, excluding the Nursing Branch; (b) only in very limited areas (such as rare emergency situations) can male nurses be more suitably employed than their female counterparts; and (c) a predominately female branch is desirable, despite the large turnover of female personnel due to marriage. Because of this turnover, Mr. Levesque suggested that male nurses would eventually accrue more seniority than female nurses, an unacceptable situation for a predominately female branch. Mr. Levesque's reasoning did not directly address the issue of why male registered nurses could not engage in direct patient care. The MNC judged that this policy was discriminatory and that it was not based on the proper use of service personnel.

Mr. Wedgery reported to the MNC that the provincial Executive Secretaries and Registrars held a meeting in Ottawa in February 1962.[24] A letter from Doris Gibney, CNA Assistant Executive Secretary, stated that members had been most sympathetic on the matter and "supported whole heartedly the principle of equal rights for all members of the CNA."[25] At the February meeting in Ottawa, Miss Stiver, CNA Executive Director, agreed to arrange a meeting between representatives of the MNC and the Surgeon General; members of the MNC decided that Mr. Wedgery should represent them.

On October 12, 1962, the long-anticipated meeting with the Deputy Surgeon General took place,[26] with nursing and military perspectives presented. The MNC outlined a series of pertinent arguments related to the employment of female and male nurses in the Armed Forces. The government's representatives, mainly Surgeon Commodore George Elliott, countered these arguments. According to Mr. Wedgery, the military "administrative machinery is geared to handle only female personnel and the introduction of male nurses on a commissioned basis would create undesired administrative problems."[27]He observed that the government agreed that the policy was discriminatory, but "the decision to restrict commissions to female nurses is deliberately designed to avoid the administrative problems, real or imagined, which male nurses would produce."[28] In conclusion, Mr. Wedgery stated that "the present policy is predicated on preserving an unbroken tradition, rather than on an exercise in judgment."[29] It was apparent that the military had a vested interest in preserving the status quo. "Any change in policy of the Department of National Defence towards the male registered nurse in the Armed Forces would come only as the result of pressure being exerted on it from outside, namely, through public opinion."[30] Peter H. C. du Domaine, a member of the MNC, expressed a need for widespread publicity about the military policy. Because the meeting with the Deputy Surgeon General proved unsuccessful, the

MNC recommended that the RNAO "continue its efforts to achieve a change in policy relating to male registered nurses being commissioned as nurses in the armed forces."[31]

According to records obtained from the RNAO, the last meeting of the MNC was held on March 6, 1963. It should be noted that at this meeting a motion to disband the MNC, although defeated, may explain why the Committee became inactive shortly thereafter. Another reason for its demise was probably Mr. Wedgery's decision to return to school to further his education. Attempts to locate additional data about MNC activities were unsuccessful.[32] It appears that the issue lay dormant between the years 1963 and 1966, since no other records obtained from the CNA or the RNAO made reference to this military policy.

The Issue Resolved: 1966-1967

At the CNA annual general meeting of July 4-8, 1966, Resolution V, "Male Nurses in Armed Forces," was submitted by the RNAO and moved by Eleanor Graham and Reverend Sister Gagnon. The motions read as follows:

> THAT: this convention go on record as directing the Canadian Nurses Association to meet with the Minister of National Defence to interpret in the strongest possible terms the attitude of nurses in this country toward the continued disregard of a basic Canadian principle in denying equal rights to all registered nurses seeking commissions as nursing officers in the Canadian Forces; and

> THAT: Canadian nurses exert the necessary pressure to bring about a change in this discriminatory policy of the Department of National Defence.

The resolution was passed unanimously. That same month, the CNA Executive Director, Helen K. Mussallem, met with the Associate Minister of National Defence, Léo Cadieux. The following accounts are based on an interview conducted with Dr. Helen Mussallem on December 5, 1994.

Dr. Mussallem was "called" to a meeting with Mr. Cadieux; the Surgeon General of Canada, Dr. George Elliott; and the Chief Nurse in the Armed Forces, Lieutenant Colonel Harriet Sloan. Dr. Mussallem described the setting:

> Léo Cadieux couldn't be more gracious. He greeted me and he said, "Now would you bring in your advisors." And I said, "Oh, I've just come alone." So alone I was. I remember sitting down with Dr. George

Elliott on my right and Hallie [Lt. Col. Sloan] on my left. George Elliott was seated behind a great stack of papers. I had just a very thin file.

The following exchange took place between Dr. Mussallem and Mr. Cadieux.

Mr. Cadieux asked me what I came for – or words to that effect. Holding out a printed sheet, I said, "This resolution has been passed by the membership of the Canadian Nurses Association." I explained what CNA was and how many members it represented. He had a copy of the resolution and asked me if I would like to read it. I said, "Yes, I would." So I read the whole resolution out to him. And he said, "Well, we are not in a position to comply with your request from CNA." I said, "Mr. Cadieux, I understand. What I will do is report to the CNA that you are discriminating against male nurses and I know that the Board of Directors will make this public knowledge." I knew that I had a strong case and that the CNA would be successful if I just played my cards right.

Discussion ensued between Mr. Cadieux, Dr. Elliott, Lieutenant Colonel Sloan, and other government officials at the meeting. Mr. Cadieux then asked Dr. Elliott, "Could we have one, two, or three male nurses?" Dr. Mussallem recalled that Dr. Elliott refused to consider this option. Mr. Cadieux then stated that the Armed Forces would permit six men to become commissioned officers within the nursing branch. Dr. Mussallem replied, "Oh, Monsieur Cadieux, that will not do. If I report to the Board, it will still be regarded as discrimination." The Associate Minister then stated, "This is the best we can do." As Dr. Mussallem left, she said, "I hope you reconsider your decision. Will you kindly convey your decision by letter to the Association?"

Mr. Cadieux's subsequent letter to the CNA did not mention a quota of six male nurses. Dr. Mussallem observed, "As I recall, the letter stated that a decision was made to have men as nursing officers in the Armed Services." The revised Canadian Forces Administrative Orders[33] outlined the following basic enrolment standards for commissioned officers employed as nurses:

[An] applicant must:

a. be a graduate of a school of nursing accredited by the Canadian Nurses Association; and

b. be currently registered by an officially recognized provincial registered nurses association.

In 1967, Lieutenant Roy D. Field became the first male Armed Forces nurse to receive officer status.[34] Although Lieutenant Field had been a nurse prior to his commission, he worked as an X-ray technician for

18 years. Mr. Wedgery, who was then serving as the first male President of the RNAO, applauded this change in military policy:

> The news that a number of male registered nurses are to be commissioned as nursing officers in the Canadian Armed Forces marks the end of a long and perplexing struggle for equal rights. It means that at last the knowledge and skills of professional male nurses will be properly utilized. Certainly this positive move by the Department of National Defence will be greeted with resounding approval by all nurses throughout Canada.[35]

Observations Regarding Resistance to Male Nurses in the Nursing Division

Throughout the period when the MNC, the RNAO, and the CNA challenged the policy against employing and commissioning male registered nurses in the Nursing Division, the Armed Forces failed to offer substantive justification for the policy. The military arguments were not reasonable (e.g., changing policy would be "impractical," or males had other routes within the branches of the Medical Services to become commissioned officers). Rejection of outsiders, conformity to norms, and protection of vested interests and cultural cohesion established the military as a distinct culture (Watson, 1969). Such forces of resistance contributed to the entrenchment of a discriminatory policy. Collectively, these forces were strong enough to resist a 25-year struggle for change on behalf of the nursing profession.

Systemic resistance (Watson, 1969) to employing men in the Nursing Division of the Armed Forces arose from the need to: (a) protect the vested interests of those who could lose status or position through the proposed change, (b) conform to a perception of societal norms such as appropriate work for men and for women, and (c) preserve cultural cohesion – in this case the military, male-dominated culture where women were given exclusive domain over a nurturing profession. When a meeting with Armed Forces representatives finally transpired, their reasons for maintaining the status quo were preservation of the administrative system and conformity to norms. Mr. Wedgery recognized the military's decision as "...preserving an unbroken tradition, rather than...an exercise in judgment." Introduction of male registered nurses and nursing officers into the Nursing Division was considered a threat to the status quo. Gaston Levesque implied that male nursing officers could have a detrimental effect on morale in the Nursing Division, including erosion of the administrative flexibility associated with the employment of unmarried

nursing sisters. Presumably these nursing sisters would not be leaving the Nursing Division because of pregnancy; they were readily uprooted and moved around as dictated by staffing needs, and it was more cost-effective to manage a nursing sister than a nurse with a family. Furthermore, it was commonly understood within the military and society that nursing was "women's work."

The resistance to having commissioned male nurses in the military may also have been a result of cultural cohesion in the Nursing Division itself. The Nursing Division was an enclave richly steeped in tradition and cultural norms. Nursing sisters may have had a vested interest in maintaining things as they were to preserve their status in a world when little status was accorded to women and women's work. Dr. Mussallem suggested that resistance to change (i.e., admitting male officers into the Nursing Division) was based in part on a desire to maintain cultural cohesion. "My feeling is that they [nursing sisters] were uncomfortable having men in their ranks. I think maybe a major factor was resistance to change and how it would affect [them]."

In addition to these forces of resistance, moving the concerns of the MNC through the complex channels of the military bureaucracy frequently led to a dead end. Effective pressure for change was applied to the military only after the MNC raised this issue at the national level, whereby the CNA membership provided the Executive Director with a solid mandate to advocate for Canadian nurses. By the late 1960s, changes in politicians' attitudes towards women and towards work roles was occurring – albeit slowly – and that is when Léo Cadieux ceded victory to the nursing profession. Continued resistance to the commissioning of male nurses gradually came to be seen as an injustice. The policy was a grievous affront to women in that it appeared to protect their interests while in reality serving to reinforce the notion of women's work as confined to traditional nurturing roles. The nurturing role was discordant with the traditional male role in military culture. Thus the policy was offensive to both the nursing profession and the men who had chosen nursing as a career.

