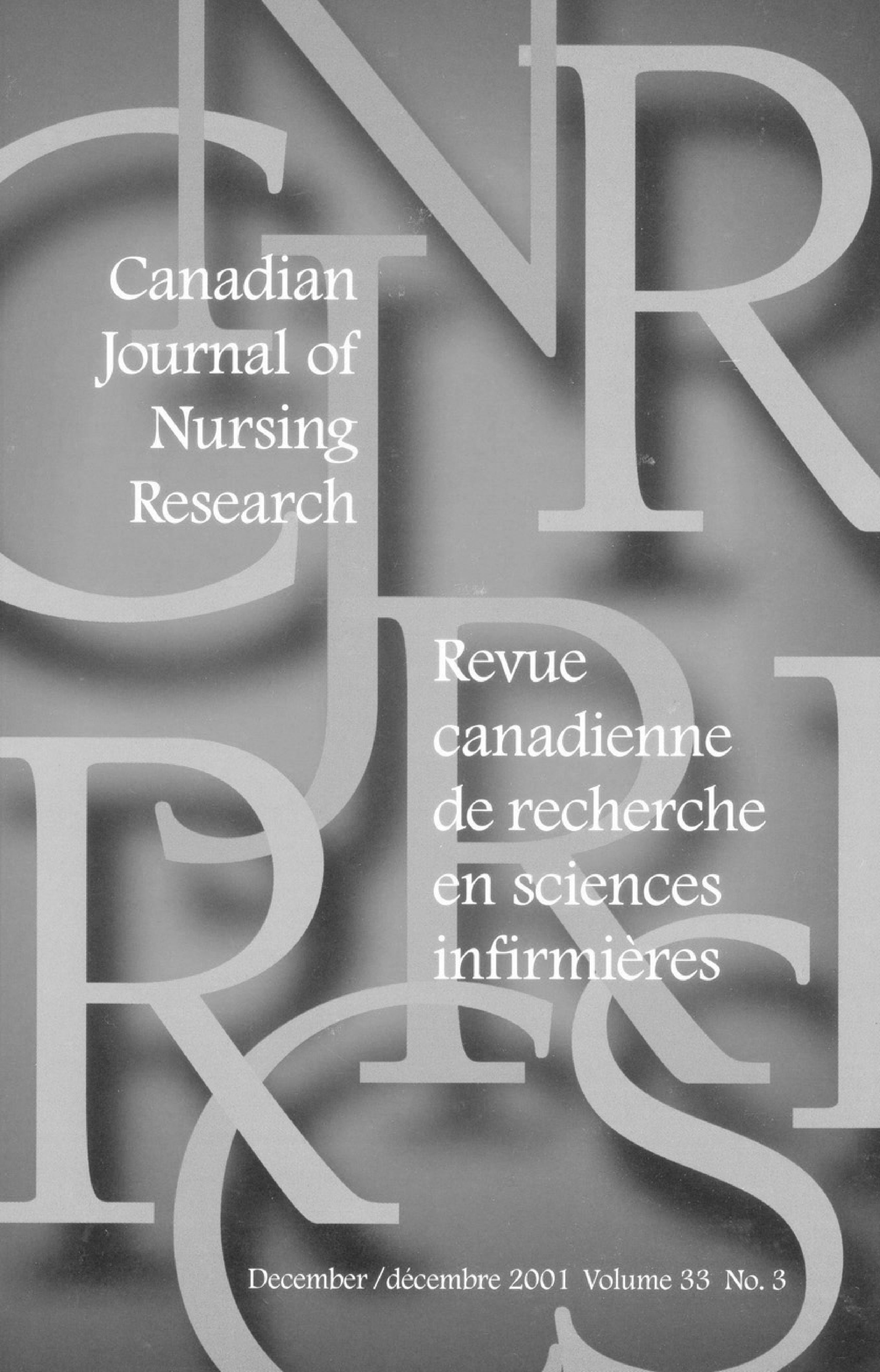

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GUEST EDITORIAL

Women's Health

Anita J. Gagnon

This is an exciting time to be conducting research in Canada, especially in the area of women's health. The social significance of women's health and its relevance as a field of inquiry have increased tremendously in recent years. A variety of research methodologies are becoming more widely accepted and few topics are now taboo. In addition, support is available to researchers in women's health through a range of mechanisms, including, most importantly in this country, the newly created Canadian Institutes of Health Research (CIHR).

The articles published here represent various facets of women's health research both in terms of subject matter and in terms of methodology employed. Dr. Stewart and her colleagues set the stage by providing us with an overview of current research priorities related to gender and health. Her position as Director of the CIHR's Institute of Gender and Health affords her a particularly clear vantage point from which to discuss the key research themes of our times in terms of women's health.

Dr. Arthur and her colleagues describe a participatory action research study designed to develop and implement a community-based support group for women living with heart disease. This study goes beyond testing an intervention that might have been developed for men and subsequently applied to women; it adds to our knowledge of the experiences of women by describing an intervention that *emanates* from women's perspectives.

Dr. Loiselle and her colleagues describe women's perceptions of breastfeeding information and support received from hospital- and community-based health professionals in a multiethnic community, based on a telephone survey of Canadian-born and immigrant women. This paper informs nursing practice both in terms of new knowledge required to care for families originating from a greater number and variety of countries for immigrants to Canada and as postpartum care provided between hospital and home are continuously being redefined.

The abortion experience is a relatively understudied area of women's health. Dr. McIntyre and her colleagues advance our knowledge of this area by describing a hermeneutic phenomenological study of the experience of living with the decision to have an abortion, and of the meanings abortion generates in the context of women's lives.

Abuse affects the lives and health of millions of women worldwide. Dr. Tiwari and her colleagues add greatly to our understanding of how Chinese women living in Hong Kong respond to battering. The combined research methodology these investigators used is one not frequently seen in the health field — narrative inquiry drawn from stories published by a service-providing agency. The experiences of the women, and particularly the resilience and resourcefulness they demonstrated, provide evidence of the universality of battering and women's response to it.

Finally, Dr. Heaman describes research strategies to be used with vulnerable women, including visible minorities and other marginalized groups. This paper offers us suggestions for practical research approaches which will permit us to respond to the women's health research priorities of our time, as initially set out in the Discourse.

The variety of topics of inquiry and methodologies employed in women's health research, as evidenced in this issue of the Journal, is vast. Certain topics relevant to women are notably absent, including sexuality, lesbian health, and female cancer care. Although space limitations restrict the number of articles that can be published in each issue, I believe the absence of such inquiry from these pages is more likely reflective of the relatively smaller amount of research and resulting manuscript development being done in those areas and may suggest a need for more research focusing on them. The richness of women's health as a field of research, and the variety of types of investigations being conducted, are, however, well reflected in this volume.

Anita J. Gagnon, RN, PhD, is Assistant Professor, School of Nursing, McGill University, Nurse Scientist, McGill University Health Centre, Montreal, Quebec, Canada, and Associate Editor, Canadian Journal of Nursing Research.

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Discourse

Research Priorities in Gender and Health

Miriam J. Stewart, Kaysi Eastlick Kushner, and Denise L. Spitzer

This year we witnessed an unprecedented event, the creation and exponential growth of a national research institute devoted to the study of gender and health. The launch of the Canadian Institutes of Health Research (CIHR) Institute of Gender and Health represented the culmination of directions recommended by research- and policy-influencing groups in Canada. Key international and national initiatives that provided a foundation for this Institute were the Canada–USA Women's Health Forum in 1996; the development of five Centres of Excellence on Women's Health, funded by Health Canada in 1996; and the creation of Wyeth-Ayerst and MRC-PMAC Clinical Research Chairs in Women's Health. Guiding documents included *CIHR 2000: Sex, Gender and Women's Health* (British Columbia Centre of Excellence for Women's Health, 1999), *A Women's Health Research Institute in the Canadian Institutes of Health Research* (Working Group on CIHR, Gender and Women's Health Research, 2000), and *Agenda for Research on Women's Health for the 21st Century* (National Institutes of Health, 1999).

Initial consultations across the country elicited input on strategic research priorities. Mechanisms used for these consultations included

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Miriam J. Stewart, MN, PhD, is Scientific Director, CIHR Institute of Gender and Health, and Professor in the Faculty of Nursing and in Public Health Sciences, Faculty of Medicine, University of Alberta, Edmonton, Canada. Kaysi Eastlick Kushner, RN, PhD, is Assistant Director, CIHR Institute of Gender and Health, and Assistant Professor, Faculty of Nursing, University of Alberta. Denise L. Spitzer, PhD, is Visiting Assistant Professor, Women's Studies Program, and Adjunct Professor, Department of Anthropology, University of Alberta.

brainstorming sessions, information and feedback sessions, meetings with individuals and groups, conference presentations, written submissions, and discussions with the Scientific Directors of all CIHR Institutes and other potential partners.

Priorities for Research in Gender and Health

The key themes and issues emerging from the consultations across the country and from review of the relevant literature were summarized and synthesized. Five major themes were: (1) access and equity for vulnerable groups, (2) promoting health in the context of chronic conditions, (3) gender and health across the lifespan, (4) promoting positive health behaviours, and (5) gender and the environment. The exemplar issues, generated in diverse consultations, were ranked based on a weighting system, to identify priorities for research. The "Top Ten" list (see Table 1) of the research priorities and relevant literature are briefly outlined below.

Gender, Health Equity, and Access to Health Services for Vulnerable Groups

Inequities in health are grounded in disparities in access to health determinants, such as income, social support, and housing, and are exacerbated by experiences of discrimination, the demands of multiple roles, and geographic location (Amaratunga, 2000). Members of marginalized populations may either have limited access to health services or feel constrained in their participation due to their marginalized status. Social exclusion due to income, culture, gender, ability, or geography can also have multiple impacts on health (Buckner, 1988; Nasar & Julian, 1995). Gender-sensitive research should investigate issues of the political economy of health, health equity, and access to health services for visible minority, First Nations, immigrant and refugee women and men, people with disabilities, rural residents, prisoners, intravenous drug users, the homeless, and international populations. The mediation between gender, social environment, psychological well-being, and human physiology is poorly understood; consequently, attention to gender and psycho-social context are perceived to be inadequately addressed in clinical settings. Clinical practice in terms of both prescribing regimes and client-practitioner interaction require further investigation. This research priority focuses on socio-cultural environments and access to, and appropriateness of, health services.

Table 1 *Research Themes and Priorities*

Research Theme	Priority Issues
Access and equity for marginalized groups	Gender, health equity, and access to health services for vulnerable groups Gender, violence, and health across the lifespan
Promoting health in the context of chronic conditions	Gender and chronic conditions across the lifespan Gender and cardiovascular disease
Gender and health across the lifespan	Gender and healthy child development Gender and healthy aging Gender and work, leisure, and health Gender and mental health across the lifespan Gender and reproductive and sexual health
Promoting positive health behaviours	Gender, promoting positive health behaviours, and preventing addictions
Gender and the environment	

Gender, Violence, and Health Across the Lifespan

The physical, physiological, and psychological impacts of violence on females and males interact with socio-cultural contexts to influence their response and help-seeking behaviour (Lenssen, Doreleijers, van Dijk, & Hartman, 2000; Rigby, 1998). The experience of violence increases risk of physical injury, psychological distress and disorders, infectious diseases, and addictions (Saringiani, Ryan, & Petersen, 1999; Taussig & Litrownik, 1997). There is a need to focus on the experiences of survivors of violence, including visible minority women, persons with disabilities, lesbian, gay, bisexual, and transgendered individuals, and men; the effects of these experiences on survivors and witnesses; and the efficacy of services provided to survivors. Social, cultural, and environmental influences on survivors and perpetrators of violence should be considered in investigations into the social and political contexts and gender and social roles that contribute to the perpetuation of, or abstinence from, violence. In addition, the relationship among gender, socio-economic status, social and cultural identity, and the uptake of services must be explored.

Gender and Chronic Conditions Across the Lifespan

The experience, prevalence, and meanings of chronic diseases and disabilities are influenced by gender, age, culture, sexual orientation, socio-economic status, and geographic location. Help-seeking behaviour, symptom expression, treatment options, and coping strategies are influenced by gender. This can affect relationships with health-care practitioners for diverse people with chronic conditions, including cancer (Nicholas, 2000; Znajda, Wunder, Bell, & Davis, 1999), disabilities (Krause, Kemp, & Coker, 2000), and HIV/AIDS (Sowell, Moneyham, & Aranda-Naranjo, 1999). Although attention to structural factors, such as poverty, gender inequality, and migration, that contribute to disease transmission has increased, further research is needed (Parker, Easton, & Klein, 2000). Sex and gender differences inform vulnerability to, expression of, and response to chronic diseases; however, these variations require further exploration. Research can illuminate the relationships among sex, genetics, and immune response, and can explore sex/gender differences in symptom expression and treatment response. Deployment and efficacy of coping strategies, the influence of the social world, and cultural scripts regarding stoicism and pain expression offer rich areas of investigation that can enhance gender-appropriate health services.

Gender and Cardiovascular Disease

One chronic condition that has received particular attention from a gender perspective is cardiovascular disease. This leading cause of death in Canada is associated with various social factors, including gender, education, employment, socio-economic class, and social isolation (Heart and Stroke Foundation of Canada, 1999). Morbidity and mortality, as well as symptoms, treatment options, and psychosocial adjustment, appear to differ according to gender. Only recently have researchers attended to gender differences in presentation and diagnosis of heart disease, observing that women and men report different symptoms — the perceived seriousness of which will determine whether they seek medical attention (Beery, 1995; Mendes, 1997). Furthermore, gender appears to affect perceptions of quality of life, physical activity, and impairment of role status (Chin & Goldman, 1998; Heart and Stroke Foundation of Canada); treatment offered (Beery; Mendes); and participation in cardiac rehabilitation (Brezinka & Kittel, 1996). Investigation is required into the relationships among gender, culture, socio-economic context, help-seeking behaviour, and access to and satisfaction with health services.

Gender and Healthy Child Development

From childhood through adolescence, females and males face changing and disparate threats to their health and well-being, including injuries, vulnerability to physical and psychological complaints, and the adoption of risky behaviours (Gabhainn & Kelleher, 2000; King, Pickett, & King, 1998; Kolip, 1997). Social and cultural factors interact with gender to influence growth and development and engagement in health-promoting and health-damaging behaviours. These trends have implications for research on response and access to treatment and prevention strategies. Health promotion programs are necessary for youth to prevent injuries, encourage positive health behaviours, and promote healthy social, emotional, and physical development.

Gender and Healthy Aging

Gender and sex differences in the biophysical consequences of aging have ramifications for longevity, impairment, treatment strategies, adherence to regimens, and the delivery of health services. Female seniors are often economically disadvantaged in comparison to men (Health Canada, Division of Aging and Seniors, 2000); however, males are more likely to adopt negative health behaviours in response to stress (National Advisory Council on Aging, 1999). According to the World Health Organization (1998), "In order to be effective, health research and programs need to recognize gender differences in both health and ways of living. Men die earlier, while women experience greater burdens of morbidity and disability. Women constitute the majority of caregivers; supporting them is a key health policy challenge." The issues of aging, isolation, and poverty from a gender perspective must be studied. Social context and cultural constructs of gender and age influence the potential for healthy aging and require further investigation.

Gender, Work, Leisure, and Health

Gender inequality in paid and unpaid labour, such as the demands of the "double shift" and workplace hazards, and gender discrimination underpin some health inequities between women and men (Emslie, Hunt, & Macintyre, 1999). Women have been burdened disproportionately by the impact of health-care restructuring both in the workplace and as family caregivers (National Coordinating Group on Health Care Reform and Women, 2000). Furthermore, occupational health measurements often do not consider the types of jobs most often performed by women (Messing, Dumais, & Romito, 1993). More research is required on the impact of marginalization, caregiving, other forms of unpaid work, and work stress on women and men. The context of changes in institutional, community, and familial responsibilities resulting from health-system reform, and the impact of work demands on leisure time, should be studied. Research needs to encompass the multiple forms of labour in which women and men engage and to examine the demands of the double shift on health.

Gender and Mental Health Across the Lifespan

Mental health is influenced by the biophysical, personal, and socio-cultural environment (Krause et al., 2000; Rothbard & Azarian, 1998). Gender roles may interact with other stressors to have a differential impact on mental well-being for men and women. Research needs to focus on mental health issues among particular groups, including adolescents, immigrants and refugees, and adult men and women. The relationship between mental and physical health should be explored and special attention paid to the role of spirituality in maintaining mental well-being. Differential treatments and services offered to women and men, and the physical and psychological sequelae of personal violence and trauma, require investigation. Cultural constructs of mental health and its relation to gender roles and well-being must be considered along with culturally grounded coping and healing strategies.

Gender and Reproductive and Sexual Health

Although reproductive and sexual health studies are primarily focused on women's procreative activities, they encompass a range of issues, including disabilities and sexuality, reproductive technologies, environmental influences on male and female reproductive health, sexual minorities, and the impact of sexual and physical abuse (Lensson et al., 2000; Proctor, 2001; Waxman, 1996). Pregnancy-related issues, including maternal care, hysterectomies and alternatives, assisted reproductive technologies, and pelvic health, require research. Reproductive and sexual health benefits from a bio-cultural approach to fertility and infertility. Cultural and social constructions of reproductive and sexual health circumscribe the context in which sexual activities and discussions of sexual matters can take place. The demands for health services that are sensitive to sexual minorities need to be addressed.

Gender, Promoting Positive Health Behaviours, and Preventing Addictions

Sex and gender differences are apparent in the engagement of both negative and positive health behaviours. Negative health behaviours, such as smoking and alcohol and substance abuse, have been linked with "gendered" responses to stress, gender role performance, and personal histories of physical and sexual abuse (Barber, Bolitho, & Bertrand, 1998; Roxburgh, 1998). Treatment strategies are differentially effective for women and men (Booth & McLaughlin, 1996). Positive health behaviours, such as physical activity and healthy nutrition, also differ according to gender and age. Women's desires to exercise are balanced against perceived "male" sports, disempowering stereotypes of the female body, familial obligations, and the inability to put personal needs first (Bialeschki & Pearce, 1997; Thomsson, 1999). Research should be launched to investigate the relationships of physical activity, physical labour, or eating disorders with gender. Researchers must delve further into sex-specific physiological effects of tobacco, alcohol, illegal drugs, and the pharmaceutical preparations used to curb addictions to these substances. Gender differences influence the motivation to engage in positive or negative health behaviours.

Gender and the Environment

Health outcomes are the result of individual, communal, and societal interactions with the biophysical, socio-cultural, and political-economic environments (Kettel, 1996). Exposure to environmental toxins can be structured by gender roles and socio-economic status (Falk et al., 1999; Washington, 1999). Research needs to explore how gender, intersecting with variables of class, ethnicity, sexual orientation, and (dis)ability, influences interactions with environments to produce differential health outcomes. Physiological response to, and mitigation of, biophysical and social environmental hazards interest researchers. Social, cultural, and environmental influences are pivotal to understanding and implementing health service delivery.

Concluding Comments

The Institute of Gender and Health was designed to link across national borders and have international impact. From the outset, it was recognized that this Institute would benefit from the groundbreaking work of the Centres of Excellence on Women's Health and Clinical Research Chairs in Women's Health, but that there was likely a wealth of additional expertise on gender and health that may not have been tapped. Consequently, an environmental scan of Canadian capacity to conduct gender and health research was initiated. The Institute reviewed 15 databases of funding agencies, foundations, and organizations to identify researchers engaged in gender and health research. Moreover, consultations with stakeholders in policy, public, practice, and academic realms yielded information. Through these mechanisms, over 1,700 researchers have been identified to date.

The objectives that guide opportunities offered by the Institute are to: (1) *generate evidence* regarding (a) health status, health behaviour, and health services use of females and males across the lifespan; and (b) influence of gender and sex on health status, health behaviours, and health services use, and interactions with other determinants of health (e.g., ethnicity, socio-economic status, education); (2) *provide evidence* to inform design of programs, policies, and practices that enhance health of women, men, girls, and boys in Canada; and (3) *enhance the capacity* to conduct gender and health research in Canada.

The credibility of the Institute of Gender and Health will be enhanced through strategic initiatives that draw attention to gaps in research, address major health-related issues in Canada, and reflect the diversity among women, men, and transgendered individuals across the lifespan. The Institute will continue to launch capacity-building initiatives for researchers and neglected research areas and attract investigators to the study of gender and health. It is hoped that the innovation and scope of this Institute's research will engender enthusiasm among researchers, policy influencers, practitioners, program planners, and the public. Nurses have played a key role in consultations, applications, Institute leadership, peer review, and on the Advisory Board. The Institute provides a vital opportunity for nurses to participate in bringing gender-sensitive health research into the mainstream of health research. This will support the continuing development of innovative interdisciplinary knowledge to underpin nursing and promote the health of Canadians.

References

Amaratunga, C. (Ed.). (2000). *Made to measure: Women, gender and equity.* Halifax: Maritime Centre of Excellence for Women's Health.

Barber, J., Bolitho, F., & Bertrand, L. (1998). Age and gender differences in the predictors of adolescent drinking. *Social Work Research, 22*(3), 164–172.

Beery, T. (1995). Gender bias in the diagnosis and treatment of coronary artery disease. *Heart and Lung, 24*(6), 427–435.

Bialeschki, M., & Pearce, K. 1997. "I don't want a lifestyle — I want a life": The effect of role negotiations on the leisure of lesbian mothers. *Journal of Leisure Research, 29*(1), 113–131.

Booth, B., & McLaughlin, Y. (1996). Barriers to and need for alcohol services for women in rural populations. *Alcoholism, 24*(8), 1267–1275.

Brezinka, V., & Kittel, F. (1996). Psychosocial factors of coronary heart disease in women: A review. *Social Science and Medicine, 42*(10), 1351–1365.

British Columbia Centre of Excellence for Women's Health. (1999). *CIHR 2000: Sex, gender and women's health.* Health Institute Design Grant. Ottawa: Social Sciences and Humanities Research Council and Canadian Health Services Research Foundation.

Buckner, J.C. (1988). The development of an instrument to measure neighborhood cohesion. *American Journal of Community Psychology, 16,* 771–791.

Chin, M.H., & Goldman, I. (1998). Gender differences in 1-year survival and quality of life among patients admitted with congestive heart failure. *Medical Care, 36*(7), 1033–1046.

Emslie, C., Hunt, K., & Macintyre, S. (1999). Problematizing gender, work and health: The relationship between gender, occupational grade, working conditions and minor morbidity in full-time bank employees. *Social Science and Medicine, 48,* 33–48.

Falk, C., Hanrahan, L., Anderson, H.A., Kanarek, M.S., Draheim, L., Needham, L., & Patterson, D. Jr. (1999). Body burden levels of dioxin, furans, and PCBs among frequent consumers of Great Lakes sport fish. *Environmental Research, 80*(2), S19–S25.

Gabhainn, S., & Kelleher, C. (2000). School health education and gender: An interactive effect? *Health Education Research, 15*(5), 591–602.

Health Canada, Division of Aging and Seniors. (2000). *Canada's seniors: Gender differences in income.* Ottawa: Statistics Canada. [Available: www.hc-sc.gc.ca/seniors-aines/pubs/factoids/en/no23.htm (May 28, 2001).]

Heart and Stroke Foundation of Canada. (1999). *The changing face of heart disease and stroke in Canada 2000.* Ottawa: Author.

Kettel, B. (1996). Women, health and the environment. *Social Science and Medicine, 42*(10), 1367–1379.

King, M., Pickett, W., & King, A. (1998). Injury in Canadian youth: A secondary analysis of the 1993–94 Health Behaviour in School-Aged Children Survey. *Canadian Journal of Public Health, 89*(6), 397–401.

Kolip, P. (1997). Gender differences in health status during adolescence: A remarkable shift. *International Journal of Adolescent Medicine and Health, 9*(1), 9–17.

Krause, J., Kemp, B., & Coker, J. (2000). Depression after spinal cord injury: Relation to gender, ethnicity, aging and socioeconomic indicators. *Archives of Physical Medicine and Rehabilitation, 81*(8), 1099–1109.

Lenssen, S., Doreleijers, T., van Dijk, M., & Hartman, C. (2000). Girls in detention: What are their characteristics? A project to explore and document the character of this target group and the significant ways in which it differs from one consisting of boys. *Journal of Adolescence, 23,* 287–303.

Mendes, L. (1997). Congestive heart failure in patients with coronary artery disease: The gender paradox. *American Heart Journal, 134,* 207–212.

Messing, K., Dumais, L., & Romito, P. (1993). Prostitutes and chimney sweeps both have problems: Towards full integration of both sexes in the study of occupational health. *Social Science and Medicine, 36*(1), 47–55.

Nasar, J.L., & Julian, D.A. (1995). The psychological sense of community in the neighborhood. *Journal of the American Planning Association, 61,* 178–184.

National Advisory Council on Aging. (1999). *1999 and beyond: Challenges of an aging society.* Ottawa: Government of Canada.

National Coordinating Group on Health Care Reform and Women. (2000). *Women and health care reform.* Ottawa: Women's Health Bureau, Health Canada.

National Institutes of Health. (1999). *Agenda for research on women's health for the 21st century: A report of the Task Force on the NIH Women's Health Research Agenda for the 21st Century.* NIH Publication #99-4385. Bethesda, MD: US Department of Health & Human Services, Public Health Services, National Institutes of Health.