Finally, the CNA[36] intended to "go public" with this issue. Public scrutiny would have moved the military's discriminatory policy into the political arena. This measure proved unnecessary, as Mr. Cadieux did not establish a quota system for male nurses in the Nursing Division of the Medical Services Branch of the Canadian Armed Forces.

Resistance to change can be profound, as this study has shown. The combined efforts of the Male Nurses Committee of the RNAO (and Albert Wedgery in particular), the Board of Directors of the

RNAO, a mandate from the CNA membership, and the political acumen of Dr. Helen Mussallem were required to overturn a discriminatory military policy.

This study illustrates the importance of moving beyond strictly matriarchal history perspectives in nursing. The history of Canadian men in nursing remains little researched and the subject is too often glossed over as historical curio. Careful and focused studies on men in nursing will lead to a more complete understanding of the history of the nursing profession in Canada.

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Endnotes

1. Minutes of the Male Nurses Committee (MNC) of the Registered Nurses Association of Ontario (RNAO), November 30, 1957.

2. *Canadian Nurse*, February 1970, p. 10.

3. Air Force Administrative Orders, Appendix D, c.01/02, 22 Feb 63, p. 3.

4. Male Nurses Committee minutes and annual reports for the years 1956-1964.

5. CNA Executive Committee minutes dealing with "Employment of Male Nurses in Medical Nursing Corps, Nursing Services" (June 7, 1952; January 29, 1953).

6. Minutes of the CNA 33rd General Meeting, July 4-8, 1966, p. 358.

7. Air Force Administrative Orders, Appendix D, 6.01/02, 22 Feb 63, p. 3; Regulations and Instructions for the Royal Canadian Navy 1942, Chapter VI, 137A, p. 56; Terms of Service-Officers of the Canadian Army (Regular), 256-3, date of issue – 24 July 61, Annex A, p. IV.

8. Correspondence was often cited in the minutes of the Male Nurses Committee. The original letters were not found in the primary archival sources obtained from the RNAO. For example, private correspondence between Pierre Sevigny, Associate Minister of National Defence, and Hazen Argue, National Leader of the CCF Party, was not located. This correspondence addressed the desirability of commissioning male nurses, thus putting them on the same level as nursing sisters (minutes of the Male Nurses Committee, June 21, 1961, p. 3).

9. *Canadian Nurse*, March 1968, p. 12.

10. Dr. Helen K. Mussallem, CNA Executive Director, 1963-1981. Interview by David Gregory, December 5, 1994, Ottawa. Dr. Mussallem confirmed the accuracy of the primary archival data and provided an insider's view of events as they unfolded. Transcript available from Dr. Gregory, University of Manitoba, Faculty of Nursing, Winnipeg, Manitoba.

11. Although reference is made to the RNAO's efforts to bring about change in this military policy, beginning in 1942, we were unable to locate primary data to substantiate it. The minutes of the 33rd CNA General Meeting (July 4-8, 1966) are a secondary source regarding this matter.

12. CNA Executive Committee minutes, June 2, 1952, p. 6.

13. Recruitment of men into the nursing profession and gender pronoun issues were identified in the MNC minutes of June 9, 1956. That there should be no differentiation in educational programs for male and female nursing students was identified in the minutes of November 30, 1957.

14. MNC minutes, June 14, 1958, p. 2.

15. MNC minutes, June 6, 1959, p. 1.

16. MNC minutes, May 7, 1960, p. 3.

17. Ibid., p. 4.

18. MNC minutes, February 14, 1961, p. 1.

19. MNC minutes, June 21, 1961, p. 2.

20. Ibid., pp. 2-3.

21. Unfortunately, copies of the original correspondence were not part of the MNC minutes for the June 21, 1961, meeting. Thus this information is considered secondary data.

22. MNC minutes, June 21, 1961, p. 3.

23. MNC minutes, October 4, 1961, p. 1.

24. MNC minutes, March 7, 1962, p. 1.

25. Ibid.

26. "Meeting of Representatives of the Male Nurses Committee with Deputy Surgeon General, Department of National Defence, Ottawa, Friday, October 12, 1962."

27. Ibid., p. 1.

28. Ibid.

29. Ibid., p. 2.

30. MNC minutes, March 6, 1963, pp. 1-2.

31. Ibid., p. 2.

32. During the latter stages of this study, RNAO was in the process of relocating. The MNC records were "boxed away" and could not be readily found.

33. Canadian Forces Administrative Orders, 6-1, October 1967, Annex A, Appendix 1, p. 1.

34. *Canadian Nurse*, (1968), 64(3), p. 12.

35. Ibid.

36. CNA Board minutes, July 1966, p. 11: "Male Nurses in the Armed Services."

Acknowledgements

Prédicteurs de l'activité physique régulière chez les participants à un programme canadien de promotion de la santé

Adèle Jomphe Hill

A series of predisposing and facilitating factors were examined to determine their contribution to the adoption of regular physical activity. The original longitudinal study *Healthstyles* was a comparative, before and after design, in which the participants ($N = 640$) were involved for 18 months in a multibehaviour health promotion program. The theoretical framework of Green, Kreuter, Deeps, and Partridge (1980) used for this study, the PRECEDE Model, reveals the role of three categories of factors at different levels of influence. In a correlational study, the sedentary subjects ($N = 377$) of a secondary analysis of data, were classified at the end of the program according to two behavioral status : adoption or non-adoption of regular physical activity. The nature of the study, the results of the preliminary analysis and the testing of the hypothesis, required a multivariate analysis approach. The logistic regression technique was used to differentiate between the adopters and the non-adopters. The results regarding the role of the combined predisposing and facilitating factors, show that only some of the predisposing factors predicts the adoption of regular physical activity. The adopters are relatively younger (OR = 0.48) males (OR = 1.7) with good or excellent self- evaluated health (OR = 0.51) and with a high score at the onset of the program, on the internal locus of control scale (OR = 1.8). Moreover, they are not different from the non-adopters in their need for external support in the change process. The impact of these results has been examined in terms of target groups and of content and approaches for future health promotion programs and research.

L'identification des prédicteurs de l'adoption de l'activité physique régulière fait l'objet d'une analyse secondaire à partir de données recueillies auprès de 640 participants au programme *Healthstyles* (1982-1986). Pour l'évaluation originale du *Healthstyles* une étude longitudinale devis avant et après, a été réalisée. Ce programme de promotion de la santé innovateur, échelonné sur 18 mois, a été offert à la population adulte d'Ottawa-Carleton. Le cadre de référence retenu pour l'analyse secondaire des données de *Healthstyles*, l'approche PRECEDE de Green, Kreuter, Deeps, et Partridge (1980) met en évidence, à différents degrés d'influence, le rôle de trois catégories de facteurs dans l'adoption de comportements sains. Une étude corrélationnelle identifie la contribution de facteurs prédisposants et facilitants sélectionnés sur l'adoption de l'activité physique régulière par les sujets sédentaires à l'étude ($N = 377$). La nature de l'étude, les résultats des analyses préliminaires et la vérification des hypothèses requièrent un cadre d'analyses multivariées. L'identification des facteurs distinguant les adopteurs des non-adopteurs est

Adèle Jomphe Hill, Inf., Ph.D. est Professeure et Chercheure en santé communautaire au Département des sciences infirmières de l'Université du Québec à Hull.

effectuée principalement à partir de la technique de la régression logistique. L'analyse du rôle des facteurs prédisposants et facilitants combinés montre que seuls des facteurs prédisposants prédisent l'adoption de l'activité physique régulière. Son adoption est liée surtout aux caractéristiques internes du groupe, soit relativement plus jeune (OR = 0,48), de sexe masculin (OR = 1,7), avec un profil de santé positif au départ (OR = 0,51) et un foyer de contrôle interne élevé (OR = 1,8). Par ailleurs, les adopteurs ne se distinguent pas des non-adopteurs dans leur recours au soutien externe dans ce processus de changement. L'impact de ces résultats a été examiné en termes de populations cibles à privilégier ainsi que d'orientations des programmes de promotion de la santé et de la recherche.

Belloc et Breslow (1972) ont démontré que les comportements suivants sont associés de façon significative à l'état de santé physique et à la longévité : n'avoir jamais fumé, boire moins de cinq verres d'alcool à la fois, faire de l'exercice régulièrement, maintenir une masse pondérale appropriée, prendre de sept à huit heures de sommeil, éviter les collations entre les repas et prendre le petit déjeuner quotidien. En effet, plusieurs études montrent que les gens qui ont adopté ces sept comportements positifs ont une espérance de vie plus longue, et que les effets sont additifs. Il y a également de plus en plus d'évidences que le comportement individuel joue un rôle important dans l'étiologie de plusieurs maladies et que pour au moins neuf des dix principales causes de décès, on retrouve une composante comportementale (McQueen, 1987). Entre autres, le mode de vie sédentaire est considéré comme un facteur de risque important pour les hommes et les femmes (Berkman & Breslow, 1983). L'évidence actuelle suggère que l'activité physique régulière peut réduire l'incidence et la sévérité des maladies chroniques et, possiblement, prolonger la vie de quelques années (Bouchard, Shephard, Stephens, Sutton, & McPherson, 1990). Il semble également que l'exercice physique soit lié à différents aspects de la qualité de vie et de la santé. Il peut contribuer indirectement à la productivité et à la satisfaction au travail ainsi qu'à une diminution de l'absentéisme et des coûts médicaux. De plus, l'exercice physique a une influence sur la santé mentale et a un potentiel de bénéfices sociaux puisqu'en groupe, il peut déboucher sur un réseau social autour d'intérêts communs de récréation.

Il est bien établi que les comportements reliés à la santé, tels que l'activité physique influent sur la santé, que l'amélioration de la santé repose en partie sur l'adoption d'une vie active et que les personnes actives physiquement ont tendance à pratiquer d'autres activités préventives (Blair, 1988). La promotion de comportements sains est donc devenue une priorité des gouvernements et des planificateurs de santé.

L'enquête canadienne sur la condition physique (1983) rapporte que c'est pour se sentir bien sur le plan physique et mental que les

Canadiens tendent à être actifs, et que le principal obstacle à l'activité est le manque de temps en raison du travail. On note des différences nettes dans le profil démographique, les attitudes et les niveaux de forme physique et de santé entre Canadiens actifs et Canadiens sédentaires (Stephens, 1985).

Profitant de l'accès à une étude longitudinale, nous avons choisi d'exploiter les données relatives à un programme canadien de promotion de la santé connu sous le vocable *Healthstyles*. Ce volet d'une étude plus large sur la prédiction de comportements sains (Jomphe Hill, 1991) avait pour but d'identifier les caractéristiques des sujets sédentaires qui ont eu du succès dans leur démarche d'adoption de l'activité physique régulière. La connaissance des facteurs qui mènent à une vie active aide les professionnel(le)s de la santé, dont les infirmières, à mieux déterminer les populations cibles et le contenu des messages éducatifs en promotion de la santé.

Revue de la littérature

La définition de l'activité physique régulière est complexe, et l'analyse des écrits dans ce domaine requiert beaucoup de vigilance. En effet, les études sont souvent peu comparables en ce qui concerne la conceptualisation, la définition, la mesure et les populations à l'étude (Bouchard et al., 1990). La mesure de l'activité physique devrait inclure au moins le type, la fréquence, la durée et l'intensité de l'activité sur une période donnée (Stephens, Craig, & Ferris, 1986). Le terme « population active » est lié à une dose d'exercices requise (dépense énergétique) pour en retirer des bénéfices cardio-vasculaires. Une définition précise est essentielle pour déterminer ce qui constitue l'adoption d'un niveau adéquat d'activité physique.

Dans une revue exhaustive de la recherche sur les prédicteurs de l'activité physique, Dishman, Sills, and Orenstein (1985), ont identifié 35 facteurs associés à l'adoption ou au maintien de l'activité physique. Ces auteurs constatent qu'il est difficile de comparer les résultats de ces études puisqu'elles varient considérablement en ce qui trait à la méthodologie. De plus, il reste encore passablement d'incohérence dans les résultats quant aux facteurs spécifiques qui favorisent la pratique de l'activité physique.

Comme il s'agit d'une étude secondaire, une recension des écrits de l'ensemble des variables descriptives et explicatives mesurées dans le questionnaire *Healthstyles* a été réalisée afin de vérifier leur association avec l'activité physique régulière. La connaissance des variables

descriptives (caractéristiques socio-démographiques) reliées à la pratique de l'activité physique permet de déterminer à qui doivent s'adresser les programmes de promotion d'une vie active. Il y a une relation négative constante entre l'âge et l'activité physique (Dishman et al., 1985). Leigh (1983) montre que la scolarité a un impact sur la santé par un effet intermédiaire sur le choix des habitudes de vie. Berkman et Breslow (1983) estiment que les personnes de niveau socio-économique bas ont trois fois plus de chance de maintenir des comportements à risque. Olson et Zanna (1987) affirment qu'il y a peu de différence entre les deux sexes pour des exercices modérés. L'adoption et le maintien d'activités vigoureuses sont cependant plus fréquents chez les hommes. Ces auteurs ont trouvé également que les sujets mariés persistent plus dans leur activité parce qu'ils reçoivent plus de soutien.

L'identification des prédicteurs du comportement, soit les facteurs prédisposants qui favorisent la motivation à adopter le comportement, permet d'adapter le contenu et les stratégies des programmes de promotion de la santé. La recherche sur les caractéristiques des adopteurs précoces démontre qu'ils ont une attitude favorable au changement, un niveau élevé de succès, de participation sociale et d'exposition à l'information (Rogers, 1983). Les deux traits de personnalité les plus souvent cités pour leur impact sur l'adoption de comportements sains sont le foyer de contrôle et la personnalité de Type A. Le foyer de contrôle désigne dans quelle mesure la personne croit que le résultat de ses actions est fonction de son comportement (contrôle «interne»), en fonction des autres (externe) ou est dû à la chance (Levenson, 1974 ; Rotter, 1966). Plusieurs études font état d'une relation entre le foyer de contrôle «interne», un niveau de responsabilité individuelle élevé pour sa santé et l'adoption et le maintien de l'activité physique régulière (Sonstroem, 1988 ; Dishman, 1988). La personnalité de Type A est souvent corrélée avec les maladies coronariennes et les facteurs de risque associés à cette maladie. Talabere (1986) croit cependant que ce type de personnalité possède un niveau d'énergie très élevé, est orienté vers des buts à atteindre qui peuvent être redirigés vers des actions positives telles que la pratique régulière de l'activité physique. Un autre aspect des variables psychologiques qui peut influer sur l'adoption de l'activité physique régulière est le rôle des perceptions et des croyances. Plusieurs auteurs leur attribue une influence directe (Bandura, 1977) ou une influence indirecte (Fishbein & Ajzen, 1975) sur le comportement. Nous avons regardé plus spécifiquement la littérature pertinente aux perceptions et croyances et à la motivation qui ont été identifiées dans le cadre de *Healthstyles* comme étant des prédicteurs de comportements

sains. La satisfaction avec son réseau de soutien peut avoir un effet sur le succès dans un programme (Robbins & Slavin, 1988). Une motivation globale (Green, 1980), un désir de changer, peut faciliter l'adoption de comportements sains. Cependant la motivation spécifique dans le temps est un meilleur prédicteur (Tipton, 1988 ; Ward & Morgan, 1984) car les taux de rechute sont très élevés (environ 50 % après trois mois) pour l'activité physique (Martin & Dubbert, 1984). La croyance dans le succès futur, donc de son efficacité personnelle, favorise l'adoption de comportements sains et la persistance face aux obstacles (Biddle & Fox, 1989). La perception d'une bonne santé favorise l'adoption de l'activité physique et prédit le succès dans le programme (Segovia, Barlett, & Edwards, 1989). Berkman et Breslow (1983) postulent un effet boule de neige des comportements sains sur la santé. Le facteur style de vie positif, les habitudes de vie avant le programme, a été vu par les auteurs de *Healthstyles* comme ayant le potentiel de déclencher d'autres comportements sains. Dormir de sept à huit heures par nuit est un indicateur de style de vie sain (Berkman & Breslow, 1983). L'obésité et la consommation de cigarettes sont des prédicteurs constants de l'abandon de l'activité physique (Dishman, 1988). Enfin, une forme physique adéquate peut avoir un effet d'entraînement sur la recherche d'un niveau d'activité physique recommandé (Godin, Valois, Shephard, & Desharnais, 1987).

Le degré d'exposition ou d'implication dans un programme facilite l'adoption de comportements sains et renforce l'individu dans sa prise de décision. L'utilisation de l'appui des pairs permet d'obtenir un soutien objectif face aux barrières quotidiennes à affronter sur la voie du changement. Elle expose à des idées et à des attitudes nouvelles qui aident à poursuivre les objectifs de changement (Auweele, 1988). L'utilisation du contrat de santé semble avoir fait ses preuves en tant que moyen de favoriser la prise en charge de son propre processus de changement et en tant que technique éducationnelle (Martin & Dubbert, 1984). L'implication dans des sessions de soutien avec les pairs et les professionnels encourage la personne dans la poursuite de ses objectifs et renforce sa motivation et sa détermination au changement (Kort, 1984). La concentration des efforts sur un ou deux objectifs de changement semble favoriser l'adoption de comportement sains (Kronenfeld et al., 1988).

Cadre de référence de l'étude

Le cadre de référence retenu pour cette étude secondaire est inspiré de l'approche PRECEDE de Green et al. (1980), un modèle de planification

et d'évaluation des interventions éducatives. C'est un outil diagnostique qui permet de systématiser l'analyse des problèmes de santé et qui aide les intervenant(e)s en santé à identifier les niveaux prioritaires d'intervention en éducation sanitaire. Dans ce modèle, les facteurs prédisposants à un comportement relié à la santé sont les facteurs présents chez l'individu avant son entrée dans le programme : connaissances, croyances, valeurs, attitudes et variables démographiques. Ils peuvent faciliter ou mettre un frein à la motivation et à l'implication dans un programme et ultimement à l'adoption de comportements sains. Les facteurs facilitants et les facteurs de renforcement sont ceux qui soutiennent l'individu dans sa prise de décision et aident à prévenir les rechutes (Marlatt & Gordon, 1980).

Afin de poser un diagnostic comportemental, Green et al. (1980) suggèrent d'identifier les trois catégories de facteurs, mais négligent d'identifier spécifiquement ces facteurs et leurs liens entre eux. Le modèle PRECEDE ne constitue pas en soi un modèle psychosocial de prédiction du comportement, mais il permet l'intégration de facteurs de prédiction identifiés dans divers modèles explicatifs des comportements reliés à la santé comme le Modèle des croyances relatives à la santé (Becker, 1974), la Théorie de l'action raisonnée (Fishbein & Ajzen, 1975) et la Théorie de l'apprentissage social (Bandura, 1977). D'autre part, le programme *Healthstyles* n'ayant pas été planifié à partir d'une théorie psychosociale spécifique, nous avons choisi, pour notre étude, de vérifier l'influence de deux catégories de facteurs (facteurs prédisposants et facteurs facilitants) sur l'adoption et le maintien de l'activité physique régulière. Les facteurs de renforcement n'ont pas été mesurés dans l'étude originale.