Nicholas, D.R. (2000). Men, masculinity, and cancer: Risk-behaviors, early detection, and psychosocial adaptation. *Journal of American College Health, 49*(1), 27–33.

Parker, R., Easton, D., & Klein, C. (2000). Structural barriers and facilitators in HIV prevention: A review of international research. *AIDS, 14*(1), S22–S23.

Proctor, G. (2001). Listening to older women with dementia: Relationships, voices and power. *Disability and Society, 16,* 361–376.

Rigby, K. (1998). The relationship between reported health and involvement in bully/victim problems among male and female secondary school children. *Journal of Health Psychology, 3,* 465–475.

Rothbard, A.B., & Azarian, K. (1998). Race influences access and intensity of behavioral health care in a Medicaid managed care program. *Association for Health Services Research, 14,* 83 [Abstract].

Roxburgh, S. 1998. Gender differences in the effect of job stressors on alcohol consumption. *Addictive Behaviors, 23*(1), 101–107.

Saringiani, P., Ryan, L., & Petersen, A. (1999). Prevention of high-risk behaviors in adolescent women. *Journal of Adolescent Health, 25*, 109–119.

Sowell, R., Moneyham, L., & Aranda-Naranjo, B. (1999). The care of women with AIDS — special needs and considerations. *Nursing Clinics of North America, 34*(1), 179–202.

Taussig, H.N., & Litrownik, A.J. (1997). Self and other directed destructive behaviors: Assessment and relationship to type of abuse. *Child Maltreatment, 2*, 172–182.

Thomsson, H. (1999). Yes, I used to exercise, but. . . — A feminist study of exercise in the life of Swedish women. *Journal of Leisure Research, 31*(1), 35–56.

Washington, S. (1999). Gender, technology, and environmental policy. *Bulletin of Science, Technology and Society, 19*(5), 365–371.

Waxman, B. (1996). Commentary on sexual and reproductive health. *Sexuality and Disability, 14*, 237–244.

Working Group on CIHR, Gender and Women's Health Research. (2000). *A women's health research institute in the Canadian Institutes of Health Research: A proposal submitted by the Working Group on CIHR, Gender and Women's Health Research.* Ottawa: Canadian Women's Health Network.

World Health Organization. (1998). *Ageing and health (AHE): Programme directions and partnerships.* Geneva: Author.

Znajda, T.L., Wunder, J.S., Bell, R.S., & Davis, A.M. (1999). Gender issues in patients with extremity soft-tissue sarcoma: A pilot study. *Cancer Nursing, 22*(2), 111–118.

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Women and Heart Disease: The Treatment May End But the Suffering Continues

Heather M. Arthur, Donna M. Wright, and Kelly M. Smith

Bien que le principal problème de santé qui touche les femmes soit les maladies du cœur, la majorité des patients inscrits dans les programmes de réadaptation cardiologique axés sur la prévention secondaire sont des hommes. Les recherches indiquent que les programmes de réadaptation classiques ne satisfont pas les besoins des femmes convalescentes suite à un accident cardiaque. Chez celles-ci, le besoin le plus fondamental sur le plan de la réadaptation pourrait être le besoin de soutien, en particulier celui de femmes ayant vécu une expérience semblable; ce besoin peut en outre persister au-delà de la période de récupération à l'hôpital. Le projet avait pour but de concevoir et de mettre en œuvre, en milieu communautaire, un groupe de soutien à l'intention des femmes atteintes de maladie du cœur, qui serait axé sur la communication et fondé sur une approche psychopédagogique. On a choisi la recherche-action comme méthodologie. On a organisé deux groupes de femmes (n = 16), qui se sont réunis une fois par mois pendant une période de cinq mois. Les rencontres étaient animées par une infirmière clinicienne et une infirmière chercheuse. On a demandé aux participantes de tenir un journal intime entre les réunions. Les données de recherche comprenaient des bandes vidéo et des transcriptions des rencontres, des observations sur le terrain, les journaux tenus par les participantes et une évaluation finale. Une première analyse indique que les participantes ont apprécié l'expérience sous trois angles : les rencontres les ont aidé à analyser leurs émotions, à se sentir soutenues par l'entourage et à faire face à leur problème de santé. Une analyse itérative a mis en lumière un méta-paradigme compatible avec le concept de la souffrance. Dans l'ensemble, le bienfait que semblent procurer les groupes de soutien de ce type réside dans la reconnaissance et le partage de l'expérience de la souffrance, un aspect qui n'est pas toujours présent dans les autres sphères de la vie des femmes atteintes de maladie du cœur.

Though heart disease is the number one health problem among women, men continue to represent the majority of those in cardiac rehabilitation for secondary prevention. Research has shown that conventional rehabilitation programs do not meet the needs of women recovering from cardiac events. Women's primary rehabilitative need may be support, particularly from women with similar experiences. Furthermore, the need for

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Heather M. Arthur, RN, PhD, is Career Scientist and Associate Professor, School of Nursing, Faculty of Health Sciences, McMaster University, Hamilton, Ontario, Canada. Donna M. Wright, BHScN, is Regional Cardiac Care Coordinator, Cardiac Care Network of Ontario, Hamilton Health Sciences-General Site. Kelly M. Smith, MSc, is Research Associate, CADENCE Research Group, Hamilton Health Sciences-General Site.

support in living with heart disease may persist beyond the in-hospital phase of recovery. The purpose of this study was to develop and implement a community-based communication and psycho-educational support group for women with heart disease. Participatory action research was the methodology selected. Two groups of women ($n = 16$) met monthly for 5 months to develop the program. Sessions were facilitated jointly by a nurse clinician and a nurse-researcher. Between sessions, participants kept diaries of their experiences. Data consisted of videotapes and transcriptions of the sessions, field notes, and the women's diaries and final evaluation. Initial analysis revealed that the value of the group for the women was threefold: it helped them to cope with their emotional reactions, offered social support, and helped them to manage their health problem. Iterative analysis unveiled a meta-paradigm consistent with the concept of suffering. The apparent overall benefit of a community-based psycho-educational support group for women with heart disease is acknowledgement and sharing of suffering, something that cannot readily occur in women's other life arenas.

Background

Contrary to the conventional belief that heart disease is a serious health concern primarily for middle-aged men, coronary heart disease (CHD) is the leading cause of death for women in Canada, accounting for 41% of all female deaths annually (Heart and Stroke Foundation of Canada, 1995), and carries a worse prognosis for women than for men (Mielahn, Becker, & Carrao, 1995; Wenger, Speroff, & Packard, 1993). Until recently, heart disease research focused on men. Emerging evidence suggests that heart disease has serious physical, psychological, and social ramifications for women and that these ramifications are different from those for men. Upon examining gender-sensitive issues, some investigators have found that women's quality of life is significantly lower than men's after a cardiac event and that women report more psychosomatic symptoms and sleep disturbances (Brezinka & Kittel, 1995; Hamilton & Siedman, 1993).

With respect to rehabilitation in heart disease, there is little evidence beyond women's below-average enrolment in rehabilitation programs and above-average dropout rates (O'Callaghan et al., 1984; Thomas et al., 1996). Conventional rehabilitation goals do not often reflect goals for the female heart patient, and rehabilitation environments tend to be unappealing and inaccessible to women (Moore & Kramer, 1996). Recent work by Benson, Arthur, and Rideout (1997) and by Thomas et al. suggests that women's primary rehabilitative need may be that of support, particularly from women with the same experience. Researchers have cited social support as an important factor in recovery from CHD, for both women and men, with respect to survival and morbidity (Williams et al., 1992). In a 9-year follow-up of the Alameda County Study, Wingard and Cohn (1987) found that women who lacked social support had a higher risk of fatal CHD after adjustment for other coronary risk factors. Powell, Shaker, and Jones (1993) found that divorced women were most at risk of dying following a myocardial infarction (MI).

A limitation of much of the available research is that women have not been asked about the nature of their experiences. The instrumental work of Boogard (1984) and of Johnson and Morse (1990) illuminates the uniqueness of women's experience with cardiac illness. For example, women's recovery and rehabilitation seem to be heavily influenced by what Hawthorne (1993) calls an "otherness" orientation, referring to the tendency of women (whether healthy or ill) to put the needs of others before their own. In general, findings indicate that women tend to resume household activities immediately upon discharge from hospital and do not perceive these activities to be work or harmful to their health. As well, women report difficulty accepting help from others and are inclined to experience guilt when family members help with household tasks (Benson et al., 1997; Johnson & Morse; Lisk & Grau, 1999). Finally, women are more likely to make lifestyle changes independently, taking care not to disturb the family routine. The findings of Benson et al. and of Lisk and Grau corroborate earlier findings related to women's rehabilitation issues, which suggests that little progress has been made in the past 10 years with respect to helping women to live with heart disease after the acute, in-hospital phase.

At present, there are no known community-based programs for women living with heart disease in the province of Ontario, Canada. Therefore, the focus of this study was issues related to community-based assistance for women with heart disease, as an adjunct to existing institution-based cardiac rehabilitation services. Two key areas were targeted: psychosocial factors associated with women living with heart disease; and women's special needs with respect to community-based, long-term recovery and rehabilitation. A potentially useful model of rehabilitation for women would include psycho-educational support groups; provision of such groups in the community would enhance women's accessibility to the resources required for living with heart disease beyond the acute phase.

Purpose and Sample

The purpose of the study was to develop and implement a community-based communication and psycho-educational support group for women living with heart disease.

Twenty was determined to be the ideal number of participants, based on two factors: previous experience with the number of women required for data saturation (Benson et al., 1997), and the 1-year term stipulated by the funding agency.

Women were eligible to participate if they met the following criteria: had experienced MI, coronary artery bypass graft surgery (CABGS), or percutaneous transluminal coronary angioplasty (PTCA) within the previous 6 months or angina during the previous year; had made a commitment to participate in the group process; reported no physical or mental health disabilities that would preclude participation; were able to speak, read, and understand English; and provided written informed consent. The criterion of within 6 months post-MI or -CABGS was based on evidence suggesting that the first 6 months is a period of transition and adaptation, after which time a patient's needs change (MacKenzie, 1993; Young & Kahana, 1993), and also on the likelihood that the need for community-based support is at its peak in the first weeks and months after such an event, and thus a prototype for assisting women to resume their lives would be most useful during this period.

Prior to commencement of the study, the research protocol underwent ethics review by the joint hospital-university Research Ethics Board and was approved.

Method

Participatory action research was selected as the most appropriate design for this study. This method involves the systematic collection and analysis of information to be used in developing a plan of action. Smits (1997) describes action research as "the process of attending to experience, open(ing) up possibilities for conducting practice more thoughtfully" (p. 291).

With this design, community representatives from the target group are key players. Participants not only share their subjective views on the specific issues being examined but actually generate those issues. Further, they contribute to the decision process surrounding interpretation and utilization of the data. In this study, the participants co-designed the program that they thought would be of most benefit to other women living with heart disease, through a process of discussion, deliberation, and evaluation.

Potential participants were identified daily from hospital admission lists of patients who had experienced MI, CABGS, PTCA, or angina.

These women were approached by a research assistant, either in hospital (the Hamilton Health Sciences hospital) or within 6 weeks of discharge. They were provided a detailed description of the study as well as an opportunity to pose questions. The women who agreed to participate provided written informed consent.

As the women consented to take part, they were given the names of other women enrolled in the study and were asked to phone and introduce themselves, as a means of developing a communications network outside of the planned group sessions. Once 10 women had agreed to participate, the first group session was convened. After an additional 10 women had agreed, the second group session was convened. The groups met in a church, the selection of which was based on maximum accessibility from the participants' homes; the meeting location was carefully chosen based on literature suggesting that access issues account for a significant proportion of women's non-participation in rehabilitation programs after a cardiac event (Moore & Kramer, 1996).

The two groups met monthly in 2-hour sessions for 5 months to develop the program. The sessions were facilitated jointly by a nurse clinician with expertise in cardiac disease and women's issues (DMW) and a nurse-researcher with expertise in group process and women and heart disease (HMA). A research assistant (KMS) videotaped the group sessions and made field notes during all meetings.

At the first session, issues related to group process and confidentiality were discussed. The research goals were presented for discussion and the objectives of each participant elicited. The purpose of the telephone network was described. The participants were reminded that the telephone network was a suggestion only and that their evaluation of its usefulness was critical. Each woman was given a diary, pen, and folder. She was asked to write in the diary after or between sessions, describing her experiences living with heart disease both within and outside of the group. The diary had both a therapeutic and an evaluative purpose. The women were constantly reminded of the participatory nature of their role in developing the program. Comments such as "please tell us what women with heart disease need from a group like this" or "tell us what we should consider in planning a group for women with heart disease" were repeated frequently throughout the five sessions.

During the first session, the women spent a significant amount of time getting to know each other and describing their particular cardiac event. They were then encouraged to identify any issues they felt needed to be addressed in subsequent sessions. Consensus was used to choose the focus for session two. This process of consensus-driven issue identification continued throughout the course of the five monthly meetings.

Between sessions, the two primary investigators (DMW and HMA) independently reviewed and analyzed transcripts of the videotapes and the videotapes themselves, then discussed their interpretations and reached consensus on the main themes. A typewritten summary of their interpretations was distributed at the next session. The first part of sessions two through five was dedicated to a review of the summary, thus providing the women an opportunity to accept, reject, or refine the investigators' interpretations; they made corrections as necessary, but these were minor and infrequent, with no substantive changes around the main themes. Utilization of the telephone network and the diaries was also discussed at the start of each session. The final session was dedicated to overall evaluation.

Analysis

The two primary investigators reviewed the videotape and transcript of each session independently and made interpretive notes. Statement-by-statement analysis was used to find exemplars of thick descriptions in the women's accounts of living with heart disease. Based on these exemplars, the researchers attempted to interpret the observed and described experiences as well as the meanings they conveyed. A combination of analytical approaches was used (Streubert & Rinaldi Carpenter, 1995). The constant comparison method was selected for the simple processing of data. According to Jenks (1995), when used in naturalistic inquiry, constant comparison is performed not to generate theory but to develop formulations applicable only to the study being conducted. The second method of analysis used, reflexive critique, is particularly suited to action research in that it includes analysis of the written and spoken language of both participants and researchers. Reflexivity in the context of participatory action research refers to the "belief that the language individuals use to describe an experience reflects the experience being described and also all other experiences in the individual's life" (Jenks, p. 258). The text was not semantically coded or themed, based on the assumption that understandings may deserve recognition or exploration even if they occur in a single instance (Gadamer, 1960/1989). Prior to making their interpretations known to the participants, the investigators agreed that their emerging understandings were substantiated by the data. Typewritten summaries were distributed to the participants as described in the preceding section. Primary categories were generated from the text, first within each session and finally across all sessions and groups.

Results

A total of 43 women were approached over a 3-month period and 20 consented to participate. Two groups of 10 women each were formed. One person dropped out of group 1 and three dropped out of group 2. Reasons for dropping out were: health concerns and family constraints ($n = 1$), moving in with daughter/situation changed ($n = 1$), no longer physically mobile ($n = 1$), and complications due to recurrent angina and congestive heart failure ($n = 1$).

Ultimately, group 1 comprised nine women: three had undergone CABGS and five PTCA, one had angina; group 2 comprised seven women: three had undergone CABGS and two PTCA, two had had MI.

The 16 participants ranged in age from 46 to 76 years (*mean* = 59.4 years); 11 were married, four were widowed, and one was separated from her husband. Eight of the women were retired from work outside the home, two were working full-time, five were on sick leave from their jobs, and one was a career homemaker.

Interestingly, though the two groups met separately and had no contact with each other, the topics they chose for the group sessions were essentially identical. The first issue that both groups identified and wanted to focus on was the stress of living with heart disease and associated family pressures, in particular the need to find a way of coping with emotional reactions as opposed to the logistics of everyday living. The second issue that emerged from both groups was the need for support and information related to heart disease, medical management, and communicating with physicians. Although the women selected these specific topics for discussion, the overriding theme identified in the data was that their expression of suffering was facilitated by both the relationships among the women and the relationship between the women and the nurse-facilitators.

Care as Recognition of Suffering

Arthur Frank (1991) describes suffering primarily in terms of loss and isolation. From the physical losses that accompany illness to the emotional isolation that results from the illness, suffering the pain of loss and isolation is an integral part of any disease process.

The participants said they felt alone, vulnerable, and confused. They revealed that they suppressed their feelings and emotions both within the family and with friends. One woman stated that the group was "one way of expressing your feelings where your family may not understand. I feel that these group meetings give you better insight on life with heart disease and how to cope with it." Another said, "It's important to talk to people who share your problem. Family and friends seem to want to protect you."

Some women described the recovery period as "terrible," "you are fighting your battle alone," and termed the isolation as "destructive." Frank (1991) describes this suffering in the following way: "The loss that accompanies illness begins in the body then moves out until it adversely affects the relationships connecting that body with others" (p. 36).

The participants expressed the need to talk about their feelings and share their experiences. It helped to relieve anxiety and to bring suppressed emotion to the surface, and it provided insight into lives that had been changed by heart disease:

> *Talking helps with stress. It's much easier to talk about our problems with those who have similar problems. I thought support groups showed weakness. I now believe it's a place to find strength.*
>
> *It was nice to have a place to go to share common feelings — somewhere that just dealt with issues common to women. I felt close to the women even though we only met once a month. I felt like I belonged. I also felt genuine concern from people who were really strangers when this all began.*
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> *Although I thought I had handled this event well, I discovered through the group that I had suppressed my emotions. After my first group meeting I noticed, with each meeting, more and more emotions coming to the fore and a need to talk about it.*

It is Frank's (1991) view that losses must be mourned, and mourned in an appropriate environment. For women, the home and family environment may not be the ideal setting to gain the support required to mourn losses.

Frank (1991) also describes the emotional work of "keeping up appearances." The ill are not praised for expressing their fear or grief. At home they must appear to be engaged in the normal family routine. For women, this may mean focusing on the needs of other family members. In order to maintain family function and prevent further losses to self, they may need to resume the "otherness" orientation of their role in the family post-event.

"Keeping up appearances" seemed to be a part of the women's relationship with their physician as well. They reported being given almost no opportunity to express their suffering to their physician, generally being encouraged to "put the heart problem behind you and move on." Because of discussions with their physician, the women interpreted heart attacks, CABGS, and angioplasties as static events — "blips" in one's life path or brief interruptions in normal functioning. If, as suggested by Frank (1991), losses must be mourned, women appear to have few opportunities to openly and comfortably mourn their experiences with heart disease.

The participants told us that family members were less likely than their support-group peers to understand their expressed feelings. They sensed that family and friends were inclined more to protect than to acknowledge and share feelings. They told us that they would be reluctant to share not only their fears and their feelings, but also the thoughts written in their journals, on the assumption that family and friends would not want to know of their pain. Frank (1991) suggests that there is a deliberate weighing of the need for support against the potential for receiving it: before taking any action, persons who are suffering make the most conservative estimate of the support they are likely to get; thus in everyday life there may be many consciously chosen missed opportunities for revealing suffering and receiving support.

The participants indicated that they understood the feelings expressed by other members of the group and felt both supported and supportive. One woman stated, "I heard other ladies' problems and felt great concern. This caring sends a message that they are being heard and understood." Another said, "I have felt the support of other women. You can make a comment and not be criticized." In this caring environment, group members felt heard, understood, supported, and strengthened. Frank's (1991) contention that human suffering becomes bearable when it is shared was substantiated by the findings of this study.

The role of the expert facilitators appeared to be an essential element in the promotion of caring and revelation of suffering. Though the researchers had envisioned each group becoming self-sustaining, the participants said they could not foresee a time when it would function without the facilitators. Apparently the facilitators were not only a resource for information about heart disease, but also a comforting and understanding presence concerning women's issues.

Tapp (2000) explains that although health professionals have knowledge, information, and ideas to impart, at times it may be best to resist the expectation that we propose solutions or interventions and, instead, invite patients to reflect upon their own explanations, possibilities, and preferences with respect to decisions about their lives. "The nurse can choose to offer advice, but can do so in a manner that might enable the recipient to choose whether they want to accept the advice" (Tapp, p. 86). In the present study, the facilitators communicated their ease with and acceptance of the women's overt demonstrations of suffering, without rushing them forward to an adaptation stage. As Tapp suggests, we explicitly acknowledged that we did not have their particular firsthand experience of illness and suffering, and that their choices were legitimate and worthy of our respect. Thus, although the women may have identified problems in their relationships (e.g., marital strain) or difficulty in making lifestyle changes (e.g., with diet and exercise), ultimately it was accepted that they had to decide for themselves the best way to proceed. This relational stance, we think, was critical to the reported benefits of the support groups.

Finally, the participants had mixed feelings about the telephone network. Though they appreciated the concept, they found it difficult to use in practice. They described impediments to calling other women such as a reluctance "to interfere with people's personal lives" and "not knowing when it would be a good time for others." They also described the act of phoning another woman as "selfish" and "needy." These descriptions reinforce Frank's theories about "keeping up appearances" and weighing the need for support against the potential for receiving it.

Limitations

As noted, 43 women were approached and 20 agreed to participate. It is possible that those who chose not to participate did not require this type of group support and that the needs of some women living with heart disease are adequately met by standard programs.

In addition, the findings of participatory action research are not generalizable beyond the study situation. The main result of action research is the production of practical knowledge, which can be used to improve a system or change a pattern of practice in a given situation.

Summary

The participants in this study identified a current deficit in both institutional and community-based health care (including care provided by family physicians), in terms of dealing with women's issues around living with heart disease. They also indicated that their recovery needs might be better addressed in a setting that emphasizes information-seeking, sharing, and mutual support. Though they demonstrated strong support for typical institution-based cardiac rehabilitation programs that focus on exercise and education related to CHD risk factors, the women expressed a belief that such programs do not meet the emotional and coping needs of women with heart disease over the long term. Cardiac rehabilitation programs are typically 4 to 6 months in duration. This study found that women living with heart disease may have issues that take longer than 6 months to resolve. While all but one of the participants had their cardiac events in the previous 6 months, they were still attempting to cope with the sequelae well beyond 6 months, given that from the time of consent to the time of completion of research an additional 6 months had passed. As well, the issues for these female participants were different from those reported in the literature for men. This in itself is not a new finding. However, the "otherness" orientation (Hawthorne, 1993) that has been described as responsible for the uniqueness of women's recovery may in fact be related to women's inability to deal openly with their suffering within the family.

An ongoing community-based support group for women with heart disease, in which understanding these issues is part of the experience of all members, may enhance coping due to the sense of caring that results from shared suffering.

References

Benson, G., Arthur, H.M., & Rideout, E. (1997). Women and heart attack: A study of women's experiences. *Canadian Journal of Cardiovascular Nursing, 8*(3), 16–23.

Boogard, M. (1984). Rehabilitation of the female patient after myocardial infarction. *Nursing Clinics of North America, 19*(3), 433–440.

Brezinka V., & Kittel, F. (1995). Psychosocial factors of coronary heart disease in women: A review. *Social Science and Medicine, 42(10),* 1351–1365.

Frank, A.W. (1991). *At the will of the body.* New York: Basic.

Gadamer, H.G. (1960/1989). *Truth and method* (2nd Rev. Ed.) (J. Weinsheimer & D.G. Marshall, Trans.). New York: Continuum.

Hamilton, G.A., & Siedman, R.N. (1993). A comparison of the recovery period for women and men after acute myocardial infarction. *Heart and Lung, 22,* 308–315.

Hawthorne, M.H. (1993). Women recovering from coronary artery bypass surgery. *Scholarly Inquiry for Nursing Practice: An International Journal, 7*(4), 223–243.

Heart and Stroke Foundation of Canada. (1995). *Heart disease and stroke in Canada.* Ottawa: Author.

Jenks, J.M. (1995). New generation research approaches. In H.J. Streubert & D. Rinaldi Carpenter (Eds.), *Qualitative research in nursing: Advancing the humanistic imperative.* Philadelphia: Lippincott.

Johnson, J.L., & Morse, J.M. (1990). Regaining control: The process of adjustment after myocardial infarction. *Heart and Lung, 19*(2), 126–135.

Lisk, C.J., & Grau, L. (1999). Perceptions of women living with coronary heart disease: A pilot investigation. *Women and Health, 29*(1), 31–46.

MacKenzie, G. (1993). Role patterns and emotional responses of women with ischemic heart disease 4 to 6 weeks after discharge from hospital. *Canadian Journal of Cardiovascular Nursing, 4*(2), 9–15.

Mielahn, E.N., Becker, R.C., & Carrao, J.M. (1995). Primary prevention of coronary heart disease in women. *Cardiology, 86,* 286–298.

Moore, S.H., & Kramer, F.M. (1996). Women's and men's preferences for cardiac rehabilitation program features. *Journal of Cardiopulmonary Rehabilitation, 16,* 163–168.

O'Callaghan, W.G., Teo, K.K., O'Riordan, J., Webb, H., Dolphin, T., & Horgan, J.H. (1984). Comparative response of male and female patients with coronary artery disease to exercise rehabilitation. *European Heart Journal, 5*(8), 649–651.

Powell, L.H., Shaker, L.A., & Jones, B.A. (1993). Psychosocial predictors of mortality in 83 women with premature acute myocardial infarction. *Psychosomatic Medicine, 55,* 426–433.

Smits, H. (1997). Living within the space of practice: Action research inspired by hermeneutics. In T.R. Carson & D. Sumara (Eds.), *Action research as a living practice.* New York: Peter Lang.

Streubert, H.J., & Rinaldi Carpenter, D. (Eds.). (1995). *Qualitative research in nursing: Advancing the humanistic imperative.* Philadelphia: Lippincott.

Tapp, D. (2000). The ethics of relational stance in family nursing: Resisting the view of "nurse as expert." *Journal of Family Nursing, 6*(1), 69–91.

Thomas, R.J., Houston Miller, N., Lamendola, C., Berra, K., Hedbäck, B., Durstine, J.L., & Haskell, W. (1996). National survey on gender differences in cardiac rehabilitation programs: Patient characteristics and enrollment patterns. *Journal of Cardiopulmonary Rehabilitation, 16*(6), 402–412.

Wenger, N.K., Speroff, L., & Packard, B. (1993). Cardiovascular health and disease in women. *New England Journal of Medicine, 329,* 247–253.

Williams, R.B., Barefoot, J.C., Califf, R.M., Haney, T., Saunders, W.B., Pryer, D.B., Hlatky, M.A., Siegler, I.C., & Mark, D.B. (1992). Prognostic importance of social and economic resources among medically treated patients with angiographically documented coronary heart disease. *Journal of the American Medical Association, 267*(4), 520–524.

Wingard, D.L., & Cohn, B.A. (1987). Coronary heart disease mortality among women in Alameda County, 1965 to 1973. In D.B. Eaker, D. Packard, N.K. Wenger, T.B. Clarkson, & H.A. Tyroler (Eds.), *Coronary heart disease in women.* Bethesda, MD: National Heart, Lung, and Blood Institute, National Institutes of Health.

Young, R.F., & Kahana, E. (1993). Gender, recovery from late life heart attack, and medical care. *Women and Health, 20*(1), 11–31.

Authors' Note

Correspondence may be directed to: Dr. Heather Arthur, Faculty of Health Sciences, School of Nursing, McMaster University, 1200 Main Street West, HSC-2J29, Hamilton ON L8N 3Z5 Canada. Telephone: 905-525-9140, ext. 22404. Fax: 905-570-0667.

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Impressions of Breastfeeding Information and Support Among First-Time Mothers Within a Multiethnic Community

Carmen G. Loiselle, Sonia E. Semenic, Brigitte Côté, Monique Lapointe, and Roxanne Gendron

Cette étude vise à identifier les perceptions des mères concernant l'information et le soutien professionnel reçu en milieu hospitalier et communautaire, notamment au sein d'une communauté multiethnique. Un sondage téléphonique a été réalisé dans le but d'évaluer les impressions des mères face au soutien professionnel dont elles ont bénéficié dans le processus d'allaitement, de déterminer si les professionnels de la santé ont bien observé les pratiques recommandées concernant l'allaitement et d'identifier la nature et les sources d'information reçue. Un échantillon de 108 femmes de différentes origines ethniques étant à leur première expérience d'allaitement maternel a été interviewé trois semaines après l'accouchement. Dans l'ensemble, les commentaires des mères quant au soutien professionnel reçu en matière d'allaitement étaient positifs, bien qu'elles aient signalé la présence de certaines pratiques qui ne respectaient pas les normes recommandées. Les mères immigrantes étaient plus nombreuses à avoir fait l'expérience de pratiques hospitalières nuisibles au bon déroulement de l'allaitement, comparativement aux mères nées au Canada. Toutefois, les immigrantes recevaient davantage de soutien de la part des professionnels œuvrant au sein de la communauté. Des différences importantes ont aussi été relevées entre les immigrantes et les mères nées au pays en ce qui à trait aux sources d'information. Les résultats démontrent l'importance du rôle des infirmières quant à la promotion de l'allaitement maternel et au soutien optimal dispensé aux mères.

The purpose of this study was to document mothers' perceptions of breastfeeding information and support received from hospital- and community-based health professionals within a multiethnic community. A telephone survey was conducted to assess: mothers' impressions of professional support for breastfeeding, whether recommended breastfeeding practices were followed by health professionals, and the nature and sources of breastfeeding information received. An ethnically diverse sample of 108 first-time breastfeeding mothers was surveyed at 3 weeks postpartum. Overall, the mothers' evaluations

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Carmen G. Loiselle, PhD, N, is Assistant Professor, School of Nursing, McGill University, and nurse researcher, CLSC Côte-des-Neiges, Sir Morimer B. Davis Jewish General Hospital, and Hôpital Sacre-Cœur, Montreal, Quebec, Canada. Sonia E. Semenic, N, IBCLC, is a PhD candidate, School of Nursing, McGill University. Brigitte Côté, MD, FRCP, and Monique Lapointe, N, work at CLSC Côte-des-Neiges. Roxanne Gendron, BSc, MSc, is Research Assistant, Centre de recherche, Hôpital Sainte-Justine, Montreal, and volunteer, Nourri-Source breastfeeding support group, Montreal.

of professional support for breastfeeding were positive, even though they reported breastfeeding practices that fell short of recommended standards. Immigrant mothers were found more likely to experience hospital practices detrimental to breastfeeding success than Canadian-born mothers, but were also found more likely to receive professional breastfeeding support in the community. Significant differences were also found between immigrant and Canadian-born mothers in the sources of their breastfeeding information. The findings underscore the key role of nurses in ensuring the promotion and optimal support of breastfeeding.

The physiological, nutritional, immunological, and economic benefits of breastfeeding are well documented (Canadian Pediatric Society, Dietitians of Canada, & Health Canada, 1999). Breastfeeding protects infants against a host of illnesses and infections, reduces the incidence of allergies, and enhances neurological development (Bick, 1999). Health benefits for the breastfeeding mother include improved postpartum bone remineralization, increased child-spacing, and reduced risk of ovarian and premenopausal breast cancer (Lévesque, 1998). However, whereas approximately 75% of all mothers in Canada begin breastfeeding after delivery, studies report a rapid decline in breastfeeding rates during the early weeks and months postpartum (Health Canada, 1999).

Breastfeeding promotion and support have been identified as a public health priority in Quebec, which has one of the lowest breastfeeding initiation and duration rates in the country (Ministère de la Santé et des Services Sociaux, 1999). Breastfeeding promotional efforts increasingly take into consideration the fact that breastfeeding is a complex, culturally shaped behaviour influenced by an array of personal and contextual factors (Maclean, 1998). Breastfeeding initiation and duration rates are found to correlate significantly with broad sociodemographic variables such as maternal age, education, socio-economic status, and social support (Piper & Parks, 1996). In addition, factors influencing a woman's experience of breastfeeding include maternal confidence (Dennis, 1999), the incidence of early breastfeeding problems (Kearney, Cronenwett, & Barrett, 1990), level of comfort with breastfeeding in public (Sheeshka et al., 2001), and the baby's temperament (Hughes, Townsend, & Branum, 1988). Other important predictors of breastfeeding initiation and duration are mothers' overall breastfeeding knowledge (Duckett et al., 1998; Hoyer & Horvat, 2000; Rentschler, 1991) and the amount and quality of breastfeeding information they receive (Humphreys, Thompson, & Miner, 1998). Culturally determined health beliefs, values, and practices related to breastfeeding add to the complexity of informational interventions among women of diverse backgrounds (Riordan & Gill-Hopple, 2001).

Health professionals are in a key position to enhance breastfeeding success by providing and mobilizing timely, consistent, and culturally sensitive forms of support, particularly for first-time mothers (Côté et al., 2000; Humenick, Hill, & Spiegelberg, 1998). Several studies have explored the potential contribution of various types of support such as emotional (e.g., empathy, caring, trust), instrumental (e.g., helpfulness, task orientation), and informational (e.g., education, sharing of knowledge) to breastfeeding outcomes. Both informal and professional sources of support impact on mothers' commitment to and confidence in their ability to breastfeed (Duckett, Henly, & Garvis, 1993; McNatt & Freston, 1992; Raj & Plichta, 1998). The amount of support women receive from a partner, mother, and female relatives and friends significantly predicts the initiation and duration of breastfeeding (Matich & Sims, 1992; Bar-Yam & Darby, 1997). Professional and peer support also lead to improved breastfeeding outcomes, particularly among high-risk groups (Bronner, Barber, & Miele, 2001; Sidorski & Renfrew, 2000). The influence of health professionals on breastfeeding initiation and duration, however, appears to be contingent on the quality and availability of their informational support (Barber, Abernathy, Steinmetz, & Charlebois, 1997).

A lack of accurate information on and negative attitudes towards breastfeeding are acknowledged as significant barriers to the promotion and support of breastfeeding by health professionals (Bernaix, 2000; Schanler, O'Connor, & Lawrence, 1999). Inconsistent or conflicting information provided by nurses and physicians is identified frequently by patients and professionals alike as a deterrent to the initiation of breastfeeding (Coreil, Bryant, Westhover, & Bailey, 1995; Lewinski, 1992). However, few studies have documented the specific content of breastfeeding information that new mothers receive from health professionals, or their perceptions of the quality and helpfulness of the information and support provided. Addressing this gap in the literature is an important step in improving breastfeeding interventions and outcomes, as the nature, source, and mode of information delivery have been shown to impact on subsequent search, processing, recall, and actual health-related behaviour (Loiselle, 1995). In addition, little is known about the nature of informational support for breastfeeding among ethnically diverse populations. In the context of an increasingly culturally diverse population, a better understanding of similarities and differences in the breastfeeding needs and resources of both immigrant and Canadian-born mothers is needed for health professionals to support optimal breastfeeding practices (Health Canada, 1999).

A worldwide standard for evaluating health-professional support for breastfeeding has been set by the Baby Friendly Hospital Initiative (BFHI), a joint effort of the World Health Organization and UNICEF to promote and support breastfeeding within institutions (World Health Organization, 1989). Central to this program is implementation of the Ten Steps to Successful Breastfeeding, a set of evidence-based practices (WHO, 1998). Although representatives of Montreal-area hospitals have been surveyed for their institution's adherence to the Ten Steps (Levitt, Kaczorowski, Hanvey, Avard, & Chance, 1996), no data are available on consumers' (e.g., new mothers') perceptions of whether or how the recommended practices were followed during their perinatal experience.

Therefore, the purpose of this study was to examine mothers' perceptions of breastfeeding information and support received from health professionals within a multiethnic community. This study was part of a larger, multidisciplinary, multi-method investigation of factors influencing breastfeeding rates in one of the most ethnically diverse neighbourhoods of Montreal, Quebec, Canada (Sévigny & Tremblay, 1998). The research questions for this part of the investigation were: (1) What are mothers' overall *impressions* of breastfeeding support on the part of hospitals and community health services? (2) Are practices to protect, promote, and support breastfeeding being *followed* by hospital and community health services, as reported by mothers? (3) What *types* of breastfeeding information do mothers receive from health professionals, and what are their other *sources* of breastfeeding information? and (4) Do immigrant and Canadian-born mothers *differ* in their perceptions of breastfeeding support?

Method

Participants

Inclusion criteria for the study were: primiparous, breastfeeding women who lived in the territory served by one specific CLSC (the acronym for Quebec's network of community health centres, which translates into English as Local Community Service Centres), who delivered a full-term healthy baby (i.e., birthweight > 2,500 grams and > 36 completed weeks gestational age, with no known medical problems) at one of the three maternity centres in the territory served by the CLSC during the period December 1, 2000, to June 30, 2001, and who were able to communicate in English or French over the telephone. Of a total of 841 births in the territory during the study period, 381 mothers met all criteria except that of language. Of these mothers, 273 either could not be reached, were no longer breastfeeding at the time of recruitment, were unable to communicate in English or French, or refused to participate. The final sample consisted of 108 mothers.

The mean age of the participants was 29.4 years, with a range of 17–42 years. More than two thirds of the participants (*n* = 69) were born outside Canada, representative of the predominantly immigrant population in the territory served by the CLSC. The immigrant mothers represented more than 30 countries of origin, the most prevalent being the Philippines (15%), Romania (6%), Sri Lanka (6%), and Vietnam (4%). Over 50% of the immigrant mothers in the sample had been in Canada for 5 years or less.

Procedure

Following CLSC Ethics Committee approval, the Montreal Regional Health Board compiled and made available a database using Quebec government Notification of Birth records of all first-time mothers living in the territory served by the CLSC who delivered a healthy, term baby at one of the three maternity centres within the specified period. Potential participants were telephoned by a research nurse within 1 week of delivery and screened for infant feeding method and language ability. Several (up to six) attempts were made to telephone each potential participant. All mothers contacted who met the inclusion criteria were invited to participate. These mothers were telephoned again at 3 weeks postpartum for the actual interview, which took an average of 20 minutes to complete. The mothers' consent to be interviewed by telephone constituted consent to participate in the study. All interviews were conducted by the same trained interviewer.

Instruments

A telephone questionnaire was developed by the principal investigator and the second author, a lactation consultant with extensive experience with a multiethnic population, based on the Ten Steps to Successful Breastfeeding, clinical experience, and a systematic review of the breastfeeding, social support, and information-seeking literature. The questionnaire includes three subscales, exploring: (1) mothers' overall impressions of breastfeeding support received from hospitals and community health services, (2) whether recommended practices in support of breastfeeding were followed during their hospital stay and postpartum community-care follow-up, and (3) mothers' perceptions of the type and sources of breastfeeding information sought or received. The 58-item questionnaire was reviewed by a panel of eight perinatal experts and then pre-tested with a convenience sample of 10 English-speaking breastfeeding mothers from the same CLSC territory. Three items were refined to enhance clarity. For the purposes of this study, the questionnaire was then translated from English to French and back into English by a research nurse with perinatal nursing expertise and a lay breastfeeding support person, both of whom were fluent in English and French (Brislin, 1970; Vallerand, 1989). The final translated questionnaire was not further tested before administration to the study sample.

Impressions of breastfeeding support. The first subscale contains 18 items assessing *affective* (e.g., "helped you to feel confident about breastfeeding"), *instrumental* (e.g., "gave good 'hands-on' help with breastfeeding"), and *informational* (e.g., "got enough information about breastfeeding") support received from health-care providers. This subscale consists of nine items for Hospital support and nine items for Community support, rated on a five-point Likert scale (1 = strongly disagree; 5 = strongly agree). Individual items were summed to create separate total scores (with a possible range of 5 to 45) for Hospital and Community support. To evaluate internal consistency of the measures of Hospital and Community breastfeeding support, Cronbach's alpha coefficients were obtained for both the English and French versions of the scale. For the English version, Cronbach's alpha was .85 for Hospital Breastfeeding Support ($n = 58$) and .91 for Community Breastfeeding Support ($n = 44$), and for the French version .85 for Hospital Breastfeeding Support ($n = 50$) and .78 Community Breastfeeding Support ($n = 38$), demonstrating acceptable internal consistency (Nunnally & Bernstein, 1994).

Hospital and community-care practices. The second subscale consists of 20 items assessing mothers' perceptions of whether recommended practices to support breastfeeding had been followed by the health-care providers perinatally. The items, which are based on the Ten Steps, address hospital breastfeeding support (12 items) and community-care breastfeeding follow-up (eight items). Mothers were asked to respond "yes," "no," or "do not know" to each item to indicate whether the stated practice had been followed.

Types and sources of breastfeeding information. The third subscale, comprising 20 items, addresses breastfeeding issues and concerns commonly reported in the breastfeeding literature. Items cover the advantages of breastfeeding, breastfeeding techniques, ways of dealing with common breastfeeding problems, and strategies for incorporating breastfeeding into the mother's lifestyle. To determine the *type* of informational support provided, mothers were asked to respond "yes," "no," or "do not know" to whether they had ever received information on each item from a health professional. In addition, they were asked to respond "yes," "no," or "does not apply" to having ever received breastfeeding information from each of 16 sources (e.g., books, husband or partner, hospital nurses). Three additional items asked mothers to identify the *most helpful item* of information ever received on breastfeeding, *who* had provided that information, and what they considered to be their overall *most important source* of breastfeeding information.

At the end of the interview, information was obtained on background and demographic characteristics, including the mother's age, education, total household income, country of origin, date of arrival in Canada, date and type of delivery (i.e., vaginal or Caesarean), length of hospital stay, and prenatal class attendance.

Results

The data were analyzed using SPSS 10.0. Descriptive statistics were used to summarize the demographic information and scores on the BIS. Student's t test and Chi-square analysis were used to test differences between immigrant and Canadian-born participants.

Background and Demographic Characteristics

The immigrant and Canadian-born mothers in the sample did not differ significantly regarding type of delivery (75% vs. 77% vaginal, 25% vs. 23% Caesarean), length of hospital stay (M days ± SD = 3.1 ± 1.46 vs. 2.7 ± 1.47), or breastfeeding prevalence at 3 weeks postpartum (94% vs. 90%). However, the immigrant mothers were slightly older than the Canadian-born mothers (M age in years ± SD = 30.4 ± 4.6 vs. 27.8 ± 5.0, $p = .011$) and had significantly lower prenatal-class attendance (47% vs. 74%, $p = .006$). Overall, the immigrant mothers also reported lower educational levels and lower total household income. Whereas 40% of immigrant as compared to 64% of Canadian-born participants were educated at the university level or higher (indicating a well-educated sample in general), one quarter of immigrant versus only 13% of Canadian-born participants had high school education or less. Approximately one third of both immigrant and Canadian-born mothers chose not to disclose their household income; of those who did disclose, more immigrant than Canadian-born participants (28% vs. 8%) reported an annual income of less than $20,000, and fewer immigrant than Canadian-born mothers (15% vs. 39%) revealed an income greater than $50,000.

Impressions of Breastfeeding Support

Immigrant and Canadian-born mothers reported similar mean total scores for both Hospital ($M \pm SD = 36.\ 5 \pm 5.02$ vs. 35.0 ± 7.26) and Community breastfeeding support ($M \pm SD = 38.5 \pm 4.63$ vs. 40.7 ± 4.18). However, the observed power to detect differences between the groups was low (i.e., .24 for Hospital and .48 for Community support), possibly contributing to the non-significant findings. However, differences were noted in overall impressions of breastfeeding support. Immigrant mothers agreed more strongly that hospital staff helped them to feel confident about breastfeeding ($p = .003$). Canadian-born mothers, on the other hand, were more likely to feel that they had received contradictory information about breastfeeding from hospital staff (32% vs. 7%, $p = .001$).

Following hospital discharge, 99% of immigrant and 95% of Canadian-born mothers received a follow-up telephone call from a community-care nurse. However, significantly more of the immigrant mothers (88% vs. 67%) also received at least one home visit by a community-care nurse ($p = .01$). Although Canadian-born mothers were less likely to receive community-care follow-up, those who did receive home visits agreed more strongly than their immigrant counterparts that the community-care providers valued breastfeeding ($p = .007$), that providers were available to help with breastfeeding whenever needed ($p = .023$), and that they felt comfortable asking providers for help with breastfeeding ($p = .01$).

Hospital and Community-Care Practices

Hospital and community-care practices to protect, promote, and support breastfeeding fell short of the guidelines recommended in the WHO's Ten Steps to Successful Breastfeeding. Only four of the Hospital and four of the Community practices were reported by a minimum of 80% of mothers, this cut-off having been established by the Baby Friendly Hospital Initiative to evaluate adherence to the Ten Steps.

More Canadian-born mothers reported having roomed-in day and night with their baby during their hospital stay, a practice that promotes early and frequent breastfeeding (Yamauchi & Yamanouchi, 1990) (Table 1). Immigrant mothers were more likely to report that their breastfeeding infant was given supplemental water or formula during their hospital stay and that they were provided with formula samples upon discharge, practices that may be detrimental to breastfeeding success (Blomquist, Jonsbo, Serenius, & Persson, 1994; Perez-Escamilla, Pollin, Lonnerdal, & Dewey, 1994). In addition, a larger proportion of immigrant mothers were shown how to express their milk during their hospital stay (Table 1).

Table 1 *Mothers' Reports of Hospital Practices in Support of Breastfeeding*

Hospital Practices	All Mothers ($n = 108$) %	Immigrant ($n = 69$) %	Canadian-born ($n = 39$) %	χ^2	p
Staff demonstrated how to position baby to breast	94	96	90	1.44	.231
Baby was not provided with a pacifier	93	90	97	2.09	.148
Staff offered help with breastfeeding	90	90	90	.00	.985
Baby was breastfed on demand in the hospital	87	84	92	1.56	.210
Formula samples were not provided at hospital d/c	64	57	76	4.15	.042*
Staff provided information on breastfeeding resources	63	59	68	.85	.357
Baby roomed-in 24 hours/day in hospital	57	49	69	4.04	.045*
Staff offered help breastfeeding within 1 hour of birth	45	41	53	1.44	.230
No supplements of water or formula were given to baby unless medically indicated	32	25	44	3.95	.047*
Staff provided breastfeeding information to family members	32	38	21	3.13	.077
Staff demonstrated how to express milk, if needed	57	65	44	4.77	.029*

*$p < .05$

Of the participants who received postpartum follow-up services ($n = 90$), immigrant mothers were significantly more likely to have been offered breastfeeding help and shown how to breastfeed by community-care staff, whereas Canadian-born mothers were more likely to have been provided information about breastfeeding support groups or breastfeeding specialists (Table 2).

Table 2 *Mothers' Reports of Community-Care Practices in Support of Breastfeeding*

Community-Care Practices	All Mothers ($n = 108$) %	Immigrant ($n = 66$) %	Canadian-born ($n = 24$) %	χ^2	p
Staff demonstrated how to position baby to breast	82	89	65	7.09	.008*
Baby was not provided with a pacifier	77	76	80	.16	.690
Staff offered help with breastfeeding	90	97	83	6.21	.013*
Mother was counselled to breastfeed on demand	87	89	96	1.23	.268
Staff provided information on breastfeeding resources	67	60	84	5.86	0.15
No supplements of water or formula were given to baby unless medically indicated	80	78	87	1.08	.299
Staff provided breastfeeding information to family members	41	35	52	2.29	.130
Staff demonstrated how to express milk, if needed	64	70	52	2.67	.102

*$p < .05$

Types of Breastfeeding Information

No significant differences were found in the two groups regarding type of professional breastfeeding information received. Most mothers (80–95%) reported receiving information related to initiation of breastfeeding (e.g., positioning, frequency of feeding, dealing with common breastfeeding discomforts). A smaller percentage of mothers (30%) reported receiving information on the social aspects of breastfeeding (e.g., breastfeeding discreetly in public, dealing with unwanted comments).

Mothers were much more likely to have received information about the advantages of breastfeeding (90%) than the disadvantages of formula-feeding (47%). One third of the sample reported receiving no information on problems associated with early introduction of bottles or pacifiers. A surprisingly high percentage of mothers (30–56%) reported receiving no information on how to ensure adequate milk production (e.g., how breast milk is produced, signs of adequate infant intake, managing milk supply).

The two groups differed on the type of professional information they considered *most helpful*. Immigrant mothers considered information on the advantages of breastfeeding for the baby the most helpful (33% vs. 10%), whereas Canadian-born mothers saw information on how to position the baby to the breast as the most helpful (40% vs. 19%).

Sources of Breastfeeding Information

The most and least commonly identified sources of breastfeeding information are summarized in Table 3. Significant differences were found

Table 3 *Most and Least Commonly Identified Sources of Breastfeeding Information*

	All Mothers ($n = 108$) %	Immigrant ($n = 69$) %	Canadian-born ($n = 39$) %	χ^2	p
5 *most* common sources					
Books on breastfeeding	92	94	87	1.61	.205
Hospital nurses	92	94	87	1.61	.205
CLSC (community-care) nurses	88	96	74	10.92	.004*
Pamphlets/information sheets	78	70	92	7.46	.006*
From Tiny Tots to Toddlers[a]	64	61	69	.76	.385
5 *least* common sources					
Husband or partner	26	28	23	.26	.611
Info-santé[b]	22	25	18	.65	.422
Breastfeeding specialist	21	13	36	7.76	.005*
Internet	16	9	28	7.15	.007*
Breastfeeding support group	13	12	15	.32	.573

[a] Government-sponsored infant-care booklet, provided free to all new mothers in Quebec.
[b] Quebec's 24-hour health information telephone hotline.
* Indicates significant differences between immigrant and Canadian-born mothers; $p < .01$.

between immigrant and Canadian-born mothers in their use of breastfeeding informational sources. Community-care nurses were identified as a source of breastfeeding information by 96% of immigrant as compared to 74% of Canadian-born mothers ($p = .004$), whereas a greater number of Canadian-born mothers (36% vs. 13%) reported having received information from a breastfeeding specialist ($p = .005$). Canadian-born mothers were also significantly more likely to identify pamphlets/information sheets ($p = .006$) and the Internet ($p = .007$) as a source of information (Table 3).

Furthermore, of sources of breastfeeding information surveyed for importance, books were identified by a significant proportion of both immigrant (36%) and Canadian-born (41%) mothers as their *most important* source. The second most frequently reported answer to this question was "community-care nurse" among the immigrant mothers, but "breastfeeding specialist" among the Canadian-born mothers. However nurses were identified by both groups of mothers as the source of the *most helpful item* of breastfeeding information from a health professional. More mothers reported relying on informal sources of breastfeeding information, such as friends or colleagues (63%) and family members (56%), than medical sources, such as obstetrician/family physician (33%) or pediatrician (43%).

Discussion

This study examined the impressions of first-time mothers regarding breastfeeding information and support on the part of hospital- and community-based health professionals in a multiethnic community. Overall, mothers' evaluations of professional breastfeeding support were found to be positive, despite their reports of what breastfeeding experts would consider less than optimal standards of hospital and community-care practice concerning breastfeeding.