Objectifs de l'étude

Cette étude de prédicteurs a trois objectifs principaux : identifier le statut d'adoption de l'activité physique des participants sédentaires à la fin du programme, identifier la contribution spécifique de facteurs prédisposants et de facteurs facilitants sur l'adoption de l'activité physique régulière, examiner les implications de ces résultats en termes de populations cibles à privilégier et d'orientation future des programmes de promotion de la santé et de la recherche. La recension des écrits nous amène à postuler qu'il existe une relation entre certains facteurs prédisposants et l'adoption de l'activité physique chez les sujets sédentaires à l'étude. Nous postulons également que le degré d'implication et de participation à l'ensemble du programme de soutien (facteurs facilitants) jouent un rôle sur l'adoption. Après avoir fait ces

constatations et en raison de l'intérêt de vérifier l'influence de ces deux catégories de facteurs sur l'adoption de l'activité physique régulière, nous avons formulé deux hypothèses de recherche.

Hypothèses

H₁) Les seize facteurs prédisposants suivants ont favorisé l'adoption de l'activité physique régulière : âge (-), scolarité (+), sexe masculin, statut marié, objectif « activité physique » priorisé, maintien de l'objectif, foyer de contrôle « interne » élevé, personnalité de Type A, satisfaction avec réseau de soutien, motivation globale de changement, croyance dans le succès futur, perception de bonne santé, heures de sommeil adéquates, poids santé adéquat, statut de non-fumeur, forme physique adéquate.

H₂) Les quatre facteurs facilitants suivants, ajoutés aux facteurs prédisposants significatifs, ont favorisé l'adoption et le maintien de l'activité physique régulière : nombre élevé de mois d'utilisation du soutien des pairs, nombre élevé de mois d'utilisation du contrat de santé, nombre élevé de sessions de support suivies, nombre bas d'objectifs de changement poursuivis.

Méthodologie

Devis de l'analyse secondaire

Dans cette étude secondaire, les hypothèses ont été vérifiées à partir d'un devis corrélationnel. Les données de l'étude évaluative originale ont servi à analyser les prédicteurs de l'adoption de l'activité physique régulière chez les sujets sédentaires lors de leur entrée dans le programme *Healthstyles*.

Description et évaluation de Healthstyles

Healthstyles, auquel 640 personnes ont participé, a été créé, expérimenté et évalué de 1982 à 1986 grâce à une subvention de la Fondation Kellogg. C'est un programme de promotion de la santé dont le but est de promouvoir l'adoption de comportements sains et l'abandon d'habitudes de vie malsaines. Le programme est cohérent avec la philosophie de promotion de la santé de l'O.M.S. (1984) et de Santé et Bien-Être Social (1986). Le programme a été fortement influencé par l'expérience de quatre infirmières en santé communautaire et élaboré à partir du modèle de santé positive d'Ardell (1977), du modèle de changement de style de vie de Kripalu (1980), du processus de groupe, du processus de

changement planifié et des modèles d'apprentissage chez l'adulte. Il met l'accent sur les relations entre les comportements de sa nté, la responsabilité individuelle et les forces sociales en tant que déterminants des valeurs et des comportements reliés à la santé. Les objectifs du programme de 18 mois visaient des changements significatifs chez les participants dans les domaines de la responsabilité individuelle, de la vision holistique de la santé, du stress, de l'usage de la cigarette et de l'alcool, de l'activité physique, de la nutrition, du poids et de l'utilisation des services de santé.

L'évaluation de *Healthstyles* a été planifiée et réalisée par l'Unité de recherche en Sciences de la santé de l'Université d'Ottawa, en collaboration avec les responsables du programme. Un devis quasi expérimental a été utilisé, selon lequel les participants ($N = 640$) et les cas témoins ($N = 1\,180$), tous des volontaires, ont été suivis pendant 18 mois. Les participants, des volontaires adultes de 18 ans et plus, ont été recrutés à partir de différentes stratégies (media électroniques, brochures, kiosques, présentations audiovisuelles), dans des milieux variés. Les 640 participants, divisés en 40 cohortes de 8 à 18 individus, ont cheminé ensemble pendant une fin de semaine intensive et un programme de support entre janvier 1983 et octobre 1984. Des 691 participants potentiels, 30 ont abandonné avant le début du programme et 21 durant la fin de semaine du programme. Des données ont été recueillies afin d'identifier les caractéristiques des sujets exclus de l'étude. La sélection des cas témoins s'est faite en deux étapes : 1) recrutement d'un grand nombre de sujets potentiels par questionnaire, 2) appariement de deux cas témoins avec chaque participant pour les variables âge ($\pm$ 5 ans), sexe, niveau de scolarité, niveau de stress, statut face à la cigarette et score global de cinq caractéristiques (poids, habitudes de sommeil, consommation d'alcool, indice d'activité physique et petit déjeuner quotidien) (Belloc, 1972). La représentativité de l'échantillon a été démontrée en comparant les caractéristiques démographiques, des participants et des témoins avec les données régionales sur plusieurs caractéristiques démographiques et en comparant leurs comportements et état de santé négatifs avant le programme. Il s'agit d'une étude longitudinale avec groupe témoin, avec comparaison avant et après le programme. Après 18 mois, les résultats ont révélé des différences significatives dans le progrès accompli par les deux groupes à l'étude pour la plupart des objectifs du programme. Les auteurs concluent que ces résultats sont très prometteurs et devraient être reproduits à partir d'autres populations et dans d'autres contextes (McDowell, Black, & Collishaw, 1988).

Échantillon

Les 377 sujets sédentaires parmi les 640 participants au programme de promotion de la santé *Healthstyles* ont été identifiés à partir du critère de dépense énergétique de 1,99 Kcal/kg/jour et moins.[1]

Instruments de mesure

Une revue détaillée de la littérature et des instruments de mesure disponibles a servi à l'élaboration des guides d'entrevue et des quatre questionnaires utilisés à quatre étapes du programme. Les questionnaires comprennent huit sections qui abordent les objectifs visés par le programme. Plusieurs des questions ont été tirées de l'enquête canadienne sur la santé (1981), permettant la comparaison avec des données régionales et nationales. Il s'agit des questions sur les caractéristiques sociodémographiques, la personnalité, la motivation, les perceptions et croyances et le style de vie. De plus, l'auteure a identifié dans les questionnaires la présence de la priorité « activité physique » dans le programme, son maintien comme objectif ainsi que le degré d'utilisation des modalités de soutien offertes par le programme.

Le *Multi-dimensional Health Locus of Control Scale* (Wallston, Wallston, & Devillis, 1978) classe les sujets, à partir de leurs croyances, sur trois dimensions distinctes (interne, externe et chance). *Healthstyles* a utilisé la dimension foyer de contrôle « interne » comme indicateur du niveau de responsabilité individuelle pour la santé. L'échelle est composée de six éléments et de six choix de réponse (extrêmement en accord [6] à extrêmement en désaccord [1]) et produit un score entre 6 et 36. Un score élevé correspond à un niveau plus grand de prise en charge de sa santé. L'échelle a été validée dans plusieurs études et auprès de populations similaires : O'Connell et Price (1982) alpha 0,83 ; Winefield (1982) alpha 0,70 ; Wallston, Wallston et Devillis (1978) alpha 0,77.

L'échelle qui mesure la personnalité de Type A est composée de six éléments et de quatre choix de réponse allant de à « me décrit bien » à « pas du tout ». Elle génère un score de 6 à 24, où un score bas indique une personnalité de Type A. Les alphas de Cronbach rapportés sont les suivants : Haynes, Feinleib et Kannel (1978) alpha 0,71 (homme), 0,70 (femme).

Une échelle de mesure de la satisfaction avec le réseau de soutien social a été construite par l'équipe de *Healthstyles* à partir de deux questions d'un élément chacune de trois choix de réponse allant de « très satisfaisant » (2) à « pas du tout satisfaisant » (-1). L'échelle combinée

(parents et amis) génère un score allant de -2 à +4. La consistance interne de cette échelle a été vérifiée par le coefficient de Guttman (*Reproducibility* 0,90, *Scalability* 0,70).

Le niveau de forme physique a été mesuré par une infirmière lors de l'entrevue initiale à l'aide du «*Canada Home Fitness Test*».

Procédure

Les participants à *Healthstyles* se sont présentés à une entrevue avant et après le programme, et les quelques mesures physiologiques suivantes ont alors été obtenues : poids, taille, tension artérielle et niveau de forme physique. De plus, les participants et les témoins ont répondu à quatre questionnaires à quatre étapes du programme de 18 mois. Dans l'étude secondaire, les données ont été extraites de la banque originale de données pour ce qui est des facteurs prédisposants. Par contre, l'opérationalisation des facteurs facilitants, a requis un travail considérable de prétraitement, et de recodification, ainsi qu'une nouvelle extraction de données des questionnaires. Ces données n'avaient pas été exploitées dans l'évaluation originale.

Définition opérationnelle des variables

La variable dépendante. Les questions et les objectifs de recherche ainsi que le cadre de référence de l'étude ont conduit à la construction d'une variable dépendante dichotomique, en termes de l'adoption (1) ou de la non-adoption (0) du comportement, « activité physique régulière ». Une révision récente du terme « population active » dans la littérature a établi la dose d'exercices requise pour en retirer des bénéfices cardiovasculaires à quatre kilocalories de dépense énergétique par kilogramme de poids, par jour ou, au moins, par deux jours (2-4 kcal/kg/jour, (Blair, Kohl, Paffenbarger, Cooper, & Gibbons, 1989 ; Stephens et al., 1986). Dans l'étude actuelle, l'adoption du comportement se définit donc par une dépense énergétique de 2 kcal/kg/jour à la fin du programme des 18 mois.[1]

Les variables indépendantes (prédicteurs). Quatre critères généraux ont guidé le choix des variables indépendantes pour l'analyse secondaire. Les variables de prédiction devaient avoir été mesurées à partir de questions validées, les facteurs prédisposants et facilitants devaient avoir été mesurés aux temps pertinents, devaient être identifiés dans la littérature comme jouant un rôle dans l'adoption de l'activité physique régulière et devaient être cohérents avec le cadre théorique de l'étude.