The survey also indicates that immigrant and Canadian-born mothers differ in their perceptions of breastfeeding support. Whereas the immigrant mothers were more likely to experience practices detrimental to breastfeeding success (e.g., in-hospital formula supplementation), their evaluations of in-hospital breastfeeding support were more positive than those of the Canadian-born mothers. On the other hand, the immigrant mothers were more likely to receive breastfeeding support from community health services, yet were less positive about the follow-up care that was provided. These observations may reflect either social desirability biases on their part or differential care expectations based on cultural beliefs and practices (Rossiter & Yam, 2000).

Also, immigrant mothers may have been less cognizant of gaps in professional knowledge and skills related to breastfeeding management, due to language barriers and/or less exposure to breastfeeding information (e.g., lower prenatal-class attendance; less reliance on informational sources such as the Internet).

Overall, the breastfeeding information provided to the mothers tended to focus more on the successful initiation of breastfeeding than on strategies to incorporate breastfeeding into the mother's lifestyle. In addition, despite evidence that perceived inadequate milk supply is the most common reason for early termination of breastfeeding (Hill & Aldag, 1991), mothers were provided with minimal information on ensuring adequate milk production.

As supported by the literature (e.g., Rentschler, 1991), books were found to be the most common source of breastfeeding information. Both hospital and community-care nurses were also identified as significant sources of information, the latter particularly among immigrant mothers, who may be more intensely targeted for community follow-up. Canadian-born mothers, on the other hand, were more likely to use fee-for-service lactation consultants.

The present findings are limited to the profile of new mothers who met the selection criteria for the study and were willing to take part in this survey. There is no background information available on mothers who were not contacted (e.g., did not have a phone) or who refused to participate. Also, the observed significant differences between the immigrant and Canadian-born participants may have been related to other background characteristics such as age or education. In addition, the instrument used for the survey was developed in the context of the present study and warrants further testing.

In a recent position paper, the Order of Nurses of Quebec (1998) underscored the role of nurses in supporting breastfeeding and urged nurses to take action towards fostering public and professional attitudes that promote successful breastfeeding. The present study validates mothers' perceptions of nurses as a central source of breastfeeding information and support but also documents professional practices that fall short of recommended standards. Further research is needed to determine how contextual factors such as the knowledge, attitudes, and behaviour of health-care providers, as well as family and social attitudes, may be perceived by mothers as supportive or not supportive of breastfeeding. It is through the concerted efforts of clinicians, researchers, policy-makers, and the public that the success of promotional activities pertaining to breastfeeding can best be achieved.

References

Barber, C.M., Abernathy, T., Steinmetz, B., & Charlebois, J. (1997). Using a breastfeeding prevalence survey to identify a population for targeted programs. *Canadian Journal of Public Health, 88*(4), 242–245.

Bar-Yam, N., & Darby, L. (1997). Fathers and breastfeeding: A review of the literature. *Journal of Human Lactation, 13,* 45–50.

Bernaix, L. (2000). Nurses' attitudes, subjective norms, and behavioral intentions toward support of breastfeeding mothers. *Journal of Human Lactation, 16*(3), 201–209.

Bick, D. (1999). The benefits of breastfeeding for the infant. *British Journal of Midwifery, 7*(5), 312–322.

Blomquist, H.K., Jonsbo, F., Serenius, F., & Persson, L.A. (1994). Supplementary feeding in the maternity ward shortens the duration of breastfeeding. *Acta Paediatrica, 83,* 1122–1126.

Brislin, R.W. (1970). Back-translation for cross-cultural research. *Journal of Cross-Cultural Psychology, 1,* 185–216.

Bronner, Y., Barber, T., & Miele, L. (2001). Breastfeeding peer counseling: Rationale for the National WIC survey. *Journal of Human Lactation, 17*(2), 135–139.

Canadian Pediatric Society, Dietitians of Canada, & Health Canada. (1999). *Nutrition for healthy term infants.* Ottawa: Minister of Public Works and Government Services.

Coreil, J., Bryant, C., Westover, B., & Bailey, D. (1995). Health professionals and breastfeeding counseling: Client and provider views. *Journal of Human Lactation, 11*(4), 265–271.

Côté, B., Colgan, J., Loiselle, C., Gastaldo, D., Semenic, S., Gendron, R., Bussières, J., Lapointe, M., & Morin, C. (2000). *Allaitement maternel et marrainage en milieu pluriethnique.* Research Report. Ottawa: Health Canada.

Dennis, C.-L. (1999). Theoretical underpinnings of breastfeeding confidence: A self-efficacy framework. *Journal of Human Lactation, 15*(3), 195–201.

Duckett, L., Henly, S., Avery, M., Potter, S., Hills-Bonczyk, S., Hulden, R., & Savik, K. (1998). A theory of planned behavior-based structural model for breastfeeding. *Nursing Research, 47*(6), 325–336.

Duckett, L., Henly, S., & Garvis, M. (1993). Predicting breastfeeding duration during the postpartum hospitalization. *Western Journal of Nursing Research, 15*(2), 177–198.

Health Canada. (1999). *Breastfeeding in Canada: A review and update.* Ottawa: Minister of Public Works and Government Services Canada.

Hill, P., & Aldag, J. (1991). Potential indicators of insufficient milk supply syndrome. *Research in Nursing and Health, 14,* 11–19.

Hoyer, S., & Horvat, L. (2000). Successful breastfeeding as a result of a health education programme for mothers. *Journal of Advanced Nursing, 32*(5), 1158–1167.

Hughes, R., Townsend, P., & Branum, Q.K. (1988). Relationship between neonatal behavioral responses and lactation outcomes. *Issues in Comprehensive Pediatric Nursing, 11*, 271–281.

Humenick, S., Hill, P., & Spiegelberg, L. (1998). Breastfeeding and health professional encouragement. *Journal of Human Lactation, 14*(4), 305–310.

Humphreys, A., Thompson, N., & Miner, K. (1998). Intention to breastfeed in low-income pregnant women: The role of social support and previous experience. *Birth, 25*(3), 169–174.

Kearney, M.H., Cronenwett, L.R., & Barrett, J.A. (1990). Breastfeeding problems in the first week postpartum. *Nursing Research, 39*(2), 90–95.

Lévesque, P. (1998). L'allaitement maternel : Bon pour la mère aussi. *Le Médecin du Québec, 33*(4), 101–110.

Levitt, C., Kaczorowski, J., Hanvey, L., Avard, D., & Chance, G. (1996). Breastfeeding policies and practices in Canadian hospitals providing maternity care. *Canadian Medical Association Journal, 155*, 181–188.

Lewinski, C. (1992). Nurses' knowledge of breastfeeding in a clinical setting. *Journal of Human Lactation, 8*(3), 143–148.

Loiselle, C.G. (1995). Self-evaluation and health information-seeking: A study of self-assessment and self-protection motives. Unpublished doctoral dissertation, University of Wisconsin, Madison, Wisconsin, USA.

Maclean, H. (1998). Breastfeeding in Canada: A demographic and experiential perspective. *Journal of the Canadian Dietetic Association, 59*(1), 15–23.

Matich, J., & Sims, L. (1992). Comparison of social support variables between women who intend to breast or bottlefeed. *Social Science and Medicine, 34*, 919–927.

McNatt, M., & Freston, M. (1992). Social support and lactation outcomes in postpartum women. *Journal of Human Lactation, 8*, 73–77.

Perez-Escamilla, R., Pollin, E., Lonnerdal, B., & Dewey, K.G. (1994). Infant feeding policies in maternity wards and their effect on breastfeeding success: An analytic overview. *American Journal of Public Health, 84*, 89–97.

Piper, S., & Parks, P. (1996). Predicting the duration of lactation: Evidence from a national survey. *Birth, 23*(1), 7–12.

Ministère de la Santé et des Services Sociaux. (1999). Priorités nationales de santé publique 1997–2002. Quebec: Author.

Nunnally, J.C., & Bernstein, I.H. (1994). *Psychometric theory (3rd Ed.)*. Montreal: McGraw-Hill.

Order of Nurses of Quebec. (1998). Prise de position : Allaitement maternel. [Web page]: http://www.oiiq.org/princ/html [Accessed October 11, 2000].

Raj, V.K., & Plichta, S.T. (1998). The role of social support in breastfeeding promotion: A literature review. *Journal of Human Lactation, 14*(1), 41–45.

Rentschler, D. (1991). Correlates of successful breastfeeding. *Image: Journal of Nursing Scholarship, 23*(3), 151–154.

Riordan, J., & Gill-Hopple, K. (2001). Breastfeeding care in multicultural populations. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 30*(2), 216–223.

Rossiter, J., & Yam, B. (2000). Breastfeeding: How could it be enhanced? The perceptions of Vietnamese women in Sydney, Australia. *Journal of Midwifery and Women's Health, 45*(3), 271–276, 197–201.

Schanler, R., O'Connor, K., & Lawrence, R. (1999). Pediatricians' practices and attitudes regarding breastfeeding promotion. *Pediatrics, 103*(3), E35.

Sévigny, R., & Tremblay, L. (1998). *L'adaptation des services de santé et des services sociaux au contexte pluriethnique.* Unpublished manuscript, Centre de recherche et de formation, CLSC Côte-des-Neiges, Montreal, Quebec.

Sheeshka, J., Potter, B., Norrie, E., Valaitis, R., Adams, G., & Kuczynski, L. (2001). Women's experiences breastfeeding in public places. *Journal of Human Lactation, 17*(1), 31–38.

Sidorski, J., & Renfrew, M. (2000). Support for breastfeeding mothers (Cochrane Review). *The Cochrane Library, Issue 1.* Oxford: Update Software.

Vallerand, R.J. (1989). Vers un méthodologie de validation trans-culturelle de questionnaires psychologiques : Implications pour la recherche en langue française. *Psychologie Canadienne, 30*(4), 662–670.

World Health Organization. (1989). *Protecting, promoting and supporting breastfeeding: The special role of maternity services.* Geneva: Author.

World Health Organization. (1998). *Evidence for the Ten Steps to Successful Breastfeeding.* Geneva: WHO Division of Child Health and Development.

Yamauchi, Y., & Yamanouchi, I. (1990). The relationship between rooming-in/not rooming-in and breastfeeding variables. *Acta Paediatrica, 79,* 1017–1022.

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Correspondence concerning this article should be addressed to Carmen G. Loiselle, School of Nursing, McGill University, 3506 University Street, Montreal QC H3A 2A7 Canada. E-mail: <cloise4@po-box.mcgill.ca>.

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The Intersection of Relational and Cultural Narratives: Women's Abortion Experiences

Marjorie McIntyre, Beverly Anderson, and Carol McDonald

Il existe un grand nombre d'écrits sur la délibération qui précède la décision de recourir à l'avortement chez les femmes; peu de textes, en revanche, portent sur l'expérience vécue une fois le geste posé et sur le sens qu'il acquiert dans leur vie. Dans cette étude ancrée dans une approche herméneutique et phénoménologique, 14 femmes âgées de 19 à 44 ans ont dit souhaiter que les professionnelles et autres personnes de leur entourage acceptent la réalité des grossesses non planifiées et reconnaissent que la décision d'avorter ne peut être entièrement comprise sans tenir compte des autres choix en matière de reproduction. Les auteures s'appuient sur une analyse féministe des tensions et les contradictions révélées dans les récits des participantes pour explorer les points d'intersection entre l'expérience de celles-ci et le cadre de narration culturel dans lequel elles se situent, tout en cherchant à cerner de nouvelles possibilités pour les femmes et à jeter de nouveaux éclairages sur leur expérience face à l'avortement.

Although a great deal has been written on women's personal deliberations in deciding to have and seeking an abortion, little has been written on the experience of living with this decision or on the meanings an abortion generates in the context of a particular life. In this hermeneutic phenomenological study, 14 women aged 19–44 expressed a need for professionals and others to accept the reality of unplanned pregnancy and to acknowledge that the choice of abortion cannot be fully understood in isolation from women's other reproductive choices. Using a feminist analysis of the tensions and contradictions in the women's accounts, the authors explore the intersections between their experiences and the cultural narratives in which they are situated, in a search for new possibilities for women and new understandings of women's experience of abortion.

Introduction

> Pregnancy does not belong to the woman herself. It is the state of the developing fetus, for which the woman is the container; or it is an objective, observable process coming under scientific scrutiny; or it is objectified by the woman herself as a "condition" in which she must take care of herself...not concerned with the subject, the mother at the site of her proceedings. (Kristeva, 1980, p. 237)

Marjorie McIntyre, RN, PhD, and Beverly Anderson, RN, PhD, are Associate Professors, Faculty of Nursing, University of Calgary, Alberta, Canada. Carol McDonald, RN, is a PhD student in the Faculty of Nursing, University of Calgary.

Although a great deal has been written on women's personal deliberations in choosing to have and seeking an abortion, little has been written on the experience of living with this decision, or on the meanings that abortion generates within the context of a particular life. Women have reported on the complex nature of their decision to have an abortion: "...her feelings about her fetus, her relationship with her partner, other children she may have, and her various obligations to herself and others — contextually defined considerations that reflect her commitments to the needs and interests of everyone concerned" (Sherwin, 1992, p. 102).

Considerable research has been carried out on the outcomes of pregnancy termination, most often with a medical, social, or political agenda. In much of this research, the pregnancy termination is viewed as a problem that could be eliminated with improved birth control, social support, and personal accountability on the part of sexual partners. A literature review yielded a paucity of studies highlighting the ways in which women integrate the experience of having an abortion into their lives, knowledge that could make a significant impact on the type of care these women receive. In a study of women's involvement in the abortions of their adolescent daughters, Norris (1991) found that "the abortion was not an isolated event in the lives of the informants and their daughters; rather, it was part of a comprehensive ongoing process of daughters' sexual socialization for which the informants had accepted responsibility" (p. 232). While Norris's work recognizes the situatedness of abortion, her use of grounded theory and her focus on the woman's mother as informant differentiate it from the present study, in which hermeneutic conversations mediate cultural narratives with the woman who has experienced the abortion.

The decision to locate this study within women's health is an essentially political one in that it recognizes the ways in which women are disadvantaged in our culture, not least through the silencing, trivialization, and dismissal of our understandings of our own experience (Weedon, 1999). For those women who are marginalized in relation to a dominant centre, the consequences of being categorized in this way can be quite serious and can range from having reduced access to resources and opportunities to being denied validation of one's understanding and interpretation of one's own experience. "A peculiar silencing occurs when what becomes most important about a person is how they are defined by others, by their relation to the dominant group, to a supposed norm or center" (Ceci, in press).

Background

Today, abortions are performed in both hospitals and abortion clinics on an outpatient basis. In Canada, abortion was legalized in 1969 subject to approval by a hospital medical committee as necessary for the preservation of the woman's "life or health" (Childbirth by Choice Trust, 1998). All other abortions remained offences under the *Criminal Code*. Application of the new law differed widely from province to province and even from hospital to hospital. The difficulty with the 1969 legislation was that it contained no definition of "health" and no requirement that a hospital have such a committee or provide such a service (Childbirth by Choice Trust). Legal "therapeutic abortions" became available to some women in some parts of Canada but remained entirely unavailable to others (Childbirth by Choice Trust).

The result of this limited availability and differing interpretations of the legislation on abortions was the introduction of free-standing clinics where abortions were openly and safely performed outside the law. Supporters of these clinics challenged the hospital-only legislation all the way to the Supreme Court of Canada, and won. In 1988, the Supreme Court struck down the 1969 law and abortion was completely decriminalized (Childbirth by Choice Trust, 1998).

Current Canadian legislation places abortion outside of criminal activity. Discursive realities — that is, social and cultural constructions — reveal another reality. The notion of criminality of abortion is kept alive through the medical, moral, and political narratives that surround abortion. A dominant medical narrative is that pregnancy is preventable, that contraception is readily available, and that abortion is an unacceptable means of "birth control." This discourse contributes to a resistance on the part of physicians to provide abortions and to limitations on women's access to abortion. In the previous legislation, physicians held the authority and responsibility to decide whether there was sufficient evidence of risk to the mother to warrant the intervention of abortion. Traces of this authority can still be seen in the medical narrative disrupting the notion that abortions are available on request. The moral-ethical narrative challenges a woman's right to make decisions about her own body, foregrounding the rights of the fetus. The dominant social narrative assigns responsibility for the decision to the individual woman, acting "as if" economic and relational supports were equally available to all women. The political narrative of the "pro-life" movement, drawing on particular interpretations of religious texts, conceptualizes women who have abortions as "bad," the abortion act as "wrong," and the professionals who perform these acts as "murderers."

Women in all their various social locations have learned who we are and how we should think and behave through discursive practices (Weedon, 1999). Thus, the struggle for each woman, when faced with the reality of an unwanted pregnancy, is to create her own narrative, in which her own understandings or interpretations of her experiences matter. There is a serious risk, however, that the woman's experience will be defined through these competing cultural narratives and that in the process her own narrative will be lost.

How can we come to understand the narrative of the woman herself as well as her experience in generating her own narrative? How can we work through the complexity of the cultural narratives that are embedded in the woman's experience?

Sample

The 14 women who participated in this study came from a range of geographic locations in western Canada. They represented different social backgrounds, economic situations, and political perspectives. They ranged in age from 19 to 44. Some were in their first marriage, some in their second marriage, some were divorced, and some had never been married. Several women were involved in relationships outside their primary relationship, whether married or single. Many of the women had children, either in their own care, in the care of an ex-partner, or in foster care. Some of the women had already had abortions. For some this was their first abortion, for some their first pregnancy. Two women had given up children for adoption. One woman had had a miscarriage, another a stillborn child.

While their stories covered a broad range of experiences, all of the women were over 19, Canadian-born, English-speaking, and White. The women learned about the study through posters in one clinic and letters included in handouts from another clinic. The letter described the study and what participation would involve. The women initially contacted the researchers by telephone.

The participants spoke about their experiences in the context of their lives, including other pregnancies and the meaning of the current pregnancy for themselves, their partners, their children, and other family members. The reasons they gave for choosing abortion were as varied as the women themselves. Several women selected abortion for economic reasons: another child, or even one child, would be more of a burden than the woman could see herself taking on. Some chose abortion in order to sustain an existing relationship, whether new or long-term; a child was seen as more than the relationship could tolerate at that time. For one of these women, the partner's lack of support for the pregnancy led to the end of the relationship; in spite of wanting a child, she could not foresee raising a child on her own. One woman was not sure the baby was her husband's; another woman was sure but her husband was not. Although not all of these women were successful in sustaining the relationship, they all still viewed it as the impetus for the abortion. Another feature of this group was ambivalence about their own and their partner's wish for a child at that time. Some couples were not sure how they felt about a having a child and the reality of a pregnancy forced them to make a decision. In some cases the woman wanted the child but her partner, once confronted with the pregnancy, did not; rather than proceed with a pregnancy when the child was clearly not wanted, she opted for abortion. In some cases the couple was not using birth control, operating under the assumption that a child would be wanted. Several younger women lacked the support in the relationship to negotiate contraception. For other women, the pregnancy occurred despite careful contraception, including in one case a partner with a vasectomy.

Purpose and Method

The purpose of this study was to create a space for women to explore and express their personal narratives of events surrounding abortion, in a way that would allow us to examine the taken-for-granted cultural narratives of the experience. In hermeneutic phenomenology a particular phenomenon is opened up for questioning. This type of examination considers how meanings are created in and through language and why we speak, think, and act as we do (Smith, 1991). Our intention in this research was to clear a space around the experience of abortion, drawing on hermeneutic philosophy (Caputo, 1987; Gadamer, 1998), such that a conversation about the experience could occur. In this process, those aspects of an experience that we take for granted, based on assumptions or beliefs, are reconsidered in light of the actual experience. While no single truth about the women's experience of abortion was sought or was expected to emerge, it was hoped that new and generative possibilities for understanding the experience would arise. The rationale for choosing a hermeneutic approach was a conviction that current understandings of women's experience of abortion are grounded in something other than the actual lived experience.

To understand a person's experience requires a knowledge of their social, material, and discursive realities. The women's choices concerning abortion were informed by their life circumstances and the meanings they gave to those circumstances. Understandings were generated through conversations between each woman and a member of the research team. The researcher's role was to encourage the woman to explore her experience, prompting clarification and elaboration, eliciting examples, and posing questions. No attempt was made to standardize the conversations. The purpose of questioning in hermeneutic phenomenology is not so much to find answers as to stimulate exploration and deep reflection. The conversations were audiotaped and transcribed verbatim.

As each member of the research team reviewed the transcripts, we highlighted experiences in the individual accounts and then traced these across multiple accounts in order to construct a coherent whole. We chose to highlight tensions and contradictions in the account as a means of capturing the essence of the woman's story, rejecting the inclination to move towards resolution or to discount any part of her experience. Unlike fragmentation — isolating events from the whole of a person's experience — the highlighting of phenomenological tensions is intended as a tentative measure, to keep the conversation alive amongst the researchers and to help them to reach an understanding of the experience.

Results

There was not one story but many. The stories involved so much more than the actual event: how the event was taken up by the woman and those who shared the experience with her, and how it was interpreted and reinterpreted by those present and within the context or conditions surrounding the event.

The tensions that arose in the women's stories are best understood in the context of the complexity of their lives. One such tension was the difference between what the woman made central in her life and what society makes central in considering abortion. A woman constructs her story in the context of a particular life, whereas the societal construction considers only the general, "as if" there were a universal social and material reality. For each of these women, then, the story was not only about the decision to have an abortion, or the experience of having an abortion, but also about the pregnancy and its meaning in her particular life. It was a conceptualization not of a procedure, but of a relational narrative, a part of her life that would never be erased from her experience.

Complicity in Societal Discourses

There was tension not only between the woman's story and the cultural narrative, but within the woman herself, arising from the narratives. Although a woman choosing abortion is located in her own particular reality, she also resides in, and is complicit with, the cultural stories of abortion. The women in the study struggled, then, to accept the reality of the abortion in light of their own and others' negative responses, fuelled by societal discourse. They did not regret their decision to have an abortion, but they did regret the lack of support and the silencing they experienced. They seemed to be on a journey, albeit each in a very different way, to come to terms with their own internalized condemnation of abortion. Once they had come to terms with their own beliefs, they better understood the stereotyping and were impelled to end what they saw as unnecessary suffering.

The women expressed the tension that resulted from their need to cope with societal messages about abortion:

> *I think that I tune it out. But I also listen, and the fact that… I just wish that people would realize they need to stand in the person's shoes that's experiencing it, and not pass judgement on somebody unless they have stood in those shoes.*
>
> *The general feeling that I have is a negativity [on the part of society] towards the decision about abortion.*

These societal messages contained judgements about the "kind of woman" they were:

> *Most women are using some form of birth control when they become pregnant. But somehow there's an attitude or an idea that is communicated to you that it must be some failure on your part.*

Medical Narratives

Several medical narratives were evident in the women's experiences. One was an expectation that the medical system would provide them with options and with access to whatever medical services they might need:

> *So I went to my doctor and talked to her about it. I kind of felt that I was being persuaded to go through with the pregnancy more so than being given the information about what I would do if I were going to terminate the pregnancy. I felt there was a lot more information on pregnancy than on termination if that was my decision. I was looking for information on both sides, so I could make an informed decision.*

Several women had encountered a medical narrative reflecting judgement of their circumstances and their decision to end the pregnancy, such as the "irresponsible woman" and the "lesson to be learned." After becoming pregnant with a partner who had had a vasectomy, one woman sought information from her doctor:

> *What really hurt me was that the doctor...I went in and explained to him that I had to have a test done, because "I'm nauseous in the morning and I feel I'm pregnant. My boyfriend had a vasectomy last February. How can that be?" And he looked at me and said, "Maybe you can tell me." After he got the test results he closed the door and said, "You'd better find a doctor, because you're pregnant." I thought, how mean, you're judging me before you even know who I am. I didn't have to ask him how this could happen. I was obviously looking for a medical opinion.*

Another woman also spoke of a cold reception from her family doctor:

> *My doctor looking at me saying, "Yes, you're pregnant," and me not really having the foggiest idea of what to do or where to go. I would have loved someone to have sat down: here are what your options are. But he very clearly had an agenda that had nothing to do with giving me options.*

A disturbing encounter was related by a woman who felt punished by the surgeon who performed her abortion:

> *When I went to the hospital for the abortion, the doctor...said to me just before he performed the procedure, "Well, we will just make sure you learn a lesson and never do this again." You know, this attitude is just so awful.*

Even brief negative encounters had a powerful effect on the women, particularly when these occurred at crucial times, such as on the day of the abortion:

> *...the lady at the front desk when I went in, the one that had to initially do my paperwork and tell me where to go, as soon as she found out what I was there for, was very abrupt and very rude actually. Being judged, big time, before I even did anything.*

Social Narratives: Silencing and Secrecy

The anticipation of a negative reaction restricted the women's ability to seek support. For some, the result was virtual isolation:

> *Actually, I didn't talk to anyone. I find it is difficult for me to discuss with other people. Even bringing it up I was feeling like, I don't know how the person is going to react.*

Closely connected to this uneasiness about reactions was a concern for privacy and confidentiality around the experience:

> *It was really, really awkward, because they have a waiting room with four sofas that were in a rectangle. Everyone was staring at the floor or looking at a magazine. I think they were kind of feeling the same way. My first thought when I walked in was: This is supposed to be confidential. What if I walked in here and there was someone I knew sitting in here? So I thought, this is not confidential, and it was really awkward.*

Some women appreciated being told up-front by the facility, "We can bill this through your health care, but it doesn't have your name on it, so no one can find out this information." This respect for confidentiality was described as a "comfort." The desire for confidentiality, and the efforts of facilities to accommodate that desire, arises from the cultural narrative that some medical procedures are more acceptable than others. Society attaches meanings and values to procedures, and makes judgements based on those meanings and values, regardless of the legality of the procedures.

In all of the conversations there was evidence of the tension of having to wrestle with the decision of whether to tell others about the pregnancy and abortion. Influenced by the societal discourse, the women constructed their abortion as a secret, and there are decisions to be made regarding the disclosure of a secret. For some of the women, secrecy led to a silencing of their experience within some or all of their relationships:

> *Women are making these decisions somehow in isolation…with the idea that it's going to be a dirty little secret: no one else has done this and I'll never speak about this. You know, we all have our histories, and I thought, I have this whole history, not just around unplanned pregnancies and abortions, but all the other things that come with being a woman, including giving birth to children, miscarriages, and all that stuff. And I thought, somehow we are silent about that entire part of our lives in so many ways…. Except when we give birth to babies. That's the one thing we'll talk about freely and openly. That's the one thing we will celebrate. Somehow that's safe and it's what we are supposed to be doing and it's OK.*

Some pregnancies are more valued by society than others. The societal narrative is that pregnancy results in the birth of a child. The birth of a child is privileged over all other events in the pregnancy, including the woman's experience of the pregnancy.

The secrecy surrounding abortion tends to limit a woman's means of seeking support. Some participants discovered that other women with whom they had close relationships had also experienced abortion, yet they had never talked about this part of their lives:

> *I knew a woman who had gone through it as well. And I never knew she had until I had spoken of my experience.*

The women spoke of feeling silenced about not only the abortion, but also the pregnancy — as though it did not exist. They expressed a belief that although abortion ends pregnancy it does not cancel it out:

> *I think with an abortion, society wants you to just forget about it. But when you go through it you just don't want to forget, you really don't want to forget. You want to know that you were pregnant and it was a special thing, because it always is. Yet society wants you to say, well, you've had an abortion, just get on with things, don't worry, your life will go on, and they don't want you talking about it.*

Some women felt silenced or hurt regarding the disclosure within their closest relationships:

> *Well, I come from a mother who is extremely pro-life, like extremely pro-life. She rallied, and we had, like, all of the information, like all of the information...the photographs, the pictures; we knew about the procedure and how it affected the fetus. I still believed when I went in — I still believe now — that you are killing something, and killing a living being, a person. That's how I feel about it, because I guess I was raised to have that belief. But I did what I did. I disagree with my mother.*

> *I have a sister who wasn't able to have children, desperately wanted children, so she adopted two boys. So I felt I couldn't talk to her about it, because I know it really is a touchy issue for her and I was feeling somewhat selfish in terminating a pregnancy that someone like her would just die for, so I didn't feel I could talk to her about it.*

The experience of being silenced or of facing disapproval influenced the amount and sources of support the women received. Yet in the face of pervasive societal norms they made decisions that might be viewed as contentious by those close to them. In conversations in which the women dwelt on their experiences of being silenced, there emerged a conviction to reclaim the voice of their own narratives: the silence was broken by a voice whose echo would drown out the sound of the dominant social narratives.

Narratives Spoken Through Social and Material Realities

The women's decision to end the pregnancy was informed by the tension between their feelings about the pregnancy and the realities of their lives. For several, the baby was wanted and the pregnancy was a positive experience but their circumstances made having a child untenable:

> *Having a child with him would be just wonderful — you know, the opportunity for us to share something together.*
>
> *The good thing that I had was that I felt good inside being pregnant with his child.*
>
> *When I found out I was pregnant I was very excited. My husband and I were hoping to have a second child.*
>
> *We were quite excited about the pregnancy, and that is what we wanted.*

Despite their desire to sustain the pregnancy, the realities of their lives, particularly their relational circumstances, contributed to the ultimate decision to end it. One woman explained:

> *Unfortunately the circumstances were such that I didn't know if the child was fathered by my husband or not. I chose to end the pregnancy on the off chance that my husband was not the father.*

Another woman described her partner's priorities as different from her own:

> *Right now he is thinking, I need to get established, I am not stable enough financially. He doesn't want to be living in the home we are in with children, because it is a half duplex and he doesn't feel there's enough room for the kids in the yard and that sort of thing. He's thinking, no, I want to be in a particular situation before I have a child. He was kind of, well, I'm not ready for this right now.*

In some relationships the tensions generated by the pregnancy itself informed the decision to have the abortion:

> *Our big problem was that he had had a vasectomy a year ago, so when I got pregnant there was tension between us to start with. So it was hard talking to him, and to have communication between us. He wasn't sure what was going on. I know that he is the father, but what happens if he goes and has the test and it's not shown? [The doctor] said there was a chance [of false results].*

For other women the tension grew out of their wish for a child as opposed to their material circumstances, which would be seriously challenged by the burden of raising another child:

> *You know, it takes a lot of time to be a really good parent. Oftentimes I am not able to meet my own standards with the two that I already have. There was no way that I was going to jeopardize them by having a new one. I swayed to the idea of what actually would happen if I decided to have this child, but the picture is rather bleak. I'm having a hard enough*

> *time dealing with what I have right now. I have to set some limitations for myself.*

A 19-year-old woman felt she lacked the interpersonal support and material resources needed to raise a child:

> *First I didn't tell my parents. My boyfriend had moved to go to university. I knew I was pregnant before he left. When the test came out positive I phoned him. He said he didn't want anything to do with it. He said it wasn't his. And then I decided I wasn't going to tell my parents, but then I really got scared because I had no one.*

A 43-year-old woman related:

> *I was very disappointed to begin with, but I decided that, mainly because of my age, I didn't want to raise a child on my own at this particular point. I felt that if I really wanted to do that I would have done it earlier in my life.*

For many women, the desire to have a child, even this particular child, competed with the reality of their limited human and material resources. They faced abandonment from myriad sources of support — the types of support they would require if they decided to sustain the pregnancy. The women were left with the option, usually unrealistic, of providing for the child alone. Given the complex and competing demands of their other dependants and their partner, the voice of social and material circumstances was unyielding.

Existential Aloneness and Sole Responsibility

Even women in established partnerships expressed feelings of aloneness in their decision to have the abortion and in the experience itself:

> *Somehow, it became mine to deal with and I unquestioningly took that on. I sought out counsellors, I got the information, and the role he played was to be there and to drive me home afterwards. And I remember feeling absolutely alone with it, including afterwards.*

One woman spoke of her partner as being outside of the experience:

> *Although my partner was aware of it, I still basically had to find a place for it [the suffering] in my life all by myself.*

She went on to wonder about the experience for other men and about the lack of male socialization on abortion. Her questioning shows an awareness of the gaps in the cultural narrative that informs the male role in the abortion experience. For men, there are no clear directives; faced with their uncertainty they can either withdraw or interpret the absence of a clear directive as a directive to do nothing. One woman expressed this well:

> *They don't know what to say, they don't want to say the wrong thing, they don't want to make it appear as though they are pressuring her to do one thing or another. And so they remain sort of alienated from the process, just because they don't quite know where their attitudes, their feelings and ideas come. So they stay quiet.*

Another participant said:

> *I know this decision is mine and mine alone to make, but it would have been helpful for a couple of days to have that support. He said he was going to stay with me. He stayed with me for the appointment and after that he went to work and I didn't see him again that day. Actually, I didn't see him the next day either, so I think that was part of why I was feeling so upset the next day, because I had kind of counted on that support and it wasn't really there. He hasn't mentioned it, not one word, since that day.*

The aloneness was also existential in nature. There was evidence of tension originating in the women's awareness of their ultimate aloneness in the decision to have an abortion. They bore sole responsibility *not* for becoming pregnant but for the decision, and living with the outcome of that decision. Juxtaposed with their sense of aloneness were a desire for connection and a feeling of resentment for the inevitability of their having to bear sole responsibility. Amidst this struggle was a wish that their partner could be more central in the decision.

Creating Space for Grieving the Loss

The women expressed a sense of emptiness and suffering, in spite of having absolute confidence in their decision. There was no regret or remorse, but clearly there were feelings:

> *I felt really empty after. You definitely feel like there is something missing after that, like something is gone that was there before, that isn't there any more, that was the feeling. It's hard for me to describe and hard for me to get something for, because I didn't really know what I wanted anybody to do for me. Having people around was important afterwards. I still need to have people around, not even to talk, just to have somebody there. I still feel I really don't regret this decision. I feel like it's...the only decision I could make in this situation.*
>
> *Mentally and emotionally it's hard to...you feel very empty. If you really think about it, you know you really killed a person. You have to justify to yourself why you did it. The issue about losing the baby itself... I will always wonder about that baby.*

> *[Two days after the abortion] I had just real emotional turmoil. Everything I was doing I would just break down and cry. I couldn't pinpoint my feelings much though. It was a very strange day. I just couldn't tell if I...I wasn't angry, I just kind of felt empty, not angry or sad that I had made the wrong decision, I just was really emotional and teary that day.*

The women's narratives also indicated a need for acknowledgement and sharing of their grief:

> *I think often the woman is left with those feelings because there isn't much acknowledgement by society that you have gone through a major loss. So you carry that with you.*

Some women compared this loss to that experienced with stillbirths and miscarriages:

> *It's interesting, because I have been through a miscarriage as well and I remember sensing the same thing after the miscarriage. You're just sort of expected to put it away and carry on. And again there was no one to talk about it. No one acknowledged it as a pregnancy that has come to an end. And somehow you have to deal with it, and you are very much on your own with that as well.*

A woman who had gone through a full-term stillbirth recalled her grief for the loss of that child. She spoke of the stillborn baby as a "final result, I could still hold him." In the journey of her grief she often visited her baby's grave with flowers and toys, whereas

> *When you're pregnant and have an abortion, you haven't held anything, you haven't seen anything, you don't have pictures. You have nothing to look back on and remember the good times.*

How can space be created, in the lives of women and in society, to accommodate grieving for the loss of a pregnancy? Co-existing with a woman's decision to end her pregnancy is her relationship with the child and, for many, a desire for that child to be born.

Mutual Narratives

> Speaking together in personal voices and mutual narratives, women gain access to their own particular healths. Whether these conversations occur within or outside of the health care system will depend upon whether that particular access is considered the critical element in women's health care. (Gadow, 1994, p. 306)

Women's abortion experiences are mediated by multiple cultural narratives that intersect with the particular situatedness of a woman's life. In considering the woman's construction of her own narrative, we come to realize that she is not located outside of the dominant narratives but, rather, lives her life immersed in them. A particular experience can serve to disrupt our participation in the dominant discourses. In this study, new understandings were generated about the women's participation in and disruption of the dominant narratives. Through their abortion experience — including their participation in this study — the women showed that they were capable, albeit in different ways, of negotiating new ways of relating to the dominant discourses.

Implications for Practice

This study illuminates the tensions between dominant and non-dominant discourses, between what the women hoped would happen and what they actually experienced. In contrast to the expectation that health professionals will offer options and support in dealing with an unplanned pregnancy, these women encountered a medical narrative with an agenda that had nothing to do with offering options. This medical narrative was of the "irresponsible woman," of abortion as "a lesson to be learned." In contrast to the expectation that abortion, as a legal procedure, will be available, these women spoke of a cultural narrative where abortion is wrong. They found themselves caught between the need for secrecy — given the values and meanings the culture assigns to abortion — and the need to create their own narratives where both the pregnancy and the decision to have an abortion are discussed freely and are understood. This experience taught the women that some pregnancies are more valued than others and some medical procedures are more acceptable than others, and that although they might wish for a child — even this child — relational and material resources do not always support such a wish. The women spoke of tension developing as they recognized their own participation in the dominant narratives, and even their own complicity in the judging of women who choose abortion.

In considering our practice as nurses we must listen for both the dominant and non-dominant discourses in the voices of women and in ourselves. From women we may learn that we, like a woman experiencing an abortion, live immersed in dominant narratives. Only by recognizing our complicity in sustaining these narratives will we be able to disrupt them, and to generate new possibilities for understanding the experience for the woman and for ourselves. In talking with these women we have come to realize that what we had constructed as the experience of an abortion can be more meaningfully understood as the experience of a pregnancy that ends in abortion, an experience that is rich and complex and is best situated within the life of a particular woman.

References

Caputo, J. (1987). *Radical hermeneutics: Repetition, deconstruction and the hermeneutic project.* Indianapolis: Indiana University Press.

Ceci, C. (in press). When difference matters: The politics of privilege and marginality. In M. McIntyre & E. Thomlinson (Eds.), *Realities of Canadian nursing: Politics, power and practice.* Philadelphia: Lippincott.

Childbirth by Choice Trust. (1998). *No choice: Canadian women tell their stories of illegal abortion.* Toronto: Author.

Gadamer, H. (1998). *Truth and method (2nd Rev. Ed.).* New York: Continuum.

Gadow, S. (1994). Whose body? Whose story? The question about narrative in women's health care. *Soundings, 77,* (3/4), 295–307.

Kristeva, J. (1980). *Desire in language.* New York: Columbia University Press.

Norris, J. (1991). Mothers' involvement in their adolescent daughters' abortions. In J.M. Morse & J.L. Johnson (Eds.), *The illness experience: Dimensions of suffering.* Newbury Park, CA: Sage.

Sherwin, S. (1992). *No longer patient: Feminist ethics and health care.* Philadelphia: Temple University Press.

Smith, D. (1991). Hermeneutic inquiry: The hermeneutic imagination and the pedagogic text. In E. Short (Ed.), *Forms of curriculum inquiry* (pp. 187–209). Albany, NY: SUNY Press.

Weedon, C. (1999). *Feminism, theory and the politics of difference.* Malden, MA: Blackwell.

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Inquiries may be directed to: Dr. Marjorie McIntyre, Faculty of Nursing, 2500 University Drive, Calgary AB T2N 1N4 Canada. E-mail: <mcintyre@ucalgary.ca>.

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Ren and *Yuan:* A Cultural Interpretation of Chinese Women's Responses to Battering

Agnes Tiwari, Margaret Wong, and Heidi Ip

L'étude a pour but d'examiner les réactions des femmes chinoises face à la violence conjugale, dans le contexte de la culture chinoise. Cette étude s'appuie sur le vécu de 11 Chinoises vivant à Hong Kong. Une analyse des témoignages de ces femmes révèle la présence de valeurs chinoises dans leurs réactions quant à ce type de violence. Elles ont recours au *ren,* ou à l'endurance, comme mécanisme d'adaptation, et au *yuan,* au destin, pour expliquer l'échec de la relation. Les stratégies que ces femmes utilisent pour composer avec la violence démontrent clairement la présence d'une attitude de tolérance et de créativité. Leurs réactions face à la violence révèlent de la détermination et diffèrent selon le statut de la relation

The purpose of the study was to examine women's responses to battering within the context of Chinese culture. The stories of 11 Chinese women living in Hong Kong formed the basis of the inquiry. Analysis of the women's accounts revealed Chinese values in their responses to battering: they adopted *ren,* or endurance, as a coping mechanism and used *yuan,* or predestination, as an explanation for their failed relationship. The resilience and resourcefulness of the women are clearly demonstrated in the strategies they employed to cope with the abuse. Their responses to battering were purposeful and varied according to the status of their relationship.

Introduction

Traditionally, Chinese culture ascribes women inferior status and condones violence against women (Cheung, 1996; Honig & Hershatter, 1988). Studies show that in response to wife battering, women employ strategies to protect themselves and their children and to survive the abusive relationship (Campbell, Rose, Kub, & Nedd, 1998; Dutton, 1996; Koss et al., 1994). Given the socialization of Chinese women into submissive and subservient roles, how do they respond in abusive relationships? Despite the increasing attention paid to violence against women in Chinese societies, there is still a paucity of information on the responses of Chinese women to battering. In places such as Hong Kong,

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Agnes Tiwari, RN, PhD, is Assistant Professor, Department of Nursing Studies, University of Hong Kong, Hong Kong. Margaret Wong, BSW, MSc, is Executive Director, Harmony House, Hong Kong. Heidi Ip, BASW, Dip. Chinese Lang. & Lit., is Coordinator, Harmony House.

where Chinese values are mixed with Western norms, the extent to which Chinese culture affects the mentality and behaviours of battered women is an under-researched area. Studies conducted in Hong Kong have concentrated on the nature and effects of violence against women (e.g., Tang, 1998; Tang, Wong, Cheung, & Lee, 1999; Yeung, 1991), while little is known about the women's responses to battering.

The purpose of this study was to examine the responses of battered women in Hong Kong based on their own stories, which were the first accounts by battered women ever to be published in Hong Kong. By locating these stories in the context of Chinese culture, the study attempts to provide a cultural interpretation of Chinese women's responses to battering. As traditional values and beliefs have been shown to persist in many Chinese societies, despite Western influences and socio-economic changes (Cheung, 1996), it is hoped that the findings will also be relevant for Chinese communities outside of Hong Kong.

In this paper, wife battering is defined according to the definitions offered by Campbell (1999). Wife battering, which is different from wife beating, is defined as ongoing severe violence inflicted by men on their female partners. Such violence is not seen as usual in the society, and is accompanied by other means of coercion. It is a pattern of abusive behaviour and control rather than an isolated act of physical aggression.

Literature Review

Women in Chinese Societies

Chinese culture emphasizes harmony, discipline, and self-restraint in interpersonal relationships, yet condones violence against women (Goodwin & Tang, 1996). It has been suggested that due to the inferior status traditionally ascribed to women in Chinese societies, aggression against women may be seen as more acceptable and less evil in these societies than in others (Tang, Lee, & Cheung, 1999). In Hong Kong, a former British colony, remnants of traditional patriarchal values are evident despite Westernization and rapid socio-economic changes. Although educational attainment among women has improved significantly and women have achieved greater social status, gender differences remain in higher education and employment (Westwood, Mehrain, & Cheung, 1995). Gender inequality is particularly evident in rural Hong Kong, where attempts to modify patriarchal traditions have met with strong opposition (Wu, 1995). Local studies show that while

Hong Kong people generally accept gender equality, many still adhere to traditional views concerning women and their roles (Cheung et al., 1994; Choi, Au, Cheung, Tang, & Yik, 1993).

Chinese culture is not the only culture that institutionalizes the inferiority of women. Many other cultures give men the right to control women and to use force in disciplining their wives. For example, in countries as far apart as Bangladesh, Mexico, and Nigeria it is considered a husband's right to use violence in disciplining an errant wife (Gonzalez Montes, 1998; Osakue & Hilber, 1998; Schuler, Hashemi, Reily, & Akhtar, 1996). Chinese or non-Chinese, as long as cultural beliefs and practices favour male dominance and female submissiveness, women's autonomy will be undermined and their vulnerability exploited. However, it has been suggested that culture can be a double-edged sword in gender-based violence. While culture can disadvantage women and aggravate their vulnerability, it can also be a creative resource in confronting abuse against women (Heise, Ellsberg, & Gottemoeller, 1999). In a Canadian Aboriginal community, for example, traditional sanctioning and healing practices are used to restore justice to the woman and punish the perpetrator (Match International Centre, 1994), while in India and Bangladesh domestic violence is addressed through *Salishe*, a traditional system of local justice (Datta & Motihar, 1999). It has been suggested that Chinese people use a "persevering approach" to life's problems (Hwang, 1988). The persevering approach is derived from the Confucian tradition of self-control and includes such strategies as self-instruction in patience and non-resistance. Also, Chinese people may use the Buddhist concept of *yuan*, meaning predestination, to explain interpersonal matters and social events. It has been found that *yuan* serves a protective function in explaining away negative exchanges and that those who use *yuan* tend to have fewer depressive symptoms (Bond, 1991). To what extent have traditional Chinese values offered protection to battered women? The paucity of information on the experience of Chinese women in abusive relationships makes it impossible to speculate.

Women's Responses to Battering

Studies of women's response to battering show that battered women are not passive victims. Gondoff and Fisher (1988) provide evidence that women in abusive relationships are active survivors rather than helpless victims. The women in their study increased their help-seeking as the violence increased, which refutes the hypothesis of learned helplessness. In an urban field study of battered women, Hoff (1990) found that the women were able to cope with life-threatening crises despite intimidation and self-blame. They also developed strategies for both coping within the abusive relationship and eventually leaving it. Landenburger (1989) found that as the abusive relationship continued, the woman's perception of the experience and her choices gradually changed; this study also identified a process of entrapment and recovery. The lived experiences of abused women formed the basis of Lampert's (1996) study into how women give meaning to their abusive experiences and respond to the violence. Lampert found that "within contradictory interactional contexts, these abused women developed strategies intended to halt, change or cope with their partners' violence" (p. 286). In a prospective study, Campbell et al. (1998) found strength, resistance, and resourcefulness in a sample of battered women as they faced frightening circumstances in their intimate relationships. The aforementioned studies demonstrate that the response to battering is a complex process, with the women actively employing protection and survival strategies. While the findings provide important insights into this complex phenomenon, none of the studies focused on the experience of Chinese women.

It has been suggested that women's responses to abuse are limited by the options available (Dutton, 1996) and that the fear of social stigma often prevents women from seeking help (Heise et al., 1999). In Chinese societies where domestic violence is stigmatized and wife battering is concealed within the family, since "shameful family affairs should not be disclosed to outsiders," how do battered women survive in abusive relationships? What role does culture play in accentuating or lessening the women's suffering? In light of the lack of information in this area, a closer examination of Chinese women's responses to battering is warranted.

Method

Narrative inquiry was the method used in this study. Clandinin and Connelly (1994) describe narrative inquiry as one of the personal-experience methods in social science inquiry. Narrative is, in this sense, "both phenomenon and method" (p. 416). As a phenomenon, it names the structured quality of experience to be studied. As a method, it determines the patterns of inquiry for the study of the phenomenon. To preserve the distinction between phenomenon and method, it is customary to call the phenomenon *story* (what the narrator tells) and the inquiry *narrative* (the researcher's account). In narrative inquiry, narrative researchers describe the storied lives of people, collect and tell stories of them, and write narratives of experience. Redwood (1999) says that for both the researcher and the reader of narrative research "there is a thrill from entering into another's story" (p. 674), either from glimpsing the unfamiliar or from identifying with the well-known. Although stories of personal experience may be dismissed by some as anecdotal evidence, they can be gathered and analyzed, and used as a research method (Cortazzi, 1993).

In narrative research the researched world cannot be reproduced without some form of narrative analysis. The form of analysis largely depends on the researcher's views on the construction of knowledge (Redwood, 1999). For example, where a phenomenological interpretation of a narrative is adopted, the lived experience of the narrator is emphasized in the analysis. Further, narrative analysis often appears to be an almost intuitive process (Manning & Cullum-Swan, 1994), typically taking the perspective of the narrator and using terms defined by the analyst (Reissman, 1993). An analysis of narratives "cannot reveal what someone 'really' thinks or feels because any truth is simply a construction" (Redwood, p. 674), so it is not surprising that narrative analysis struggles continuously with the problem of context, or the embeddedness of a story within personal or group experience (Manning & Cullum-Swan). However, the merits of narrative are well known. Abma (1998) contends that active sharing of stories can transform professional practice. Clark (1995) concludes that personal stories facilitate knowing, health, and caring in nursing. Coles (1989) and Mishler (1984) argue for the utility of narrative analysis in medical social science and assert that healing necessarily involves the telling, hearing, and unravelling of stories. Although narrative research has yet to play a major role in the development of nursing science, the merits of storytelling in nursing and health care are increasingly being recognized (Berman, 1999). The narrative inquiry method was chosen for this study because it provided a means of discovering a woman's experience of battering from her own point of view and because the women's stories were a rich source of information.

In this study, the experiences of and responses to battering were identified based on the stories of a group of battered women. The stories appear in the book *Herstory: Family Constraints and Violence* (Harmony House, 2000), published by an organization providing shelter and services to battered women in Hong Kong. The purpose of the book, the first of its kind to be published in Hong Kong, was twofold: as a community education project and as narrative therapy. As a community education project it was designed to raise awareness about the incidence and prevention of spousal abuse. As narrative therapy it was designed to encourage battered women and to recognize their efforts and achievements. The women either wrote their own stories or told them to interviewers; once accuracy was confirmed there was no further editing of the stories, in order to preserve the words of the women as told or written. Each story is followed by a commentary written by a social worker who was involved in providing care to the woman, in order to bring out the context of the woman's account. The commentary was checked by the woman for accuracy and authenticity and modified as required.

Of the 19 women whose stories appear in the book, 11 consented to have their stories used for research purposes. Although two of the researchers (Wong and Ip) were responsible for publishing the book, none of the researchers had taken part in interviewing the women or collecting the stories.

Sample

The 11 women whose stories were used in the study ranged in age from 31 to 45 years. All were Chinese: two had been born in Hong Kong and nine were immigrants from China who had settled in Hong Kong within the preceding 7 years. With the exception of one, whose status was "separated," all of the women were divorced at the time of telling their stories. All had left the abusive relationship. In their stories, the women were reflecting back on their lives with the abusive partner. All but one of the women had dependent children. About half of the women had received primary schooling. The remaining half were educated to secondary level. Their educational level was below the Hong Kong average. This reflects their immigrant status, as in China, unlike in Hong Kong, mass tertiary education had yet to come about. Only two of the women were employed. Nine were receiving social assistance.