Table 1
Facteurs prédisposants à l'activité physique

Description des variables	Échelle de mesure	Sens de l'hypothèse (Prédiction de AD)
Caractéristiques sociodémographiques	*Variable à intervalle*	
1. Âge réel (AGE1)	18 à 32	âge (-)
2. Scolarité (SCOLARITÉ1)	*Variable ordinale* 1 à 6	scolarité (+)
3. Sexe (SEXE1)	*Variable nominale* 0 - 1	sexe masculin (1)
4. Statut marital (MARITAL1)	0 - 1	statut marié (1)
Facteur : motivation spécifique		
5. Objectif priorisé «activité physique» (OBJACT1)	1 - 2	objectif priorisé (1)
6. Maintien de l'objectif «activité physique» (MAOACT3)	1 - 2	maintien «objectif» (1)
Facteur : personnalité	*Variable à intervalle*	
7. Foyer de contrôle «interne» (responsabilité individuelle) en santé (FOYER1) Score	6 à 36	score élevé
8. Personnalité de type A (TYPEA1) Score	6 à 24	score bas
Facteur : perceptions et croyances		
9. Satisfaction : réseau de soutien, parents et amis (SATIS1) Score	-2 à +4	score élevé
10. Motivation globale de changement (MOTIVAT1)	*Variables ordinales* 1 à 7	motivation (+)
11. Croyance succès futur (SUCCÈS1)	1 à 7	croyance au succès (+)
12. Statut de santé (SANTÉ1)	1 à 5	perception de bonne santé (+)
Facteur : style de vie	*Variables nomnales*	
13. Heures de sommeil (SOMMEIL1)	0 - 1	heures de sommeil adéquates (1)
14. Poids/santé «*Body Mass Index*» (POIDS1)	0 - 1	poids adéquat
15. Statut de fumeur (FUMEUR1)	0 - 1	non-fumeur (1)
16. Niveau de forme physique «*Home Fitness Test*» (CONDIT1)	0 - 1	forme physique adéquate (1)

Les 16 facteurs prédisposants à l'activité physique identifiés dans la première hypothèse ont été regroupés selon les cinq grandes catégories de variables mesurées à partir des questionnaires *Healthstyles* : 1) les caractéristiques sociodémographiques, 2) le facteur de motivation spécifique, 3) le facteur personnalité, 4) les facteurs perceptions et croyances, 5) le facteur style de vie. Le Tableau 1 décrit chacune des variables, identifie le type de mesure pour chacun des prédicteurs ou facteurs prédisposants et donne le sens de l'hypothèse par rapport à la prédiction de l'adoption de l'activité physique régulière.

Les quatre facteurs facilitants retenus dans la deuxième hypothèse sont liés au degré de participation du sujet au programme et ils ont été mesurés à la fin du programme. Le Tableau 2 décrit chacune des variables, identifie le type de mesure pour chacun des prédicteurs ou facteurs facilitants et donne le sens de l'hypothèse par rapport à la prédiction de l'adoption de l'activité physique régulière.

Table 2
Facteurs facilitant l'activité physique

Description des variables	Échelle de mesure	Sens de l'hypothèse (Prédiction de AD)
	Variable à intervalle	
1. Nombre de mois d'utilisation du soutien des pairs (PAIRS4) Score	0 à 18	nombre élevé
2. Nombre de mois d'utilisation du contrat de santé (CONTRAT4) Score	0 à 18	nombre élevé
3. Nombre se sessions de support suivies (SUPPORT4) Score	0 à 5	nombre élevé
4. Nombre d'objectifs de changement poursuivis (NBOBJ2) Score	0 à 8	nombre bas

Analyse des données

L'analyse des données s'est déroulée en quatre étapes : l'analyse descriptive, les analyses préliminaires et les analyses bivariées. Les résultats de ces analyses ont ensuite été soumis à des analyses multivariées, en vue de la vérification des hypothèses. La variable dépendante est une variable binaire codée (1) adoption ou (0) non-adoption de l'activité physique régulière. La proportion de l'adoption prédite suit

le modèle logistique, et la technique sélectionne les prédicteurs de façon hiérarchique, à partir de la méthode de sélection du maximum de vraisemblance (MLR). Les variables indépendantes sont continues, ou catégorielles. Les groupes « adoption » et « non-adoption » ont été comparés par rapport aux 16 facteurs prédisposants retenus dans la première hypothèse (méthode hiérarchique). Les quatre facteurs facilitants retenus dans la deuxième hypothèse ont été soumis à l'analyse et ajoutés aux facteurs prédisposants significatifs à la première étape (entrée forcée). Enfin, les facteurs significatifs ont été traduits en variables catégorielles et soumis à la régression logistique afin d'obtenir le ratio des cotes ajusté et l'intervalle de confiance pour chacune des catégories. Un seuil alpha de 0,05 a été retenu pour considérer une statistique comme significative.

Résultats

Caractéristiques des sujets sédentaires à l'étude

Les sujets sédentaires à l'étude ($N = 377$) sont en grande majorité des femmes (75,0 %), en moyenne au début de la quarantaine (42,32 ans), avec un niveau de scolarité s'échelonnant entre des études post-secondaires et universitaires. En proportion égale, elles sont mariées et non mariées. La moitié des sujets sédentaires avaient des problèmes de poids, plus du tiers avaient des habitudes de sommeil et un niveau de forme physique adéquats et un cinquième fumaient à leur entrée dans le programme. Ils ont évalué leur santé (entre bonne et moyenne) (2,36). Ils étaient très motivés à changer leurs comportements de santé (6,30) et croyaient pouvoir réussir dans cette démarche (5,70). Ils possédaient un foyer de contrôle « interne » élevé (29,27), une tendance vers une personnalité de Type A (14,52), et étaient relativement satisfaits de leurs relations avec leur réseau social (2,64). Nous constatons que la grande majorité (87 %) poursuivaient l'objectif d'obtenir un niveau adéquat d'activité physique, et parmi ceux-ci, 66 % ont maintenu cet objectif jusqu'à la fin du programme. Ils ont identifié, en moyenne, entre quatre et cinq objectifs de changement, ont participé, en moyenne, à un peu plus de trois sessions de support offertes dans le cadre du programme et ont utilisé le soutien des pairs pendant un peu plus de six mois. Ils ont, de plus, établi des contrats de santé pendant environ trois mois.

Environ un quart (24,4 %), des sujets sédentaires au début du programme, soit 92, ont réussi à atteindre un niveau adéquat d'activité physique (2kcal/kg/jour ou plus). Les autres 285 sujets sédentaires (75,6 %) ont échoué dans cette démarche.

Vérification des hypothèses

La vérification des deux hypothèses de recherche à l'aide des analyses de la régression logistique a permis de prédire l'adoption de l'activité physique en identifiant les facteurs qui différencient les adopteurs (AD) des non-adopteurs (NA). Les résultats de la première étape, la soumission à l'analyse des facteurs prédisposants (H1) selon la méthode hiérarchique, identifient ainsi quatre variables significatives : le sexe (SEXE1) (ß = 0,6763 p = 0,0157), l'âge (AGE1) (ß = -0,0353 p = 0,0033), la santé auto-évaluée (SANTÉ1) (ß = -0,5542 p = 0,0021) et le foyer de contrôle « interne » (FOYER1) (ß = 0,0700 p = 0,0297).

L'entrée forcée des quatre facteurs prédisposants significatifs et l'ajout des quatre facteurs facilitants (H2) montrent que ce sont toujours les quatre facteurs prédisposants identifiés dans la première étape qui sont les prédicteurs de l'activité physique régulière. La catégorisation des variables significatives et leur soumission à la régression logistique indiquent des tendances qui sont cohérentes avec les résultats des analyses précédentes. Les hommes qui n'avaient pas un niveau adéquat d'activité physique à leur entrée dans le programme *Healthstyles* ont presque deux fois plus de probabilité (OR = 1,7) que les femmes d'adopter ce comportement sain. Les sujets entre 35 et 44 ans ont moins de probabilité (OR = 0,48) d'adopter l'activité physique régulière que les plus jeunes (19 à 34 ans). Les sujets qui ont évalué leur santé comme étant moyenne (fair) ont moins de probabilité (OR = 0,51) d'adopter l'activité physique régulière que ceux qui l'ont évaluée comme étant excellente ou bonne. Enfin les sujets qui ont un foyer de contrôle « interne » entre 30 et 36 ont presque deux fois plus de probabilité (OR = 1,8) d'adopter un niveau adéquat d'activité physique que ceux qui se situent en dessous de 30 sur l'échelle de mesure de ce facteur.

Disscussion

Nos hypothèses voulaient que l'adoption de l'activité physique régulière soit liée aux facteurs prédisposants combinés au degré d'implication dans une démarche personnelle de changement planifiée et au recours au soutien externe (facteurs facilitants). Les résultats mettent en valeur l'importance des facteurs prédisposants (H₁) dans l'adoption d'un niveau adéquat d'activité physique : posséder un certain profil de santé positif au départ, être relativement plus jeune, de sexe masculin, avoir une santé auto-évaluée comme étant entre bonne et excellente et un score de foyer de contrôle « interne » supérieur. Rappelons que *Healthstyles* n'offrait aucun programme d'activité physique, mais aidait les participants dans leur démarche de choix et de maintien d'objectifs

personnels de santé. Le cadre théorique retenu pour identifier les prédicteurs suggère que l'adoption réelle avec maintien dans le temps fait appel à plusieurs types de facteurs complémentaires. L'hypothèse relative au rôle des facteurs facilitants (H_2) doit cependant être rejetée puisque la participation active aux éléments de prise en charge et de soutien du programme ne permet pas de différencier les adopteurs des non-adopteurs. En effet, on constate que les sujets du groupe adoption détenaient, au début du programme, un niveau élevé de santé et un niveau élevé de responsabilité individuelle envers leur santé. Ils n'ont pas nécessairement eu besoin de soutien externe dans leur processus d'acquisition de l'activité physique régulière.