Data Analysis

Thematic analysis was performed for each of the 11 stories. Patterns and unique textual data (such as events and reported behaviours) were coded, categorized, and abstracted to form themes. Descriptive data (such as marital status, absence or presence of abuse) provided the contextual aspects of the woman's personal situation. The stories were read and analyzed separately by all three researchers. Only after consensus was achieved would the themes be accepted.

As stories contain multiple meanings and are open to a variety of interpretations (Abma, 1998), and as mute material evidence cannot "speak back" (Hodder, 1994, p. 398), care was taken to interpret the women's stories in a way that would ensure auditability (Miles & Huberman, 1994). Contextual interpretation was used in analyzing the text (Hodder), and the meanings of the text were noted. To guard against imposing their preconceptions and missing the emerging themes, the researchers meticulously analyzed the women's accounts in terms of context, people, and events. The sense and coherence of the analysis from which emerging themes were derived was carefully checked for antecedents and consequences. The commentary accompanying each story also served as a means of checking convergence of the researchers' interpretations and those of people closely involved with the women and their stories.

Results

Women's Reports of Violence

All 11 women reported that they had been subjected to ongoing acts of violence such as shoving, slapping, grabbing, or threatening with weapons (usually knives or choppers). In some cases the injuries were severe enough to require hospitalization. The women also reported other forms of coercive control, including belittlement, intimidation, humiliation, financial deprivation, physical removal from the matrimonial home, and denial of access to their own children. However, only two women identified sexual abuse in their violent relationships, one of whom reported being raped by her husband during a particularly violent episode. This woman's use of the word "rape" is significant. Marital rape is not widely recognized in the local community, and traditionally Chinese women believe it is their duty and obligation to submit to their husbands sexually. While the reported low incidence of sexual abuse may be accurate, underreporting should not be ruled out. Studies have found that Chinese people are generally reluctant to discuss sexual matters (Bond, 1991; Goodwin & Tang, 1996) as sex is a taboo subject in Chinese culture. It is therefore notable that this woman described her experience of sexual coercion as rape.

Responses to Battering

When the women's stories were examined, the complexity of their responses to battering became evident. While the women might have appeared to be passive victims of violence, careful analysis of their accounts revealed that many of their actions/non-actions had been deliberate and purposeful. Also, as evident in their recalling of the experience, their responses varied according to the status of the relationship. Thus, the results presented here will be classified by relationship status.

Relationship status: still in the abusive relationship. In their stories, the women recalled how they coped with the abuse while they were still living with the partner:

> *When he used* jia fa *[rules of the family] on me, I accepted it for reasons of* ren ru fu zhong *[endure humiliation in order to carry out an important mission]. (p. 81)*
>
> *I thought that if I used* ren ru fu zhong *he would be impressed by my effort and might even change back to the good husband I once knew. (p. 86)*
>
> *For two years, I* ren shou *[endured] his bad behaviour and did everything to please him in the hope that one day he would change. (p. 54)*
>
> *For the sake of our children, I tried my best to* ren qi tun sheng *[endure the injustice and dare not say anything]. (p. 24)*
>
> *For five, six years, I responded to his behaviour with* ya ren *[suffering in silence]. (p. 70)*
>
> *I responded with* ren *[endurance] to his foul language and humiliation and tried to ignore it. (p. 10)*

The women repeatedly used the word *ren* to describe their way of coping with the abuse. *Ren,* or endurance, involved actions such as doing what the partner wanted or trying to please, as well as seemingly non-actions such as suffering in silence or ignoring the abusive behaviour. *Ren* was a conscious, purposeful choice — a means of dealing with the problematic relationship. In the excerpts above, it is apparent that some of the women used *ren* to avoid further violence or to prevent escalation of the abuser's anger. Some also used *ren* to please their partner in the hope that the relationship would improve.

The commentaries accompanying the stories also make reference to *ren*:

> *When one is abandoned by one's loved one, it is hard to get over the pain. However, such is the reality and one must* ren tong *[endure the pain] and accept it. (p. 15)*
>
> *Even though the husband uses force in every encounter, the wife responds with* ren *each time. I wonder where she has learned this. Maybe she has been influenced by traditional values. (p. 84)*

The use of a coping mechanism (*ren*) is by no means unique to this study. Similar tactics have been documented in other studies. For example, Landenburger (1989) identifies *enduring* as a phase in the entrapment and recovery process, and Campbell et al. (1998) describe "subordinating the self" (p. 755) as a strategy used by women to avoid violence. It appears that in the face of frightening circumstances, both Chinese and non-Chinese women are likely to use coping strategies to protect themselves and their children. Interestingly, a number of women in this study used Chinese idiom to describe their acts of *ren*, such as *ren ru fu zhong* (endure humiliation in order to carry out an important mission) and *ren qi tun sheng* (endure the injustice and dare not say anything). Both of these would be used regularly by Chinese parents and teachers in teaching children to discipline themselves. Whether the women's use of Chinese idiom in describing their responses to battering is rooted in the Confucian teaching of self-instruction in patience would require a more in-depth, reflective discussion than this study allowed.

The women's stories suggest that a number of factors might have influenced their decision to endure the abuse rather than end the relationship. One factor would be an inability to leave because of harsh socio-economic realities. However, this did not apply to all of the women. Indeed some were breadwinners supporting the partner. Another possibility is that the women were, like most Chinese people, brought up to believe that "shameful family affairs should not be disclosed to outsiders." Thus the need to protect the family name would cause them to conceal and endure the abuse. Further, several of the women expressed the view that *cong yi er zhong* (marriage is forever). For them, ending the relationship would be out of the question at that time; their only option was to learn to live with the abuse. Yet another possibility was that the women had been socialized into traditional Chinese thinking, in which *ren* is a feminine virtue.

More than half of the women (six out of 11) admitted to having had suicidal thoughts, though none had acted on them. It was not entirely clear from the stories what might have stopped them. While a couple of the women made vague references to their responsibility to their children, they did not elaborate on the issue. However, the women were very clear that they had to be strong in order to survive, and *ren ru fu zhong* frequently featured in their discourse. Notwithstanding this, it is impossible to conclude that *ren* acted as a buffer against self-harm.

Relationship status: had ended the relationship. In their stories, the women also recalled how they felt about the abuse after they had physically left the relationship and made a final break from the abusive partner:

> *I felt I was so silly. I put my heart in the family and yet he was only using me. He even used me as a sex object. I finally decided that I should not allow myself to be hurt any more, so I took the children with me and found a place for us in the shelter. (p. 54)*
>
> *I came to the conclusion that even if I were to struggle on, there would be no hope for our relationship. Rather than prolong the agony, I decided to divorce him. (p. 60)*
>
> *At the end I had to accept the reality. Despite years of* ren nai *[exercising restraint] in order to save our marriage, we had to part. Perhaps this is* yuan *— the end of our* yuan *as wife and husband. (p. 68)*
>
> *I learned to live again after leaving him. I now have a better understanding of* yuan. *With the blessing of those who cared about me, I left the shelter and took my first step as a single parent. (p. 82)*
>
> *I often hear people say* "yin yuan tian zhu ding" *[marriage is predestined in heaven]. How I wish that mine could have lasted forever…but it was not to be. (p. 66)*
>
> *All my life I have tried my best to fulfil my responsibilities and be kind to people. What have I done to deserve this? Perhaps it is* yin guo *[punishment for bad deeds in a former life]. (p. 108)*

The women's recalling of this relationship status was substantially different from that of the previous status. Instead of enduring the abuse, they re-evaluated their situations. As the futility of their numerous efforts and attempts at endurance became apparent, they decided that something had to change. They began to look for an explanation for the failed relationship and found an answer in *yuan*: when *yuan* is over, the relationship ends. A key feature of their responses was a playing down of *ren* and an emphasis on *yuan*.

Although the women appeared not to rely on *ren* in this relationship status, *ren* was a part of their re-evaluation: they weighed up their efforts to improve the relationship and their partner's abusive behaviour. When repeated efforts had failed to change the abusiveness or to prevent further deterioration, they concluded that it was time to change their strategy. It is apparent that in the process of weighing up the situation, the women gained insights into the relationship and their partner's abusive behaviour. Further, they were prepared to act.

Yuan featured prominently in the women's accounts of this relationship status. They referred to *yuan* as the reason for the failed relationship, perceiving it as predetermined by external forces, referring to "heaven" and "deeds of a former life." The women did not conceive *yuan* merely as a passive coping mechanism. This is evident in their use of *yuan* to explain why the relationship had failed despite their efforts to make it work. These women had no apparent feelings of guilt or self-blame. On the contrary, they were positive about their decision. One woman described her new life as "born again," another talked of her "new vision," and a third spoke of the "inner strength" she had mustered. Yet life was anything but easy for these women at that point. They were poor, were living in squalid conditions, and constantly had to hide from their abusers. As single parents, they had to fulfil the parenting role with insufficient social support and to live with social stigma and rejection. Despite these difficulties, they were positive. Some took the initiative to advance their education by enrolling in courses; others took up voluntary work to help other battered women or other people in need; all put effort into rebuilding a family life with their children in the aftermath of the abuse. There is no doubt that the support of families and friends played an important part in their rehabilitation. The shelter for abused women and social workers also played a key role in the recovery process. Given the women's references to *yuan*, it is possible that this concept was also responsible for their positive outlook and actions. Indeed, Lee (1995) suggests that *yuan* helps to preserve mental health by providing ready answers concerning life's vicissitudes, warding off feelings of guilt, and offering hope for the future.

It is clear that certain events caused these women to re-evaluate their situation and make the decision to end the relationship. In some cases the events were specific and extreme. For example, two of the women decided to leave after an episode of escalated violence when they thought they were going to die. Three were physically thrown out of the matrimonial home. In two cases, the abuse was extended to the children, causing the women to leave for the children's safety. For the others, however, the events were not so obvious and the decision to leave was a gradual one. The "suffocating effect" of the abuse, as described by one woman, repeated beatings, and lack of improvement in the partner's behaviour eventually convinced them that they had to end the relationship. The incidents that prompted these women to finally leave are not unique. They are similar to the "turning points" described in Campbell et al. (1998). The women in Hoff's (1990) study identified similar circumstances leading to their decision to leave. The complex process involved in deciding to leave is worth noting. The women in this study clearly had different thresholds for abuse, different perceptions of what was tolerable or intolerable, and different views on when it was time to leave.

Interestingly, none of the commentaries make reference to *yuan*. However, the commentaries clearly describe the resilience of the women:

> *In the end she decided to leave the home that had been her prison...even though the journey as a single parent was a difficult one, she was able to derive joy and comfort from the little achievement she made. (p. 85)*
>
> *To Ah Ling, this is a valuable lesson. She has found herself...in the middle of the darkness. She has become a new person... I believe from now on nothing could stop her from living a free and self-determined life. (p. 75)*

Discussion

As demonstrated in other studies, battered women are not passive victims (Campbell et al., 1998; Dutton, 1996; Koss et al., 1994). Rather, they actively strategize to survive in abusive relationships. The women in this study used strategies to protect themselves and their children from the abusive partner. Through the exercise of *ren*, they attempted to avoid further violence and maintain a harmonious relationship with the partner. Even when the relationship had to end, they attributed the failure to *yuan*, thus avoiding feelings of guilt and interpersonal hostility. Despite their vulnerability and socio-economic disadvantage, the women demonstrated strength, resilience, and resourcefulness in their struggle against the odds. This belief in *yuan* is significant. The stories of these women show that, even in a culture that condones violence against women, traditional Chinese values such as *yuan* can be used in a positive way.

The women's inclination to use *ren* in the face of violence may have stemmed from their socialization into Chinese women's roles. Maintaining harmony is of paramount importance in Chinese culture (Bond, 1991; Gao, Ting-Toomey, & Gudykunst, 1996), and the practice of *ren* is a way of avoiding discord. Also, women are expected to preserve harmony in the family, even if it means sacrificing themselves (Chen, 1991). Under such circumstances, it is not surprising that the women in this study chose to use *ren* in dealing with their abusive relationships.

This study reveals that socialization into traditional Chinese culture is particularly strong among certain social groups, such as immigrants from China. Among these more traditional groups, wife battering may be especially prevalent. The low status traditionally ascribed to women makes them more vulnerable in a community that gives men the right to control their wives. Also, women who have been socialized to tolerate their husband's bullying and violence will be reluctant to disclose the abuse to outsiders for the sake of family harmony. Thus, front-line professionals should be particularly sensitive to the occurrence of wife battering in these groups, so that appropriate professional attention can be promptly provided.

Interestingly, none of the women identified the stress of immigration as the cause of their abuse even though, for most, the battering had begun after they arrived in Hong Kong. Indeed, the majority of them described vividly their joy and relief upon joining their partner in Hong Kong. Their immigrant status, however, seems to have adversely affected their ability to cope once the abuse started. Some of the women expressed difficulty coping with violence from an intimate partner in a foreign land without the support of family and friends. Educated in China, they were ill-qualified for the Hong Kong job market, and this precipitated their financial dependence on their husbands and their need to tolerate the violence at least initially. The disadvantages faced by abused immigrant women should be noted so that more effective intervention programs can be designed to meet their needs.

The findings of this study have implications for nursing. First, dealing with abusive relationships is a complex matter and not one of simply choosing between staying in or leaving the relationship. The woman has to use strategies that will maximize her own and her children's safety. Therefore, nurses should try to understand why women stay in abusive relationships and the context of their response to battering. This would help to prevent disparity between the woman's and the nurse's point of view and thus facilitate communication. Second, the woman's verbalization of her responses to battering evolves with the status of the relationship. While still in the relationship, the woman is likely to express the need to endure the situation. However, once the decision is made to end the relationship, she is more inclined to talk about its failure as predestined and her about her hopes for a better future. The change of view is clearly detectable in the woman's discourse. By soliciting the woman's view of her relationship, the nurse may be able to assess the relationship status, then use the assessment to offer culturally sensitive care based on her readiness to stay in or leave the relationship. Finally, the nurse can help the woman to develop a safety plan in accordance with her relationship status. For example, while she is still enduring the violence the woman may be helped to devise ways to protect herself and her children, such as by seeking assistance from social services or identifying neighbours who might provide help in case of emergency. When a decision is made to leave the relationship, the nurse can advise the woman to prepare for the final departure, such as by packing important documents and obtain-ing contact numbers for a women's shelter. This partnership in developing a safety plan would not only improve understanding between the woman and the nurse, but also empower the woman to overcome the effects of the abuse.

Conclusion

A major limitation of this study is that the women recalled their abusive experience retrospectively. Future studies may focus on uncovering responses to battering as they occur. Also, the study involved mainly immigrant women; more indigenous Hong Kong Chinese women should be included in future studies to allow a comparison of results. In this study the women were unable to participate in the construction of meaning during the analysis. A process such as negotiated thematic analysis would have allowed them to participate in the analysis and thus add breadth and depth. In addition, as culture is only one aspect of the abusive situation, the interaction of social, economic, political, and cultural factors in influencing women's responses to battering should also be explored.

Despite its limitations, this study offers insight into women's responses to battering within the Chinese cultural context. The women's accounts reveal the Chinese values of *ren* and *yuan* in their responses to battering. Far from being passive victims, these women actively used strategies to help them survive in the abusive relationship. Their strategies were purposeful and varied according to the status of their relationship. The women's strength, resilience, and resourcefulness are clearly demonstrated in their responses to battering.

References

Abma, T.A. (1998). Storytelling as inquiry in a mental hospital. *Qualitative Health Research, 8*(6), 821–838.

Berman, H. (1999). Health in the aftermath of violence: A critical narrative study of children of war and children of battered women. *Canadian Journal of Nursing Research, 31*(3), 89–109.

Bond, M.H. (1991). *Beyond the Chinese face: Insights from psychology*. Hong Kong: Oxford University Press.

Campbell, J.C. (1999). Sanctions and sanctuary: Wife battering within cultural contexts. In D.A. Counts, J.K. Brown, & J.C. Campbell (Eds.), *To have and to hit: Cultural perspectives on wife beating* (pp. 261–285). Champaign: University of Illinois Press.

Campbell, J., Rose, L., Kub, J., & Nedd, D. (1998). Voices of strength and resistance: A contextual and longitudinal analysis of women's responses to battering. *Journal of Interpersonal Violence, 13*(6), 743–762.

Chen, R. (1991). Relationship between marital violence characteristics and family dynamics in Taiwan: A study of 25 cases. In F.M Cheung, P.W. Wan, H.K. Choi, & L.M. Choy (Eds.), *Selected papers on conference on gender studies in Chinese societies* (pp. 279–303). Hong Kong: Hong Kong Institute of Asia-Pacific Studies, CUHK.

Cheung, F.M. (1996). Gender role development. In Sing Lou (Ed.), *Growing up the Chinese way: Chinese child and adolescent development* (pp. 45–67). Hong Kong: Chinese University Press.

Cheung, F., Ngo, H.Y., Lai, O.K., Lee, C.K., Ma, S., & Tam, M. (1994). *A survey of public's perception on equal opportunities for women and men 1993–94*. Report submitted to the City and New Territories Administration, Hong Kong Government.

Choi, P.K., Au, K.C., Cheung, M.C., Tang, C.S., & Yik, M.S. (1993). *Power and dignity: Sexual harassment on campus in Hong Kong*. Hong Kong: Hong Kong Institute of Asia-Pacific Studies, CUHK.

Clandinin, D.J., & Connelly, F.M. (1994). Personal experience methods. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 413–427). Thousand Oaks, CA: Sage.

Clark, R.S. (1995). *Personal story re: knowing, health, and caring in nursing*. Doctoral dissertation, University of Colorado Health Sciences Center.

Coles, R. (1989). *The call of stories*. Boston: Houghton Mifflin.

Cortazzi, M. (1993). *Narrative analysis*. London: Falmer Press.

Datta, B., & Motihar, R. (1999). *Breaking down the walls: Violence against women as a health and human rights issue*. New Delhi: Ford Foundation.

Dutton, M.A. (1996). Battered women's strategic responses to violence: The role of context. In J.L. Edelson & Z.C. Eisikovits (Eds.), *Future interventions with battered women and their families* (pp. 105–124). London: Sage.

Gao, G., Ting-Toomey, S., & Gudykunst, W. (1996). Chinese communication processes. In M.H. Bond (Ed.), *Handbook of Chinese psychology* (pp. 280–293). Hong Kong: Oxford University Press.

Gondoff, E.W., & Fisher, E.R. (1988). *Battered women as survivors: An alternative to treating learned helplessness*. Toronto: Lexington Books.

Gonzalez Montes, S. (1998). Domestic violence in Cuetzalan, Mexico: Some research questions and results. In Center for Health and Gender Equity (CHANGE) (Ed.), *Proceedings of the Third Annual Meeting of the International Research Network on Violence Against Women* (pp. 36–41). New York: Pergamon.

Goodwin, R., & Tang, C. (1996). Chinese personal relationship. In M.H. Bond (Ed.), *Handbook of Chinese psychology* (pp. 294–308). Hong Kong: Oxford University Press.

Harmony House. (2000). *Herstory: Family constraints and violence.* Hong Kong: Author.

Heise, L., Ellsberg, M., & Gottemoeller, M. (1999). Ending violence against women. *Population Reports.* Series L, #11. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

Hodder, I. (1994). The interpretation of documents and material culture. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 393–402). Thousand Oaks, CA: Sage.

Hoff, L.A. (1990). *Battered women as survivors.* London: Routledge.

Honig, E., & Hershatter, G. (1988). Violence against women. In E. Honig & G. Hershatter (Eds.), *Personal voices: Chinese women in the 1980's* (pp. 273–307). Stanford, CA: Stanford University Press.

Hwang, K.K. (1988). *Power games of the Chinese people.* Taipei: Jiu Liu Tu Shu Co. (in Chinese).

Koss, M.P., Goodman, L.A., Browne, A., Fitzgerald, L.F., Keita, G.P., & Russo, N.F. (1994). *No safe haven: Male violence against women at home, at work, and in the community.* Washington: American Psychological Association.

Lampert, L.B. (1996). Women's strategies for survival: Developing agency in abusive relationships. *Journal of Family Violence, 11*(3), 269–289.

Landenburger, K. (1989). A process of entrapment in and recovery from an abusive relationship. *Issues in Mental Health Nursing, 10,* 209–227.

Lee, R.P.L. (1995). Cultural tradition and stress management in modern society: Learning from Hong Kong experience. In T.Y. Lin, W.S. Tang, & E.K. Yeh (Eds.), *Chinese societies and mental health* (pp. 40–52). Hong Kong: Oxford University Press.

Manning, P.K., & Cullum-Swan, B. (1994). Narrative, content, and semiotic analysis. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 463–477). Thousand Oaks, CA: Sage.

Match International Centre. (1994). The circle of healing: Aboriginal women organizing in Canada. In M. Davies (Ed.), *Women and violence: Realities and responses around the world* (pp. 234–239). London: Zed Books.

Miles, M.B., & Huberman, A.M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.

Mishler, E. (1984). *The discourse of medicine.* Norwood, NJ: Ablex.

Osakue, G., & Hilber, A.M. (1998). Women's sexuality and fertility in Nigeria. In R. Petchesky & L. Judd (Eds.), *Negotiating reproductive rights* (pp. 180–216). London: Zed Books.

Redwood, R. (1999). Important point: Narrative and narrative analysis. *Journal of Clinical Nursing, 8*(6), 674.

Reissman, C. (1993). *Narrative* analysis. London: Sage.

Schuler, S.R., Hashemi, S.M., Reily, A.P., & Akhtar, S. (1996). Credit programs, patriarchy and men's violence against women in rural Bangladesh. *Social Science and Medicine, 43*(12), 1729–1742.

Tang, C.S. (1998). Wife abuse in Hong Kong Chinese families: A community survey. *Journal of Family Violence, 14*(2), 173–191.

Tang, C.S., Lee, A., & Cheung, F.M. (1999). Violence against women in Hong Kong. In F.M. Cheung, M. Karlekar, A. De Dios, J. Vichit-Vadakan, & L.R. Quisumbing (Eds.), *Breaking the silence: Violence against women in Asia* (pp. 38–58). Hong Kong: Equal Opportunities Commission.

Tang, C.S., Wong, D., Cheung, F.M., & Lee, A. (1999). *A feminist approach to the perception of violence against women in Chinese societies: A focus group study.* Hong Kong: Women's Studies International Forum.

Westwood, R., Mehrain, T., & Cheung, F. (1995). *Gender and society in Hong Kong: A statistical profile.* Hong Kong: Hong Kong Institute of Asia-Pacific Studies, CUHK.

Wu, R. (1995). Women. In Y.L. Cheung & M.H. Sze (Eds.), *The other Hong Kong report 1995* (pp. 121–156). Hong Kong: Chinese University Press.

Yeung, C. (1991). Wife abuse: A brief historical review on research and intervention. *Hong Kong Journal of Social Work, 25,* 29–36.

Authors' Note

Questions or comments should be directed to: Dr. Aggi Tiwari, Department of Nursing Studies, University of Hong Kong, G/F, Block B, Queen Mary Hospital, Pokfulam Road, Hong Kong. Telephone: 852 2819 2629. Fax: 852 2872 6079. E-mail: <afytiwar@hkucc.hku.hk>.

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Designer's Corner

Conducting Health Research with Vulnerable Women: Issues and Strategies

Maureen Heaman

Over the past two decades, the topic of women's health has garnered increased attention and research. However, health research with vulnerable groups of women has been limited. Vulnerable women are defined as women who are susceptible to harm because of their minority status, socio-economic status, or some other stigmatizing status (Demi & Warren, 1995). Other terms used to describe such women include disadvantaged, marginalized, and disenfranchised. According to the Prairie Women's Health Centre of Excellence (1998), marginalized groups of women in Canada include but are not limited to: Aboriginal women, women of colour, immigrant women, refugee women, disabled women, women living in northern locations, lesbians, elderly women, rural women, and farm women. These vulnerable women are at increased risk for health problems (Federal/Provincial/Territorial Working Group on Women's Health, 1990) and deserve to receive greater priority in research. Issues related to conducting health research with vulnerable women will be discussed and various strategies for dealing with these issues will be proposed.

Issues Related to Recruitment and Retention

Barriers to women's recruitment and participation in research must be identified and eliminated if we are to increase the number of participants. The issue is broader than recruiting women; it is recruiting women from diverse racial, ethnic, cultural, socio-economic, and age groups (Swanson & Ward, 1995). Barriers to participation include the time and inconvenience involved, negative personal and family atti-

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Maureen Heaman, RN, PhD, is Assistant Professor, Faculty of Nursing, Helen Glass Centre for Nursing, The University of Manitoba, Winnipeg, Canada.

tudes towards research, and inadequate evidence of the benefits of participation (Swanson & Ward). Among women from minority populations and women of colour, there may be widespread fear and distrust of the health-care system. Recruitment of minority women is hindered by their lack of access to health-care services and their suspicion and scepticism regarding medical research (Larson, 1994). Knowledge of past abuses by researchers, such as in the case of the Tuskegee syphilis experiment, serves as an additional barrier (Moore, 1997).

Clinical trials present several barriers to participation (Cockburn, Redman, & Kricker, 1998; Swanson & Ward, 1995). Vulnerable women may find that information about a trial is too technical or complex to understand, and thus fail to appreciate its potential therapeutic benefits. Invasive protocols or undesirable side effects may also discourage participation. A woman may be fearful of becoming a "guinea pig" in clinical research, or believe that the investigator is more interested in the research than in her well-being as a patient. A trial may demand a great deal of time, with transportation or travel time being particularly problematic.