Des écrits confirment que l'activité physique est plus fréquente chez les hommes et chez les jeunes. Bouchard et al. (1990) constatent que les hommes ont une plus forte probabilité de s'engager dans des activités physiques de grande intensité, de longue durée et de pratique plus fréquente que les femmes. Par contre, on observe aucune différence significative entre les sexes lorsqu'il s'agit d'activités modérées (Norman, 1985). De plus en plus, on reconnaît l'importance d'identifier la fréquence de participation aussi bien que le niveau d'intensité de l'activité physique des sujets. Le critère retenu pour notre étude pour identifier le niveau adéquat d'activité, modéré à vigoureux, peut expliquer le résultat relatif au sexe et à l'âge. Bouchard et al. (1990) suggèrent de promouvoir un niveau d'activité modéré plutôt que rigoureux, puisque ce niveau a plus de chance de succès et produit également des effets bénéfiques. Il est reconnu que les adultes plus âgés s'engagent moins dans l'activité physique vigoureuse que les adultes plus jeunes (Dishman et al., 1985). Cependant, dans la plupart des études, on observe peu de variance d'âge dans les populations étudiées. Il est concevable que le besoin perçu ou réel de changement au début de la trentaine joue un rôle important dans l'adoption de comportements sains. Antonovski (1979) suggère que ce moment de la vie correspond souvent à la recherche par la personne d'une certaine cohérence de vie (*Meaning and purpose in life*). Il est également concevable qu'une certaine conscientisation sociale face à sa propre santé tende à se concrétiser chez les sujets de ce groupe d'âge. Il serait donc intéressant de développer des programmes adaptés à cette population cible, puisque ce groupe d'âge semble avoir de très bonnes chances de succès. Les résultats indiquent qu'il est plus difficile pour les femmes de tout âge et pour les personnes plus âgées en général d'adopter un niveau adéquat d'activité physique. Ces deux groupes de la population sont souvent plus sujets à la pauvreté et à l'absence de réseau social. Il serait donc nécessaire de leur proposer des activités peu coûteuses telle que la marche en

groupe. Des campagnes publiques de marketing social sur les bénéfices de l'activité physique auprès de ces groupes cibles seraient appropriées. De plus, un support plus soutenu de la part des professionnel(le)s ainsi que le développement de réseaux de soutien naturel devraient être planifiés à l'intérieur des programmes de promotion de la santé.

Les résultats de l'étude confirment le constat de la littérature voulant que les adopteurs de l'activité physique régulière aient tendance à rapporter une meilleure santé. Blair et al. (1989) notent que les personnes qui rapportent un niveau de santé inférieur ont tendance à être moins actives physiquement, ce comportement étant lié au niveau de vitalité. Il est fort probable que l'adoption d'un niveau adéquat d'activité physique passe par une étape intermédiaire d'amélioration de la santé perçue ou réelle. Cette supposition devrait faire l'objet de recherche. De plus, il est généralement accepté que l'activité physique régulière amène un ensemble de conséquences physiques et psychologiques positives. Cependant, il ne faut pas oublier que les effets négatifs souvent ressentis au début, comme la douleur, la fatigue et les traumatismes constituent des obstacles potentiels au maintien de l'activité physique, puisqu'ils sont souvent la cause du taux élevé d'abandon après l'adoption initiale (Olson & Zanna, 1987). Les conséquences positives perçues ou réelles peuvent être des déterminants de l'adoption et du maintien à long terme de l'activité physique. Plusieurs résultats de recherche suggèrent également l'impact positif de l'activité physique sur l'estime de soi, la régularité des repas et la perception de la santé (Bouchard et al., 1990). Il serait intéressant d'essayer d'influer sur ces dimensions par la promotion de l'activité physique, surtout chez les jeunes en milieu scolaire. Les adopteurs de l'activité physique régulière obtiennent un résultat élevé sur l'échelle de foyer de contrôle « interne » (Wallston, Wallston, & Devillis, 1978) utilisée pour mesurer le concept de responsabilité individuelle face à sa santé. Ce résultat peut expliquer que les adopteurs n'ont pas nécessairement eu besoin de soutien externe dans leur processus de changement. De plus, ce facteur peut influer sur la relation entre l'intention d'être actif et le comportement par son effet sur les attitudes face à l'activité physique, entre autres sur les croyances en l'efficacité personnelle, un prédicteur que plusieurs auteurs suggèrent d'ajouter aux modèles explicatifs les plus performants (Valois, Shephard, & Godin, 1986). Cependant, une certaine prudence doit être exercée dans l'interprétation des données par autodéclaration et quant à la séquence causale entre le foyer de contrôle et l'état de santé perçu, celle-ci pouvant être à la fois le produit ou le déterminant du comportement sain.

Le profil des participants dans les programmes basés sur les prédicteurs connus de l'adoption, de la non-adoption ou de l'abandon de l'activité physique devrait permettre d'identifier les candidats à l'abandon et les adopteurs précoces, mais aussi d'adapter les approches éducatives. Ce profil, avant et durant le programme, est souvent identifié dans un but de recherche, mais est rarement utilisé comme outil de diagnostic, de planification et d'ajustement de l'intervention. De plus, l'examen systématique des changements dans le temps a des implications importantes pour la prévention de l'abandon ou de l'échec. Les sujets à risque devraient bénéficier de soutien additionnel dès le début de leur programme et à plus long terme ou, du moins, recevoir du soutien pour analyser leur expérience antérieure et clarifier leurs intentions. Les adopteurs précoces pourraient jouer un rôle actif auprès du groupe en tant que modèles de rôle et de soutien aux pairs.

Les principaux résultats de l'étude apportent une certaine lumière quant aux caractéristiques et aux prédicteurs qui ont influé sur l'adoption de l'activité physique régulière dans le cadre d'un programme de promotion de la santé dans une population adulte. Ils permettent d'identifier des populations cibles et confirment la prédominance des facteurs prédisposants dans la décision de devenir et de demeurer actif. Par contre, ils ne nous éclairent pas nécessairement sur la dynamique psychosociale du changement volontaire de comportements, c'est-à-dire le lien entre les croyances, les attitudes, l'intention et le comportement, ces dimensions n'ayant pas été mesurées de façon spécifique dans l'étude originale. Green et al. (1980) attribuent aux trois types de facteurs un rôle direct sur le comportement problématique. Nos résultats et la recherche récente dans le domaine des prédicteurs psychosociaux des comportements reliés à la santé indiquent plutôt que les facteurs prédisposants agissent directement sur l'intention de changement qui, elle, prédit le comportement, alors que les facteurs facilitants et de renforcement agissent directement sur le maintien de l'intention face au comportement et indirectement sur les facteurs qui prédisposent à l'action. Godin (1991) illustre la place des modèles psychosociaux de prédiction du comportement dans un modèle de planification des interventions éducatives (Figure 1). La littérature récente dans le domaine de l'activité physique indique que la majorité des chercheurs optent pour le choix de modèles explicatifs proposés par Ajzen et Madden (1986), Bandura (1977), ainsi que Fishbein et Ajzen (1975).

Figure 1

Place des modèles psychosociaux de prédiction du comportement dans un modèle de planification des interventions éducatives
Exemple illustré à partir du modèle de Fishbein et Ajzen

FACTEURS QUI PRÉDISPOSENT À L'ACTION
- Habiletés
- Présence de ressources
  - matérielles
  - personnelles

COMPORTEMENT

FACTEURS DE RENFORCEMENT DE L'ACTION
- amis
- parents
- etc.

Intention (1)

FACTEURS QUI PRÉDISPOSENT À L'ACTION

Attitude à l'égard du comportement (Aact)

Importance relative des composantes atti-tudinale et normative

Norme subjective (SN)

Croyances quant aux conséquences de réaliser le comportement (b)

Évaluation des conséquences (e)

Croyances de ce que des personnes influentes pensent quant à ce que je devrais ou ne devrais pas faire à l'égard du comportement à réaliser (nb)

Motivation à agir dans le sens exprimé par chacune des personnes influentes (mc)

Source : Godin, G. (1991). L'éducation pour la santé : les fondements psychosociaux de la définition des messages éducatifs. *Sciences sociales et santé, IX* (1) 67-94).

Implications

Les études de prédicteurs des comportements reliés à la santé répondent à deux questions problématiques : quelles sont les populations cibles à privilégier et que devrait être le contenu et les stratégies de programmes de promotion de la santé ? La recherche sur les prédicteurs de l'adoption et du maintien de l'activité physique chez les adultes évolue rapidement. Ces questions doivent être résolues afin que les interventions dans ce domaine soient le plus efficaces et efficientes possibles. Cependant, l'accent sur le changement de comportement individuel est condamné à des résultats modestes, à moins d'une évolution fondamentale du contexte social vers une valorisation quotidienne de l'activité physique. Les infirmières, dans leur rôle d'éducatrices à la santé, ont la responsabilité de promouvoir des habitudes de vie saines pour elles-mêmes et leur client(e)s. Les habitudes de vie saines constituent une des quatre catégories de facteurs qui influent sur l'état de santé (Lalonde, 1974). Les infirmières doivent reconnaître l'importance de l'activité physique régulière sur la santé et la qualité de vie à tous les âges de la vie. La connaissance des modèles psychosociaux qui expliquent les comportements reliés à la santé et leur utilisation dans la planification d'interventions éducatives individuelles ou collectives s'avèrent essentielles à la promotion d'une vie active. Le modèle écologique de Green et Kreuter (1991, 1980) propose l'identification et la modification des facteurs prédisposants, facilitants et de renforcement qui contribuent à l'adoption de comportements reliés à la santé. Que ce soit en milieu institutionnel ou naturel de pratique, ce modèle de planification et d'évaluation des interventions éducatives constitue un outil utile pour la pratique infirmière en promotion de la santé (Hagan, 1990).

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Note

1. La dépense énergétique a été calculée à partir d'une mesure d'autodéclaration de la fréquence et du nombre de minutes accordées aux exercices, aux sports, aux activités de récréation et aux activités ménagères pendant les deux dernières semaines, de la façon suivante : kcal/kg/jour = $(N_j \times D_j \times METS_j / 14)$ où N est la fréquence de l'activité dans les deux dernières semaines, D est la durée moyenne de l'activité en heures, et METS est le coût énergétique de l'activité. Dans l'évaluation *Healthstyles*, le score final a été traduit en trois niveaux d'activité : sédentaire = 0 - 1,4 kcal/kg/jour ; activité minimale = 1,5 - 2,9 kcal/kg/jour ; activité adéquate = 3,0 et + kcal/kg/jour. Dans l'étude secondaire, un score de 2 kcal/kg/jour et plus équivaut à un comportement positif. Pour les besoins de l'analyse statistique, nous avons créé une variable dichotomique où adoption (1) = AD (2 kcal/kg/jour et plus) et la non-adoption (0) = NA (1,99 kcal/kg/jour et moins).

Remerciements

Book Review

The Colour of Democracy: Racism in Canadian Society
Frances Henry, Carol Tator, Winston Mattis, and Tim Rees
Toronto: Harcourt Brace & Company, Canada, 1995. 355pp.
ISBN 0-7747-3255-5

Reviewed by Patricia E. Stevens

The Colour of Democracy: Racism in Canadian Society is a compelling text
that, with each chapter, draws its readers into a deeper understanding
of racism and its destructive effects on the lives of individual Canadians
and Canadian society as a whole. With direct and coherent prose about
the entrenched system of White domination, the authors construct an
argument about racial bias and discrimination that is at once eminently
readable, unflinchingly honest, and deeply moving. Unlike so many
books about multiculturalism that aim to instil an appreciation of dif-
ference but obfuscate the consequences of prejudice and exclusion, *The
Colour of Democracy* focuses squarely on the social construction and
maintenance of racism.

Frances Henry, Carol Tator, Winston Mattis, and Tim Rees examine
"a central ideological struggle in Canadian society: The conflict between
the image of a country with a strong and cherished tradition of demo-
cratic liberalism and the reality of persistent and pervasive inequality
based on colour" (p. 6). They assert, "While individuals, organizations,
institutions, and the state vigorously deny the presence of racism, it
flourishes in this liberal democratic country, deeply affecting the daily
lives of people of colour" (p. 6). With an unerring commitment to lay
bare this contradiction, these four authors collectively bring to bear con-
ceptual acuity, academic wisdom, and organic knowledge of the mech-
anisms that keep racism alive and well. They define clearly their terms
and explain with uncanny insight the myths and misperceptions that
feed racist ideas and behaviours. By incorporating a comprehensive lit-
erature from Canada, Britain, and the United States, they tell the
repressed history of racism and expose its cultural and ideological
roots. Through a series of case studies, they analyze the deep-seated

*Patricia E. Stevens, R.N., Ph.D., is an Assistant Professor in the University
of Wisconsin-Milwaukee School of Nursing.*

resistance to anti-racist change in organizational culture, policies, and practices, uncovering methods commonly used today to maintain the status quo of racial subordination. The heart of the book is found in eloquently written chapters about how racism affects policing, the justice system, human services, education, the arts, media, and government. With bold and forceful brush strokes the authors paint an ornate picture of the multiple manifestations of racism in current Canadian society. Their argument culminates in strategies for ending racism that hold hope for the future.

Much more effectively than comparable cultural diversity texts, this book elaborates emotions, beliefs, and practices across societal institutions that sustain differential advantage for dominant-race people. To their immense credit, the authors honour the complexity of racism, demonstrating throughout their treatise how inequitable race relations are affected by interlocking systems of domination including sexism and class oppression. *The Colour of Democracy: Racism in Canadian Society* would serve well as a cornerstone text for any curricular offerings on cultural diversity and health, culturally competent nursing care, and social and health policy. Its value as a tool for education, consciousness-raising, and organizational change crosses disciplinary and national boundaries. It should be essential reading for Canadian, British, and American nursing scholars who practice, do research, administer programs, or teach future generations of nurses, because with knowledge, clear-sighted vision, steadfast critique of racism in all its shapes and sizes, and strategic anti-racist actions, we can help make a world less conditioned by misery, exclusion, animosity, and the politics of deceit.

Happenings

Three Quarters of a Century: Cause for Celebration

Deborah Fertuck

Four Canadian university schools of nursing recently celebrated their 75th anniversary.

In 1919 the University of British Columbia founded the first degree course for nurses in the British Empire. In 1920 programs were established at McGill and the Universities of Toronto and Western Ontario. In 1994 and 1995 the occasion was marked by events at all four institutions.

University schools of nursing face particular challenges in today's climate of health-care reform. Slogans reflecting this theme were reproduced on stationery, posters, and banners.

The schools initiated their celebrations with birthday parties and receptions for students and faculty as well as colleagues from clinical settings, other university departments, and community colleges. There were cake- and ribbon-cutting ceremonies, group photographs, and exchanges of congratulatory messages.

Each school dedicated its annual International Nursing Research conference to the anniversary. These are held by and for alumnae, adjunct faculty, and the nursing community to discuss such ideas as health-care trends and the links between hospitals and the community.

Alumnae played a key part in planning the events – symbolizing the fact that alumnae support has ensured the continued success of all four schools. An opportunity for them to reminisce was provided in a commemorative issue of the McGill alumnae newsletter, which featured photographs old and recent as well as memories from around the world.

Deborah Fertuck, M.Sc., N., is a faculty lecturer in the Undergraduate Program of the School of Nursing, McGill University, Montreal, Quebec.

Joan M. Gilchrist was honoured by two schools for her role in the development of nursing in Canada. Western Ontario presented Professor Gilchrist with an honorary doctorate, while McGill renamed a conference series for her. McGill also named a learning resource centre for Dr. F. Moyra Allen, to commemorate her important contributions to nursing.

A University of Toronto celebratory dinner featured faculty "roasts" and the screening of a videotape on the history of the school. Anecdotes were traded at a luncheon attended by 150 people, including alumnae and former professors.

At the University of Western Ontario, a luncheon for 135, including alumnae from the past 50 years, featured *The Lady with the Hammer,* a play about Florence Nightingale. Faculty members dressed in costumes from 75, 50, and 25 years ago added to the historical flavour.

The UBC celebrations featured period dress as well. Students and faculty members wore styles from a particular era, and guests were treated to an exhibition of dolls in period costume. At an alumnae dinner on May 12, Florence Nightingale's birthday, a book outlining the history of the school was presented by its authors, Ethel Warbinek and Glennis Zilm. The UBC School of Nursing also held a public lecture series.

Partnerships with communities, public support, and the role of the family were prominent themes. A McGill display on nursing and family health travelled around Montreal, while a public exhibition on campus featured photographs, newspaper clippings, and publications from the past 75 years.

Two of the schools linked past and future by naming new heads. Dr. Katharyn May was welcomed as dean of the UBC School of Nursing, while Dr. Laurie Gottlieb took on the directorship of the McGill school.

The work of faculty, students, and alumnae in mounting these anniversary events testifies to the strength and dedication of our nursing communities. This is certainly something to celebrate.

Call for Papers

Chronicity
Winter 1996 (vol. 28, no. 4)

The aim of this issue is 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 concerning people and families living with chronic health conditions are invited.

Guest Editor: Dr. Sharon Ogden Burke
Submission Deadline: July 15, 1996

Health Promotion
Spring 1997 (vol. 29, no. 1)

The following themes are suggested for this issue: theories and paradigms underlying health-promotion concepts; determinants of health; individual, family, and population approaches adapted to diverse subcultures; health education; empowerment; evaluation of nursing programs in health promotion; and research methods appropriate for this field.

Guest Editor: Dr. Denise Paul
Submission Deadline: September 15, 1996

Developing Family
Summer 1997 (vol. 29, no. 2)

This issue will focus on knowledge needed to provide effective care to contemporary families during the reproductive experience. Preference will be given to completed research that provides new knowledge to guide practitioners caring for families during conception, pregnancy, birth, and postpartum. Both qualitative and quantitative work will be welcome including research that replicates, refines, or expands previous studies.

Guest Editor: Dr. M. Colleen Stainton
Submission Deadline: December 15, 1996

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

Articles à publier

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: Dre Sharon Ogden Burke
Date limite pour les soumissions: le 15 juillet 1996

La promotion de la santé
Printemps 1997 (vol.29, no. 1)

Ce numéro cible le domaine de la promotion de la santé. Les thèmes suivants sont suggérés: théories et paradigmes sous-jacents aux concepts de santé et de promotion de la santé, déterminants de la santé, approches individuelles, familiales et populationnelles adaptées aux diverses sous-cultures, éducation de santé, appropriation (empowerment), évaluation de programmes de soins infirmiers en promotion de la santé et méthodologies de recherche appropriées à ce domaine.