In longitudinal studies, participant retention can be a greater problem than recruitment, especially for vulnerable women of low socio-economic status. Demi and Warren (1995) describe some of the problems they have encountered in conducting research with families of low socio-economic status: "They may live with others, in crack houses, in a shelter, in a car, or on the street. They tend to move frequently and may be difficult to track through traditional methods. Many families do not have transportation or telephones. They live turbulent lifestyles, because of their many stressors and lack of resources, and thus fail to inform the research team of changes in residence" (p. 193).

A variety of strategies may be used to secure the participation of vulnerable women. Researchers often experience difficulty locating, enrolling, and retaining economically and socially disadvantaged women such as those from ethnic minority, immigrant, or drug-using populations. Incentives may be useful in this regard, such as offering them tangible benefits in return for their participation and making the incentives more attractive as the study increases in longevity (Demi & Warren, 1995; Kelly & Cordell, 1996; Moore, 1997). Follow-up might be facilitated by completing a contact sheet for each woman upon her enrolment, listing the names, phone numbers, and addresses of two persons who are likely to know of her whereabouts at a later time (Johnson & Arfken, 1992). Recruitment should take place in settings where women are found, such as ethnic meeting places, drug-treatment centres, or primary-care clinics (Kelly & Cordell). Provision of transportation and child-care services may help remove impediments to the participation of women who are primary caregivers. Appointments should be scheduled at convenient times and locations (Demi & Warren; Kelly & Cordell). Vulnerable women are more likely to go to a study site if the research is conducted in the target community; they might find it more convenient — requiring less travel time and expense — and be less distrustful of the research (Arean & Gallagher-Thompson, 1996).

In addition, researchers must demonstrate their respect for participants by being non-judgemental and supportive (Kelly & Cordell, 1996). Demeanour can play a role in this regard, as can interactions with participants; researchers should show that they value the contributions of participants (Demi & Warren, 1995). Trust will likely develop if the field staff are drawn from the population that is being studied, as trust is more easily established when staff and participants share a language and culture (Kelly & Cordell).

In research with women from minority groups, members of the target community should be involved in as many dimensions of the study as possible (Johnson & Arfken, 1992; Lillie-Blanton & Hoffman, 1995). Community networking can help to establish rapport with potential participants: one-on-one contact will be more successful if the investigators have already made contact with neighbourhood groups and coalitions. The investigators should become familiar with cultural practices and beliefs and accommodate these in the research design. They should also be sensitive to cultural nuances within an ethnic group, as various subgroups may exist (Arean & Gallagher-Thompson, 1996). When members of minority populations are being recruited, the recruiters should use the language of the community. It is beneficial to use recruiters who are of the same race and ethnicity as the potential subjects and who are familiar with local culture and customs. To ensure cultural relevance, minority women could be asked to become involved in developing recruitment strategies and preparing recruitment or educational materials. Minority women could also be invited to join the research team, to add credibility to the research and to help establish rapport with the community. Linkages with the community may also be forged by employing as many local residents as possible for the project. Finally, the investigators should share the research results with the minority community and discuss with them how the results may be used to improve the health status of the community (Johnson & Arfken; Lillie-Blanton & Hoffman).

When working with Aboriginal groups, researchers must demonstrate respect for traditional beliefs and practices and develop a team relationship with the community. The Royal Commission on Aboriginal Peoples ([RCAP] 1996) offers ethical research guidelines for the respectful treatment of Aboriginal cultures, languages, and values. In studies that are conducted primarily in Aboriginal communities, researchers should establish collaborative procedures to enable community representatives to participate in planning and implementing the research and in evaluating the results (RCAP). The *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 1998) contains a section on research with Aboriginal peoples as well as "good practices" for researchers working with Aboriginal communities.

Issues Related to Reliability and Validity of Instruments

Research instruments developed using White middle-class individuals may be inappropriate for use with vulnerable low-income women. An attempt should be made to obtain instruments that are reliable and valid for the group being studied (Demi & Warren, 1995). The instruments should reflect knowledge of the culture and norms of the population group, including sensitivity to age, social class, language, reading levels, and religious customs as well as race/ethnicity (Lillie-Blanton & Hoffman, 1995). If this is not possible, focus groups can be used to review instruments for relevance and comprehensibility; the instruments can then be revised and pilot tested. An effort should be made to obtain norms for the current population, and not to compare data from the sample under study to norms for middle-class samples (Demi & Warren). Educational level, literacy, and language abilities must be taken into account in selecting a data-collection method. Interviews may be more appropriate than self-completed questionnaires for collecting data from immigrant or low-income women.

Ethical Issues in Conducting Research with Vulnerable Women

Two primary ethical concerns are informed consent and the risk-benefit ratio. To protect vulnerable women from exploitation, the investigators must ensure that they are fully informed about the risks and potential benefits of the study (Demi & Warren, 1995). To provide truly informed consent, women need appropriate and comprehensible information about the nature and purpose of the research, possible costs and benefits, what is involved in terms of filling in questionnaires or providing personal information in interviews, whether invasive procedures will be performed, whether medical records will be accessed, and their right not to participate and to withdraw at any time (Cockburn et al., 1998). Unfortunately, many consent forms are too complex to be understood by vulnerable women even when they have been reviewed by a research ethics board. One strategy is to have consent forms and other information about the study reviewed by a group of relevant consumers, to ensure that the content is clear and appropriate (Cockburn et al.).

Confidentiality is an additional area of concern, especially when the topic is sensitive or stigmatizing. Data must be aggregated in reports to conceal the identity of participants (Demi & Warren, 1995).

Another ethical issue is that of recruitment for clinical trials. Most women are invited to participate in a trial by their physician. A woman may be reluctant to refuse because she is grateful to the physician or because she believes she might lose the physician's support and interest. She may also perceive a conflict between the physician's two roles: as her treatment provider and as a researcher conducting a trial. Possible strategies include: giving women time to decide whether to participate; providing written or audiovisual resources that clearly describe the trial and the concept of randomization; training physicians in appropriate communications skills; and providing telephone support with a nurse, after the initial consultation, so that the woman can ask questions about the trial (Cockburn et al., 1998).

Summary

This paper has summarized a variety of methodological and ethical issues in conducting research with vulnerable women, and has also proposed strategies for dealing with these issues. Because vulnerable women are at increased risk for health problems, it is imperative that nurses and other health-care professionals make strenuous efforts to include vulnerable women in health research.

References

Arean, P., & Gallagher-Thompson, D. (1996). Issues and recommendations for the recruitment and retention of older ethnic minority adults into clinical research. *Journal of Consulting and Clinical Psychology, 64,* 875–880.

Cockburn, J., Redman, S., & Kricker, A. (1998). Should women take part in clinical trials for breast cancer? Issues and some solutions. *Journal of Clinical Oncology, 16,* 354–362.

Demi, A., & Warren, N. (1995). Issues in conducting research with vulnerable families. *Western Journal of Nursing Research, 17,* 188–202.

Federal/Provincial/Territorial Working Group on Women's Health. (1990). *Working together for women's health: A framework for the development of policies and programs.* Ottawa: Health Canada.

Johnson, K., & Arfken, C. (1992). Individual recruitment strategies in minority-focused research. In D. Becker, C. Hill, J. Jackson, D. Levine, F. Stillman, & S. Weiss (Eds.), *Health behavior research in minority populations: Access, design, and implementation* (pp. 24–29). NIH #92-2965. Bethesda, MD: US Department of Health and Human Services.

Kelly, P., & Cordell, J. (1996). Recruitment of women into research studies: A nursing perspective. *Clinical Nurse Specialist, 10,* 25–28.

Larson, E. (1994). Exclusion of certain groups from clinical research. *Image: Journal of Nursing Scholarship, 26,* 185–190.

Lillie-Blanton, M., & Hoffman, S. (1995). Conducting an assessment of health needs and resources in a racial/ethnic minority community. *Health Sciences Research, 30,* 225–236.

Medical Research Council of Canada/Natural Sciences and Engineering Research Council of Canada/Social Sciences and Humanities Research Council of Canada. (1998). *Tri-Council policy statement: Ethical conduct for research involving humans.* Ottawa: Public Works and Government Services Canada.

Moore, M. (1997). Recruitment and retention: Nursing research among low-income pregnant women. *Applied Nursing Research, 10,* 152–158.

Prairie Women's Health Centre of Excellence. (1998). *1998–1999 research grants program guidelines.* Winnipeg: Author.

Royal Commission on Aboriginal Peoples. (1996). Ethical guidelines for research (Appendix E, Vol. 5). *Report of the Royal Commission on Aboriginal Peoples.* Ottawa: Minister of Supply and Services Canada.

Swanson, G., & Ward, A. (1995). Recruiting minorities into clinical trials: Toward a participant-friendly system. *Journal of the National Cancer Institute, 87,* 1747–1759.

Author's Note

Correspondence may be directed to Maureen Heaman, Faculty of Nursing, Helen Glass Centre for Nursing, The University of Manitoba, Winnipeg MB R3T 2N2 Canada. E-mail: <maureen_heaman@umanitoba.ca>.

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Sticks and Stones: Racism as Experienced by Adolescents in New Brunswick

**Cynthia Baker, Manju Varma,
and Connie Tanaka**

L'objectif de la recherche était de décrire la nature du racisme tel que vécu par des adolescents affirmant être victimes de ségrégation dans la province du Nouveau-Brunswick, au Canada, ainsi que leur réaction face aux incidents de racisme perçu. Une méthodologie qualitative fondée sur un paradigme constructiviste a été utilisée dans le cadre de cette étude. Des entrevues en profondeur ont été menées auprès d'adolescents non blancs qui ont été victimes de racisme et auprès des parents de ces victimes. Bien que la recherche ait été initiée en réponse à une campagne publicitaire intensive portant sur la violence raciale chez les adolescents, les résultats indiquent que les incidents de racisme sont un phénomène connu des participants. Ces derniers décrivent un problème insidieux mais aussi persistant auquel ils ont dû faire face lorsqu'ils ont commencé à fréquenter l'école publique. Les injures constituent la forme de racisme la plus répandue et font partie de la plupart des incidents décrits. Même si les symboles d'autorité les qualifient d'inoffensives, les injures semblent produire des effets à long terme sur les personnes ciblées. Selon les résultats, les réactions des participants face au racisme comportent trois phases : l'éclatement de l'univers, la résistance en spirale et le désengagement. Les résultats révèlent que les infirmières œuvrant en milieu scolaire doivent traiter des questions ayant trait au racisme avec les enfants et les adolescents.

The purpose of the study was to describe both the nature of racism as experienced by adolescent self-described victims in the province of New Brunswick and their response to the perceived racist incidents. A qualitative methodology based on the constructivist paradigm was used. In-depth interviews were conducted with non-White adolescent victims of racism and with parents of victims. Although the study was initiated in response to an eruption of publicity about teenage racial violence, the findings indicate that racist incidents were not a new phenomenon for the participants. They described a low-key but long-term problem that had begun when they entered the public school system. Name-calling was by far the most common form of racism identified and it played a part in most of the other incidents described; dismissed as harmless by authority figures, it appeared to have long-term consequences for its targets. The participants' response to racism was found to have three phases: splintered universe, spiralling resistance, and disengagement. The results suggest that nurses working in the field of school health should address issues of racism among children and adolescents.

Cynthia Baker, PhD, is director of nursing at the Université de Moncton, New Brunswick, Canada. Manju Varma, PhD, teaches at Mount Allison University, Sackville, New Brunswick. Connie Tanaka is co-ordinator of the New Brunswick Cross Cultural Health Council.

Over the last three decades, changes in Canada's immigration policy have transformed its ethnic composition. Although the proportion of the population not born in Canada has remained stable, the percentage from non-European countries has increased dramatically (Badet, 1993). The resulting increase in visible ethnic diversity has given racism greater public salience. There has also been a growing recognition among health-care professionals that racism is a determinant of health as well as a significant social issue. Stress related to racist incidents has been associated with a wide variety of physical and emotional health problems (Rollock & Gordon, 2000).

Of particular concern has been increased interethnic conflict among adolescents. Most investigations of this problem have been conducted in metropolitan centres with large immigrant communities. A number of reported incidents of racially motivated violence targeting non-White youths in the province of New Brunswick prompted a study of the problem in a different social context, since, unlike some areas of Canada, New Brunswick has a relatively homogeneous population (Badet, 1993). The purpose of this study was to describe the nature of racism from the perspective of adolescent victims living in areas of limited ethnic diversity, as well as their responses to racist incidents. It was undertaken as a first step in a larger project designed to promote sensitive institutional responses to the needs of young victims of racism. The specific questions examined were: *What is the nature of racism as experienced by self-described adolescent victims in the province of New Brunswick? How do self-described adolescent victims of racism respond to perceived racist incidents?*

Background

Definitions of racism focus on three central attributes: assignment to a racial group based on physical characteristics, associated inferiority or superiority of designated racial groups, and policies or behaviours that differentially affect the self-esteem and life chances of members of a racial group (Green, 1995; Rollock & Gordon, 2000). Scholars differ in the extent to which they believe racism should be studied individually or structurally (Rollock & Gordon). Institutional racism is differentiated from individual racism. The former exists when institutions grant fewer rights to a given racial/ethnic group or limit the opportunities of that group to exercise its rights (Green). The health effects of both individual and institutional racism have been documented. At the individual level, racism has been linked to general emotional well-being (Vrana & Rollock, 1996, 1998), psycholophysiology (Clark, Anderson, Clark, & Williams, 1999), and restrictions on lifestyle options (Rollock &

Gordon). Perceived institutional racism has been linked to mental health (Hendryx & Ahern, 1997).

Although nurses have investigated cross-cultural relationships, they have given racism little attention as a distinct phenomenon, tending instead to see it as part of cultural differences. The few nursing studies of the phenomenon that have been done have focused on racism among caregivers. Bonaparte's (1979) investigation of nurses' attitudes towards culturally different clients suggests that ego defensiveness and closed-mindedness play a part. Similarly, racism is among the problems identified in Béguin Stockli's 1997 study of problematic issues in the care of refugees and other asylum-seekers in Switzerland (cited in Shaha, 1998). Shaha explicitly set out to determine whether patients in a Swiss hospital encountered everyday racism. Her findings, however, are ambiguous. Green (1995) also focused directly on racism. She developed a scale to measure perceived racism among African-American women in the United States. Nursing studies support findings that racism impacts on the delivery of health care.

Racism and its effects have been studied in children. Racial prejudice has been found to be distressingly common among children (Bigler & Liben, 1993; Doyle & Aboud, 1995). Despite a popular conception that prejudice is learned as people become adults, it is reported that children as young as 5 years possess perceptual and attitudinal biases. White children in particular have been found to express prejudice towards Blacks and Natives (Corenblum & Annis, 1993). Studies of the effects of racism on young people have found it to be related to poor emotional health (Tatum, 1992), low academic achievement (Harrell, 2000), and lack of hope for the future (Murray & Clark, 1990).

As noted, most investigations of the impact of racism on adolescents have been conducted in metropolitan centres where victims are numerous enough to form large groups. Little is known about the experience of racism among non-White youths dispersed in small numbers throughout a region of limited ethnic diversity.

Methodology

The study used a qualitative methodology based on a constructivist research paradigm in which realities are considered to be "apprehendable in the form of multiple intangible mental constructions" (Guba & Lincoln, 1994, p. 10). The research process is inductive and is guided by a relativist ontology. Findings are constructed through the interactions of the investigator and participants (Appleton & King, 1997). Data collection involves both a hermeneutic and a dialectical approach (Lincoln & Guba, 2000). Hermeneutics is concerned with the interpretation of texts and is used to understand the way people experience their world and their place in it (Carpenter, 1999). Interviews with participants are transcribed into a "field text," which is read and reread as the investigators categorize it and seek patterns of meaningful connection (Carpenter). This involves a hermeneutic circle of interpretation, in which the investigators move back and forth between understanding the parts of the text in light of their global view of the phenomenon and understanding their global view in light of their interpretation of its parts (Allen & Jensen, 1990; Carpenter). Interpretations of the text are checked with participants and with counterparts until consensus is achieved (Lincoln & Guba, 1985, 2000).

Dialectic logic sees oppositions and contradictions as fruitful of new and better syntheses (Appleton & King, 1997). A dialectical process guides constructivist inquiry on several levels. Investigators seek divergent views or experiences through purposeful sampling and through flexible interview schedules. They also contrast divergent views or experiences when analyzing the data in order to achieve a better understanding of the phenomenon (Appleton & King; Guba & Lincoln, 1994).

Sampling

Interviews were conducted with a sample of 25 adolescent self-described victims of racism and 14 parents of perceived victims. Sampling was purposive. In order to ensure some geographical variation, the sample was selected from the four areas of the province with the most ethnic diversity: the cities of Moncton, Fredericton, and Saint John and the region of Richibucto/Miramichi. Board members of multicultural associations in each of the four areas as well as personnel of band offices (administrative units) of four First Nations reserves assisted investigators by recruiting participants. A number of participants also referred others. During the recruitment process, participants were given a form describing the study. Selection criteria were that the subject be between 15 and 19 years of age and believe he or she had been the target of racism. In addition, an effort was made to balance the ratio of male to female respondents and to achieve even distribution among the four geographic areas. Parents of perceived victims were interviewed in order to gather additional information on the adolescents' experiences of racism. They provided triangulation of data

(Atkinson & Hammersley, 1994) in that their observations and experiences echoed what the young people were articulating.

The adolescents were a mix of first-generation Canadians and youths from communities with long roots in the province. The former group included two participants whose parents had emigrated from Africa and two whose parents had emigrated from the West Indies. The latter were either members of one of New Brunswick's two First Nations communities, the Mi'kmaq and the Malaseet, or members of an indigenous community of Blacks. The Mi'kmaq and the Malaseet have inhabited the Atlantic region for more than two thousand years (Whitehead, 1991) and in New Brunswick number approximately 15,000 (New Brunswick Family Policy Secretariat, 1995). The Mi'kmaq participants were mostly from rural reserves in the Richibucto/Miramichi region, whereas the Malaseet participants were from the St. Mary's reserve in Fredericton. The indigenous people of colour in the province are descendants of British Empire Loyalists from New York State and are estimated to number 3,500.[1] They live mainly in Fredericton and Saint John. Natives and indigenous people of colour are the two largest visible-minority groups in the province. Eight adolescents identified themselves as members of the indigenous Black community and 13 as either Mi'kmaq or Malaseet.

Data Collection and Analysis

To enhance consistency, only one member of the research team conducted the interviews. The interviewer took care to establish rapport with the respondents in order to gather data of depth. The interview schedule consisted of 10 broad, open-ended questions. It was used flexibly to collect as much information as possible about racist incidents and the participants' response to them; for instance, one question asked adolescents to describe their first racist incident. Parents were asked the same 10 questions about their child's racist experiences. To ensure a dialectical process, the interviewer sought to clarify the respondents' statements and explored alternative constructions with them. Interviews were audiotaped and transcribed. A brief socio-demographic questionnaire was administered to obtain an overview of the sample (Table 1).

Following the inductive methodology of the constructivist paradigm, data analysis was begun during data collection. It involved Lincoln and Guba's (1985) steps of unitizing, categorizing, and pattern-

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[1] Estimates from PRUDE Inc. (Pride of Race, Unity, Dignity, Education), Saint John, NB.

Table 1 *Adolescent Participants*

	Age	Gender	Ethnic Background of Parents
Moncton	18	F	Indigenous Black (from Saint John)
	17	F	Indigenous Black (from Nova Scotia)
	19	M	Indigenous Black (from Nova Scotia)
	16	F	West Indian Black
	18	F	African Black (from Zaire)
Fredericton	15	F	Malaseet
	15	M	Malaseet
	20	F	Malaseet
	17	M	Malaseet
	17	F	Malaseet
	19	M	Indigenous Black
Saint John	19	M	Indigenous Black
	17	F	Indigenous Black
	19	F	American Black
	18	M	Indigenous Black
	19	M	Indigenous Black
	19	M	Jamaican Black
Richibucto/Miramichi	18	M	Mi'kmaq
	15	M	Mi'kmaq
	18	F	Mi'kmaq
	19	F	Mi'kmaq
	18	M	Mi'kmaq
	15	M	Mi'kmaq
	15	M	Mi'kmaq
	19	F	Mi'kmaq

seeking. In the first step, the transcribed interviews were broken down into units of data. In the second step, units were brought together into provisional categories. The constant comparative method of data analysis was used, whereby researchers constantly compare data sets to redefine units and to develop and refine categories (Lincoln & Guba, 1985). Thus, as new units of data were assigned to categories, they were continuously compared with previously identified units. Finally, patterns were sought as categories were reassembled into a construction of the experiences being examined. In doing this, the investigators moved back and forth between the categorized data and the original field text. Memo writing was used to describe emerging patterns in the data and to reflect on relationships among categories (Appleton & King, 1997; Lincoln & Guba, 1985).

To enhance the credibility of the study, those affected by the phenomenon under investigation were asked to contribute to its design and to the emerging analysis, in several ways. A panel of parents of self-described victims of racism initially guided investigators in developing the study questions and suggesting ways of recruiting participants. Emergent findings were discussed first with a focus group of adolescents and parents, later with individual respondents, and finally with the original panel of parents. An audit decision trail was kept to enhance dependability. Two investigators unitized and categorized data separately and then compared and contrasted analyses until consensus was achieved. Throughout this process, the emerging categories and constructions were discussed with the investigator who conducted the interviews.

Ethical Considerations

Participants signed a consent form that described the project and guaranteed confidentiality and anonymity. The study was approved by the Université de Moncton ethics committee before data collection was begun.

Findings

The inductive nature of the methodology quickly revealed that the primary concern of both adolescent and parent respondents was not the highly publicized episodes of racial violence that had prompted the study. Rather, it was the stress of dealing with a long-term but low-key racist environment. They framed racism as a life-long burden, not a recent phenomenon. One mother summed up this view succinctly: "People sometimes need bad actions like we had lately here in Moncton to see that something wrong is going on, because what just boiled over was not new; it has been going on for ages." Furthermore, racism was a cumulative experience for the adolescents, and their response to it was an evolving one. In presenting the findings, the nature of the racist incidents experienced by the adolescents will be described first, followed by the participants' evolving response to racism.

The Face of Racism

The nature of the racism experienced by the adolescents was strikingly similar regardless of their background or geographic location. Furthermore, the perceptions of parents mirrored the accounts of the adolescents. By far the most common problem identified was name-calling. Although the specific racial slurs varied, every adolescent interviewed had been exposed to a considerable amount of this type of verbal abuse. Name-calling also played a role in most of the other types of racist incidents described.

The second most frequent form of racism reported was either threat of or actual physical violence on the part of peers. This was both an individual and a collective phenomenon. In their early years at school, participants had been "shoved," "pushed," and "punched" by individual name-callers. As the participants grew older, these situations sometimes involved groups of young people or members of particular teen groups ("the hillbilly crowd," "the skinheads," "the skaters"). Several had received written threats, often accompanied by swastikas. For example, one girl received a note "with all kinds of Nazi symbols" and the message "niggers must die," and another discovered "Squaw you're next" written on her school locker.

Even though many participants singled out a particular teacher, principal, or policeman as having gone out of their way to support them, the third most frequently identified problem was unfair treatment by authority figures. All the youths described instances in which they believed they had been subjected to injustice because of racism. These instances typically involved the participant's having responded to name-calling by fighting back. For example, a Black youth in Saint John who had been charged following a fight with a skinhead over racial slurs said, "The cop looked at me straight in the face. I couldn't believe what he says: 'Does your father have a criminal background?' My father could have been a *priest*!"

As a result of such experiences, both the adolescents and the parents were convinced that non-White youths are constantly at risk of unfair treatment because of racial stereotyping. One mother said, "I tell my kids, you can be in a crowd of a hundred White people — if something happens they will come and single you out and nobody will stand up for you except those few minority kids who are your friends." This theme was revisited frequently during the interviews.

Since schooling holds a dominant position in the lives of youths, it is not surprising that school was the key arena for racist experiences.

Most participants vividly recalled their first brush with racism, and the majority of these incidents occurred at school, often in the very early years. A Mi'kmaq participant described his initial reaction to attending school off the reserve: "I didn't really prepare myself for that [racial taunting] — all those people who don't really like us in the White world."

As the children grew older, the arena for racist experiences extended to malls, streets, parks, restaurants, bars, and dances. Incidents in these areas, however, were sporadic and as a result often caught them completely off guard. One youth described an incident at a mall: "This guy approached me and said, 'Hey, nigger.' I turned around and I thought I was hearing things. 'Are you talking to me?' And he goes, 'I hate niggers…. Nigger, you're not listening to me. I kill niggers'." The cumulative effect of these intermittent experiences left respondents with the perception that racism can surface anywhere at any time in the community.

Evolving Response to Racism

The participants' response to racist incidents involved a synergistic and negative process that compounded the effects of racism on them. Two covert factors driving this process surfaced from the data. Both involved a significant dichotomy in understandings between participants and members of the mainstream society. Before outlining phases in participants' changing response to racism, we will describe this dichotomy. The first covert factor involved incompatible views of the meaning of racist name-calling, the second an historic versus episodic understanding of individual racist incidents.