Rédactrice invitée: Dre Denise Paul
Date limite pour les soumissions: le 15 septembre 1996

La croissance de la famille
Été 1997 (vol.29, no. 2)

Ce numéro traitera des connaissances exigées pour procurer des soins efficaces aux familles d'aujourd'hui pendant le processus de procréation. La préférence sera donnée aux recherches approfondies procurant de nouvelles connaissances pour guider les praticiens qui dispensent les soins aux familles pendant la conception, la grossesse, la naissance et la post-natalité. Les travaux qualitative et quantitative seront les bienvenus, tout comme ceux qui reproduisent, affinent ou développent les études précédentes.

Rédactrice invitée: Dre M. Colleen Stainton
Date limite pour les soumissions: le 15 décembre 1996

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St. Amant Centre, a major resource centre located in Winnipeg, Manitoba, Canada, provides an array of quality services to persons with developmental disabilities. We are currently seeking an established Scientist to develop and build an exciting new research venture in quality of life enhancement.

Affiliated with the Faculty of Nursing, you will be supporting nurse researchers as well as fostering development of interdisciplinary research based at St. Amant Centre. In order to address the priorities of the funding partners, the applicants research interest must include relevance to the nursing profession, and to persons with developmental disabilities in the community and developmental centres.

The Search Committee will consider a broad range of candidates who possess a background of progressively increasing responsibility in disabilities' research and a completed doctoral level degree. The appointment will be available as early as September 1, 1996. A competitive salary and benefits package are negotiable in relation to qualifications.

Winnipeg ...

Winnipeg, with a population of 610,000, offers residents a cultural mosaic and a variety of entertainment opportunities including: symhony, ballet, opera, live theatre and professional sports. While having one of the lowest housing costs among major Canadian cities, Winnipeg is also close to some of the world's finest vacation retreats, lakes and forest country.

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Mr. Denis Bourrier
President, St. Amant Centre Inc.
440 River Road
Winnipeg, Manitoba R2M 3Z9
Telephone: (204) 256-4301
Fax: (204) 257-4349

A partnership research program with the University of Manitoba – Faculty of Nursing, St. Boniface General Hospital Research Foundation, and The Friends of St. Amant Foundation.

The University of Alberta
Faculty of Nursing

EMPLOYMENT OPPORTUNITIES

The University of Alberta Faculty of Nursing is looking for five (5) highly qualified individuals for teaching positions beginning July, 1997 at the assistant or associate professor level ($38,325.00 - $68,056.00). Appointment salary is commensurate with qualifications and experience. Ideal candidates will have clinical expertise and/or specialize in the areas of perinatal nursing, community health, epidemiology, gerontology, rehabilitative nursing, or mental health. One candidate is required with strength in quantitative research methodologies and statistical analysis.

Ideal candidates will have a doctoral degree, preferably in nursing. Other qualifications include, but are not limited to, a master's degree in nursing and an established program of research reflected in publications in refereed journals. Applicants must hold current nursing registration in Alberta or be eligible to be registered as a nurse in the Province of Alberta.

Applicants should submit a curriculum vitae, a teaching dossier, and the names of three referees to Dr. Marilynn J. Wood, Dean, Faculty of Nursing, University of Alberta, 3-129 Clinical Sciences Building, EDMONTON, Alberta, Canada T6G 2G3.
Closing date: September 1, 1996.

The University of Alberta is committed to the principle of equity in employment. As an employer we welcome diversity in the workplace and encourage applications from all qualified women and men, including Aboriginal peoples, persons with disabilities, and members of visible minorities.

University of Prince Edward Island
Dean, School of Nursing

The University of Prince Edward Island invites applications and nominations for the Dean of the School of Nursing. The School, which graduated its first class in 1996, offers a four-year integrated baccalaureate program based on Primary Health Care and currently has a proposal in review to commence a Post-RN program in September 1997. At present, the School has seven full-time and 13 part-time faculty members and approximately 100 students. As the only nursing program in the province, the School has strong links with the community and is actively involved in ensuring the delivery of quality health care in a changing health-care system.

The University of Prince Edward Island has an enrolment of 2,700 full- and part-time students and a teaching faculty of 200. The University provides a rich blend of academic programs in the arts, sciences, business, education, nursing, and veterinary medicine. These programs are predominantly at the undergraduate level and attract students from the Maritime region and beyond. The School of Nursing is one of six faculties and schools within this community of scholars.

As the senior executive officer of the School, the Dean is expected to be a dynamic leader and to serve as a role model in the pursuit of excellence in education, research, and professional practice. The successful applicant will help to create and to support opportunities for nursing students, faculty, and staff so that they may continue to have a positive impact on health care. The position involves being an effective advocate for nursing within the University and beyond. The Dean of Nursing will promote collaboration in education and research. We are seeking a recognized scholar and administrator in the field of nursing, one who is prepared to be innovative in the further development of the academic and research profile of the School. The successful candidate will have a minimum of a master's degree in nursing, an earned doctoral degree, and eligibility for registration with the Association of Nurses of Prince Edward Island.

The term of appointment is for six years commencing 1 July 1997. Salary is commensurate with experience and qualifications. In accordance with Canadian immigration requirements, priority will be given to Canadian citizens and permanent residents of Canada. The University of Prince Edward Island is committed to employment equity.

Applications, including a complete *curriculum vitae* (and the names of three referees from whom you have requested letters of reference), should be submitted by 27 September 1996; nominations should be submitted by 13 September 1996 to:

Chair, Search Committee for a Dean of Nursing
c/o Office of the President
University of Prince Edward Island
550 University Avenue
Charlottetown, P.E.I. C1A 4P3

Telephone: (902) 566-0400
Fax: (902) 628-4311

The University of Victoria
School of Nursing

The School of Nursing offers a baccalaureate program, both generic and post-R.N., in collaboration with colleges and university-colleges in British Columbia. This innovative curriculum prepares nurses to work with individuals, families, groups, and communities in a variety of settings guided by a health-promotion perspective. The program is available through both distance and on-campus formats.

The School of Nursing is also a partner in a multidisciplinary Master's Program that prepares graduates to contribute to policy and practice in health and human services. By meeting certain criteria, nurses enrolled in this program are able to earn a Master's of Nursing. The School is also planning to offer a Master's of Nursing via distance education.

Applications are invited for the following positions:

Assistant/Associate Professor

Four tenure track positions. One position will have a start date of January 1, 1997. *These positions are subject to funding.* Minimum requirements are an earned doctorate, a strong clinical background and focus, and teaching experience in a university. Evidence of a developing research and publication program is also required. Collaborative and interdisciplinary experience would be assets. There is a possibility that one of these positions may be based in Vancouver or the Lower Mainland. Salary will be commensurate with experience.

Applications should be received by October 15, 1996, and should be accompanied by a curriculum vitae and the names of three referees. Applications should be addressed to:

Dr. Janet Storch, Director
School of Nursing, University of Victoria
Human and Social Development Building
P.O. Box 1700
Victoria, B.C. V8W 2Y2

The University of Victoria is an employment equity employer and encourages applications
from women, persons with disabilities, visible minorities and aboriginal persons.

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 ½" 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 name(s), 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 follow the text.

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

Tables and figures: Tables and figures should appear only 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 approximately 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 dévelope 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 infimmières. 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 216mm x 279mm. 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.

Veuillez adresser vos manuscrits à la rédactrice en chef, *La revue canadienne de recherche en sciences infirmières*, Université McGill, 3506 rue University, Montréal, QC, H3A 2A7.

Manuscrits

Tous les manuscrits doivent se conformer à la quatrième édition du *Publication Manual of the American Psychological Association*. Les articles de recherche doivent suivrent les consignes énoncées dans le « APA » en guise de présentation de la littérature, des questions de recherche et d'hypothèses, de la méthode, et de la discussion. Tous les articles doivent obéir au manuel « APA » pour les références, les tableaux, et les schémas. N'employez pas de notes au bas de la page.

Page titre: Elle devrait inclure le nom, l'adresse et l'affiliation de l'auteur ou des auteurs, les diplômes obtenus, information sur l'aide financière obtenue, remerciements, demande de copies.

Résumé: Les articles de recherche doivent être accompagnés d'un résumé de 100 à 150 mots, incluant l'objet de la recherche, la conception, l'échantillon, les résultats et les implications. Les manuscrits de théories et de critiques doivent inclure une déclaration des arguments principaux, la structure d'analyse, et un résumé de la discussion.

Texte: La longueur acceptable d'un article n'excède plus que 15 pages, à double interligne. Les articles peuvent être rédigés soit en anglais, soit en français.

Références: Les références doivent paraître en ordre alphabétique, à double interligne, et doivent suivrent le texte. Les noms d'auteurs et les citations de revues doivent être épeler entièrement.

Tableaux et schémas: Les tableaux et schémas doivent paraître seulement si nécessaire. Ils doivent résumer des informations pertinentes sans enlève le contenu du texte. Chaque tableau doit inclure un court titre, opprimer les abréviations et doit être dactylographié sur une page à part. Veuillez remettre les originaux des schémas, qui doivent être dessinés à l'encre de Chine et prêts à photographier.

Examen des manuscrits et renseignements relatifs à la publication: Les manuscrits présentés à la revue sont évalués de façon anonyme par deux lectrices. A la réception du manuscrit original, l'auteur est avisé que le Comité de rédaction prendra une décision au sujet de la publication de son article dans les douze semaines.

Copie électronique: Les auteurs doivent remettre une copie acceptable de l'article sur disquette à l'acceptation finale de l'article.

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Nous vous invitons également à présenter des articles à la *Revue canadienne de recherche en sciences infirmiers*. La revue publie des articles traitant de recherche clinique, de questions méthodologiques, de recherche en éducation, de recherche historique ainsi que des articles théoriques et des prises de position susceptibles de faire avancer les connaissances en matière de sciences infirmières. On peut également obtenir du directeur de la diffusion des renseignements sur les auteurs ainsi que les critères d'acceptation des articles.

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