Meaning of name-calling. Participants considered racial taunts to be both highly wounding and unequivocal evidence of racism. Racist names brought to the surface a sense that people were imposing on them an inalterable and discredited social identity because they were visibly different. For instance, a Moncton girl said she had been walking by a busy coffee shop when an old man came up to her and said, "Hey, you black bitch, do you want to fuck?" She said of the incident, "It really made me realize, like, Oh my God, I'm Black and people notice it." In contrast, authority figures consistently discounted the importance of racial slurs, seeing name-calling as something all children do and all children have to put up with. One young participant said he was told by a school principal, "Being called a nigger is no different from being called a geek or a nerd." For the youth, however, it was completely different. He explained why: "When I was a kid I wasn't aware of being

Black. I was just me. And when it really hit home was being called 'nigger'."

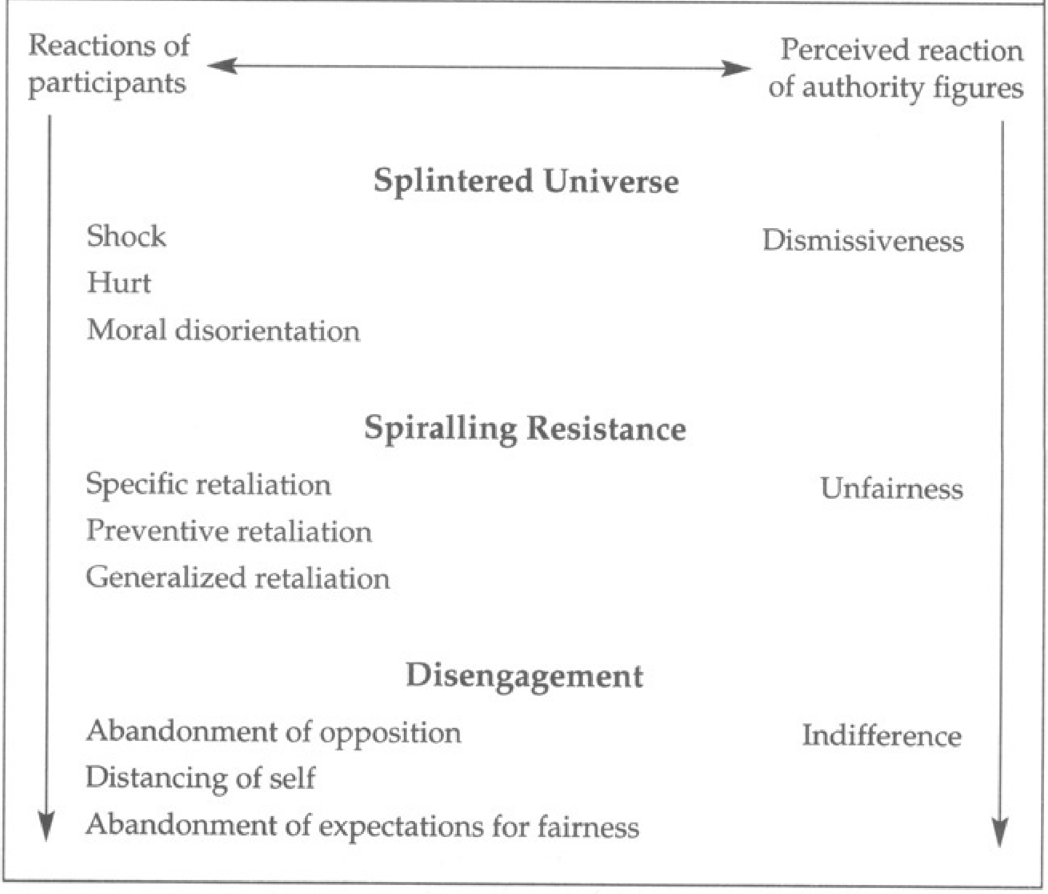
Historic versus episodic understandings. Participants' descriptions of specific racist incidents indicate that they perceived the episode through the lens of their personal, accumulated experiences of racism. Their reaction to each individual act of racism was part of a life-long battle against the imposition of a socially discredited identity. Their accounts emphasized the event that had triggered their reaction, which usually was derogatory, racist name-calling. Authority figures responded to the retaliatory behaviour rather than to the triggering event, and the participants usually ended up being punished as a result. For example, one youth reported that while he was boarding the school bus another boy called out, "Hey, black boy." He responded, "Don't call me that," and kept on walking, but the boy taunted him again, with "nigger," so our participant, as he put it, "started flipping out." The bus driver pulled over, put him off the bus, and reported to his parent that he had "started everything." The bus driver judged the youth's violent reaction as the problem. Our participant, however, felt he had been the victim: the name-calling was another cut in the life-long wound of racism, and he was fighting a collective force of experienced racism. In these situations, authority figures witnessed an individual reaction (episodic understanding of the incident), whereas our participants were responding to just one more instance of harassment (historic understanding of the incident).

From Splintered Universe to Disengagement

Three phases were identified in participants' evolving response to racism. We term the first phase "splintered universe," the second "spiralling resistance," and the third "disengagement" (Figure 1). On the one hand, the response process involved gradual changes in how they reacted to specific incidents; on the other hand, it incorporated changes in how they perceived the reaction of authority figures to racism.

Splintered universe. This occurred when participants first encountered negative racial comments from other children. As noted above, the encounters often occurred very early in their schooling, sometimes on their first day of school. Their initial reaction was one of shock. A Mi'kmaq participant explained: "I wasn't used to it — it wasn't done to me before." For many, an element of the shock was the discovery that they were visibly different from their peers. One participant said, "I'd never seen myself any different from anyone else before, and then all of a sudden I was." Their lack of awareness of being visibly different prior

Figure 1 *From Splintered Universe to Disengagement*



to these early name-calling incidents may be due to the limited ethnic diversity in the region.

Shock quickly gave way to hurt. Most of the youths and some of the parents had asked authority figures to intervene, but these people had a very different understanding of the meaning of name-calling. Teachers and principals downplayed or dismissed racist taunts with comments such as, "well, it's only names." One Black youth in Saint John said, "I was always told one way or another that I didn't feel the way I thought I felt and [that] I didn't hear that the way I thought I'd heard it." The result was moral disorientation. The message in the name-calling was that the visibly different person was irreversibly inferior, or as one participant put it, "a second-class citizen." And the message in the dismissive institutional response was that their distress was unimportant. In other words, the harm they were being done, which in their eyes was morally wrong, was being condoned by the authority figures in the moral social order. A mother spoke of having to go and retrieve her child from underneath a sink in the school bathroom: "His hands were wrapped around the pipes and he refused to come out. The kids had been calling him 'nigger'...when he tried to tell the teacher, she said, 'It's not an issue'."

As their world splintered, many of the participants wished they were White. For instance, a Mi'kmaq participant said she had thought at the time, "I bet you if I was White I'd have all the friends I need but I had no friends because I'm Indian." Similarly, a Black youth said, "I remember going home at night and praying to God that I would wake up in the morning and be White like other kids."

Spiralling resistance. Sooner or later most participants fell into a pattern of spiralling resistance, attacking first those who attacked them and then any potential threat. As racist incidents accumulated in their lives, they increasingly interpreted individual episodes from the perspective of their history of racist experiences. The first development in this phase was direct retaliation against anyone responsible for an act of racial harassment. For instance, a participant explained that when she was called names like "little squaw" and "wagon burner" she began to "punch them out...I learned after a while, you know, they're going to say something to me, I'm going to say something right back." Another said, "I just couldn't take it no more and I'd got a little bit bigger, so I just went after them."

The youths (and many of their parents as well) believed that this type of retaliation had been an effective strategy in the short run. One girl said, "I just stopped crying and started beating people up, and that's why it stopped." Another participant said, "I used to be called names.... I stood up to them, that's when they left me alone." Perhaps because fighting back appeared to be effective, many of our participants began to adopt a preventive form of retaliation, such as attempting to circumvent racist situations with verbal threats: "I told them, 'You call me names and what's going to happen is I'm going to explode and I'm going to fight.' I said, 'I'll kick all your asses' — and they smartened up!"

Finally, many advanced to a generalized form of retaliation whereby any hint of racism towards themselves or actual racism towards someone else provoked a violent reaction, because it was viewed in the context of their long-term experience. An incident described by a Moncton youth who had been suspended from school following a fight will serve to illustrate this. He had been reacting to a racist comment directed not at him but at another Black student: "She got her test back. It was...something on the test like 'niggers,' 'I hate niggers.' Of course, the teacher is not going to put that on the test! It was a skinhead in the class. He laughed about it, thought it was a big funny! So I approached him…so I got in a fight."

Authority figures, applying an episodic understanding of these incidents, punished the youths for retaliating. To the participants, applying an historic understanding of the experience, this was unfair. They felt they had been defending themselves against racist victimization and the instigators were not being reprimanded. One youth explained: "The teachers, they were always thinking that I had provoked it all. They used to say, 'Well, you must have done something for him to start going on like that,' and I would be the one in trouble. They wouldn't do anything to the kid who was calling me names." A young girl who had been sent for counselling because of her behaviour said of the counsellor, "She would say, 'So…what did you do to agitate the kid to call you that name?' How am I supposed to agitate a name like that?"

Disengagement. The third phase is one of less external disruption but may feature internal difficulties, as it involves loss of hope and connection with society. Overt acts of opposition are abandoned, as resistance seems more and more futile. Participants realized that although fighting back might help them win battles against racism, they were losing the war. One said, "I just learned no matter how many times I would get all raged up and hurt somebody would be calling me names again, so it wasn't working." Another commented that fighting "didn't…get me anywhere really, even though it got me to get them to stop calling the names."

Instead of retaliating, many of our participants began to distance themselves emotionally from racist attacks. One way they did this was by defining racism as reflecting negatively on the racist rather than on them. A Mi'kmaq youth said, for instance, "I think people that make fun of us it's because they're not educated and they don't know they're ignorant." Another way they distanced themselves was by developing a protective social wariness so as never to be caught off guard and therefore hurt by a racist remark. A young participant, surprised by a racial slur one evening outside a nightclub, said, "It made me understand that there's a lot of ignorant people out there and it might happen again and it might not happen again, but, you know, don't let your guard down completely." Another explained, "I've learned not to trust Whites."

During this last phase, our participants dropped their expectations for an equitable society, seeing low-key racism as interwoven throughout the community and a permanent feature of it. Many stated that they had come to realize that racism will never go away. Parents also believed this. A mother said, "When I was going to elementary school I got called names every day, so what I'm really trying to say is that we have never really been without racism…it's here, it's been here, and it always will be here." At this stage, therefore, there was no longer any expectation that authority figures would intervene fairly or effectively when racism surfaced. The participants understood institutional reactions to racist incidents as reflective of a fundamental social indifference to the issue. This attitude is illustrated by the comment of a mother who went to a member of the school board with a racist note her daughter had received at school: "He looked at it briefly, three seconds, and 'Oh that's terrible, Oh we'll deal with this.' So instead of dealing with this they were painting the walls [to remove racist graffiti]."

Discussion

Sticks and stones may break my bones but names will never hurt me. These words, often used to soothe hurt feelings, reflect the widespread belief that name-calling is essentially harmless. Because of our focus on the subjective experience of racism, we did not investigate the attitudes of people who downplayed racial taunts. The comments of the participants suggest that authority figures truly considered such behaviour to be innocuous. The analysis indicates that, on the contrary, their dismissal of name-calling represented a tacit endorsement of racism and was at the root of a long, cumulative process. When our young participants first encountered racist taunting they began to feel distinct from others, and when their complaints were downplayed they began to understand their reality as different from that of others. Hall, Stevens, and Meleis (1994) identify this differentiation from the mainstream as an integral component of marginalization. In many respects, the synergistic impact of racist incidents on the adolescents in the present study can be understood as a process of marginalization as conceptualized by these authors.

Margins are defined as the periphery-determining aspects of persons, social networks, communities, and environments. Marginalization is the process by which persons are peripheralized on the basis of identities, associations, experiences, and environments (Hall, Stevens, & Meleis, 1994). Contemporary scholarship treats race as a social construction and discusses racialized identities in terms of a "socially constructed otherness" (Ladson-Billings, 2000, p. 262). Our young participants' historic understanding of racist experiences caused them to vigorously resist the imposition by their peers of a socially constructed "otherness." This, in turn, merely compounded their peripheralization.

When authority figures intervened in their attempts to thwart racism, they saw a single, unconnected event. Although the punishment meted out might have fitted the actual behaviour, it was at odds with the reasons for the behaviour and therefore tended to heighten the sense of peripheralization. The youths experienced the powerlessness and silencing that Hall, Stevens, and Meleis identify as key components of marginalization. Parents fared no better in their attempts to stem the tide that was pushing the youths out from the mainstream. Most had complained to the school about racial taunts and threats, on behalf of their children, but felt that their concerns were put aside.

A recent study of sexual harassment in the lives of schoolgirls reported similar reactions on the part of authority figures. The girls' complaints were dismissed, and when they fought back they were the ones punished, not the perpetrators (Berman, McKenna, Traher Arnold, Taylor, & MacQuarrie, 2000). Sexism and racism among young people appear to have produced the same silencing of victims and to have received the same tacit endorsement by the social order. There are some important differences, however, in the experiences of the two groups of adolescents. Sexist and demeaning remarks were often tolerated by the girls in that study. The investigators report as well that the girls often discounted sexual harassment as just fun-making. In discussing the implications of their findings, they propose that nurses teach adolescent girls to recognize and name the everyday violence that they encounter. In marked contrast, the harassment faced by the youths in the present study was clearly named by the victims as racism, and it provoked a highly charged reaction from them. In fact, participants argued that it was members of the dominant group who failed to recognize and name the incidents as racism: "It's very easy for White people to say racism doesn't exist, because they've never experienced it."

Such comments reflect the broad perspective that many theorists on race have associated with marginalization and otherness (Ladson-Billings, 2000). In 1903 Cora Du Bois identified "the double consciousness" of Black Americans who understood the perspective of both those at the margin and those in the mainstream (Du Bois, 1953). Hall, Stevens, and Meleis (1994) link this perspectival advantage to the power inherent in marginalization, noting that those at the margins understand, by necessity, the way of thinking of those at the centre while the converse is seldom true.

Another difference between the adolescents in this study and those who participated in the study by Berman et al. (2000) is the reflectiveness characterizing the last stage of their response to racism. They came to see racism as an inevitable feature of their social landscape, and redirected their resistance from external opposition to internal psychic work to avoid internalizing a stigmatized identity. Hall, Stevens, and Meleis (1994) describe the reflectiveness of marginalized people as conscious introspection in order to understand and compensate for the inner conflict caused by their peripheralization.

Racism is not typically defined by nurses as falling within the domain of nursing practice. The discipline, however, places an emphasis on health promotion and illness prevention. Racism is an unsolicited and unwarranted form of violence (Dobbins & Skillings, 2000) that threatens physical, psychological, social, functional, and spiritual well-being (Harrell, 2000). A recent review of racism-related stress concluded that "the evidence is compelling and growing that racism is pathogenic with respect to a variety of physical and mental health outcomes" (Harrell, p. 48). Certainly, the marginalization experienced by our young participants as a result of low-grade racism had health consequences for them. All three phases of their response to racist incidents involved distress, but emotional anguish was especially evident during the first phase, when they began to encounter name-calling. The subsequent phase of spiralling resistance affected their functional well-being, since their response to racism during this period tended to impact on their school performance; some avoided going to school, some were frequently sent out of class, and several were suspended for extended periods. During the disengagement phase, their inability to trust those in the dominant group had implications for their social well-being.

Chopoorian's seminal work in re-conceptualizing the environment as a focus for nursing interventions (Chopoorian, 1986) is relevant in considering the nursing implications of these findings. This view of environment incorporates social, economic, and political relationships that impact on health and well-being. Nurses are challenged to direct their interventions at changing the status quo and attempting to resolve social problems. Although findings of qualitative studies are inherently provisional and incomplete, data from the present study suggest that two aspects of the social environment may well have affected the well-being of the participants: the authorities' dismissal of racist name-calling and their episodic as opposed to historic understanding of conflicts between White and non-White youths. Previous research on racism provides further support for nursing interventions concerning such incidents. Researchers have found that the subjective experience of racism is commonly disbelieved or doubted by members of mainstream society (Essed, 1991; Harrell, 2000), that generally the victim's perception of racism is accurate (Taylor, Wright, & Porter, 1994), and, finally, that others' resistance to validating the reality of a racist incident increases the stress experienced by the victim and thus the potential damage (Essed; Harrell).

As members of the school health team, public health nurses can play a key role in influencing attitudes and policy development related to racism in schools, a central element in the social environment of young people. Participants in this study proposed a range of solutions to the dichotomy of understandings of racist incidents in the school environment. We believe their suggestions provide a strategic place for nursing interventions to begin. First and foremost, the participants argued, members of the dominant group must acknowledge the racism inherent in name-calling. As one youth said, the first step is "to admit there is racism there." They argued as well for public condemnation of racial taunting and expressed the view that the school should take a formal stand by developing and implementing written policies specifying the consequences of such behaviour. Finally, they expressed the view that authority figures should always assess and take into account the triggering role of racist taunts and prior racist experiences when intervening in conflicts between White and non-White youths.

References

Allen, M., & Jensen, L. (1990). Hermeneutic inquiry: Meaning and scope. *Western Journal of Nursing Research, 12*(2), 241–253.

Appleton, J., & King, L. (1997). Constructivism: A naturalistic methodology for nursing inquiry. *Advances in Nursing Science, 20*(2), 13–22.

Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N. Denzin & S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 248–261). Thousand Oaks, CA: Sage.

Badet, J. (1993). Canada's immigrants: Recent trends. *Canadian Social Trends, 29,* 8–11.

Berman, H., McKenna, K., Traher Arnold, C., Taylor, G., & MacQuarrie, B. (2000). Sexual harassment: Everyday violence in the lives of girls and women. *Advances in Nursing Science, 22*(4), 32–46.

Bigler, R., & Liben, L. (1993). A cognitive-developmental approach to racial stereotyping and reconstructive memory in Euro-American children. *Child Development, 64,* 1507–1519.

Bonaparte, B. (1979). Ego-defensiveness, open-closed mindedness and nurses' attitudes toward culturally different patients. *Nursing Research, 28,* 166–172.

Carpenter, D. (1999). Phenomenology as method. In H. Streubert & D.Carpenter (Eds.), *Qualitative research in nursing* (pp. 43–62). Philadelphia: Lippincott.

Chopoorian, T. (1986). Reconceptualizing the environment. In P. Moccia (Ed.), *New approaches to theory development*. New York: National League for Nursing.

Clark, R., Anderson, N., Clark, V., & Williams, D. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*, 806–816.

Corenblum, B., & Annis, R. (1993). Development of racial identity in minority and majority children: An effect discrepancy model. *Canadian Journal of Behavioural Science, 25*, 499–521.

Dobbins, J., & Skillings, J. (2000). Racism as a clinical syndrome. *American Journal of Orthopsychiatry, 70*(1), 14–27.

Doyle, A., & Aboud, F. (1995). A longitudinal study of White children's racial prejudice as a social cognitive development. *Merrill-Palmer Quarterly, 41*, 210–229.

Du Bois, W. (1953). The souls of Black folk. New York: Fawcett (original work published in 1903).

Essed, P. (1991). *Understanding everyday racism: An interdisciplinary theory.* Newbury Park, CA: Sage.

Green, N. (1995). Development of the Perceptions of Racism scale. *Image, 27*(2), 141–146.

Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). London: Sage.

Hall, J., Stevens, P., & Meleis, A. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *Advances in Nursing Science, 16*(4), 23–41.

Harrell, S. (2000). A conceptualization of racism-related stress. *American Journal of Orthopsychiatry, 79*(1), 42–57.

Hendryx, M., & Ahern, M. (1997). Mental health functioning and community problems. *Journal of Community Psychology, 25*, 147–157.

Ladson-Billings, G. (2000). Racialized discourses and ethnic epistemologies. *Handbook of qualitative research, 2nd Ed.* (pp. 257–277). London: Sage.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry.* London: Sage.

Lincoln, Y., & Guba, E. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research, 2nd Ed.* (pp. 163–188). London: Sage.

Murray, C., & Clark, R. (1990). Targets of racism. *American School Board Journal, 177*(6), 22–25.

New Brunswick Family Policy Secretariat. (1995). *Foundations for the future: A proposed framework for family policy in New Brunswick*. Fredericton: Government of New Brunswick.

Rollock, D., & Gordon, E. (2000). Racism and mental health. *Journal of Orthopsychiatry, 70*(1), 5–13.

Shaha, M. (1998). Racism and its implications in ethical-moral reasoning on nursing practices: A tentative approach to a largely unexplored topic. *Nursing Ethics, 5*(2), 139–146.

Tatum, B. (1992). Talking about race; learning about racism: The application of racial identity development theory in the classroom. *Harvard Educational Review, 62*(1), 1–24.

Taylor, D., Wright, S., & Porter, L. (1994). Dimensions of perceived discrimination: The personal/group discrimination discrepancy. In M. Zanna & J. Olson (Eds.), *The psychology of prejudice: The Ontario Symposium* (Vol. 7, pp. 233–255). Hillsdale, NJ: Erlbaum.

Vrana, S., & Rollock, D. (1996). The social context of emotion: Effects of ethnicity and authority/peer status on the emotional response of African American college students. *Personality and Social Psychology Bulletin, 22,* 297–306.

Vrana, S., & Rollock, D. (1998). Physiological responses to a minimal social encounter: Effects of gender, ethnicity and social context. *Psychophysiology, 33,* 462–469.

Whitehead, R. (1991). *The old man told us.* Halifax: Nimbus.

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Comments or queries may be directed to Cynthia Baker, École de science infirmière, Université de Moncton, Moncton NB E1A 3E9 Canada. Telephone: 506-858-4255. E-mail: <bakerc@umoncton.ca>.

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Knowledge in Nursing: Contemplating Life Experience

Constance I. Will

Le vécu des infirmières génère une perception subjective face à un événement, laquelle est ancrée dans les croyances, les valeurs, les traditions, l'appartenance religieuse et culturelle et les autres aspects contextuels de la vie. Dans le but de mieux comprendre les connaissances relatives à la pratique infirmière, nous devons donc mettre en lumière la connaissance provenant du vécu et examiner comment le contexte entourant la vie des infirmières ainsi que la pratique établissent les limites de son expression. Peu d'auteurs ont fait explicitement référence à la vie des infirmières à l'extérieur du milieu clinique ou tenté de comprendre leur vécu façonnant leurs connaissances de la pratique. Cet article décrit la connaissance basée sur le vécu et sa nature et explique pourquoi il est nécessaire d'en tenir compte pour mieux comprendre les connaissances qui se rattachent à la profession.

Nurses' life experiences result in a subjective way of knowing an event, a way of knowing that is embedded in beliefs, values, traditions, religious and cultural observances, and other contextual layers of life. Thus, in order to more fully understand nursing knowledge, we must illuminate knowledge that comes from life experience and examine how the context of nurses' lives, and practice, delimits its expression. Few authors have made explicit reference to nurses' lives outside clinical practice, or have sought to understand how life experiences contribute to the way in which they know nursing. This article describes life-informed knowledge, what it is and why it needs to be considered to further our understanding of nursing knowledge.

> *In 1975, right after graduation, I went to work on what was then called a terminal care unit. I remember very clearly my first experience of a patient's death. However, the part of the experience I want to share is the aftermath of that death. A new orderly and I were assigned to post-mortem care. In the man's bedside table I found a bus pass with his picture on it, a picture of him before cancer and surgery had made him almost unrecognizable. I showed it to the orderly and started to cry, overwhelmed by what this man had endured. He was alone at the end of his life, with two strangers putting his things in bags. I was a very new nurse at the time, with only a few months of clinical experience. This was, in fact, my first experience of death since the death of my grandfather when I was 13. He too died alone.*

Nurses engage with other human beings at profoundly intimate times, providing care and support in circumstances they may have experienced themselves. Such experiences produce a unique and subjective

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Constance I. Will, RN, EdD, is Assistant Professor, School of Health Studies, Brandon University, Brandon, Manitoba, Canada.

way of knowing a particular event, a way of knowing that is embedded in beliefs, values, traditions, religious and cultural observances, and other contextual layers of life. Chinn (1992) challenges us to reveal knowledge arising in our "non-clinical" lives, to integrate "into our legitimate realm of inquiry that which we know from our own experience" (p. 7). I take Chinn's words very seriously. I seek to understand how my own and others' non-clinical life experiences inform our nursing knowledge. The story I share with you is part of that effort. What I realize, in writing about that first "professional" experience of death, is that my nursing program included no courses on death or palliation. I do not remember a discussion, in 4 years of nursing education, about the end of life. My knowledge of dying did not, therefore, come from my nursing education or clinical experience. My only experience of death was my grandfather's, 6 years before I entered nursing.

Knowledge Development in Nursing

My position in this discussion of nursing knowledge is grounded in three assumptions. First, nurses are reluctant to explicitly claim knowledge acquired in life. Dunlop (1986) suggests our lack of attention to nurses' lives can be attributed in part to contradictory messages in nursing education: "Nursing sought to teach me to maintain both separation and linkage in my practice — separation, 'you must remember that the other is a stranger' and linkage, 'you must think and act as if he were not'" (p. 663). The pursuit of separateness is sadly revealed in the words of a nurse caring for a patient with the same diagnosis as her mother: "Because my own mother had [breast cancer]...personal feelings can get into it. You have to really ignore that, leave your feelings at home" (Will & Fast Braun, 1997, p. 12). According to Pinar (1981), "our life histories are not liabilities to be exorcised, but are the very precondition for knowing" (p. 184), but this nurse appears to view her personal experience as the former, a liability better left at home.

The second assumption in which my position is grounded is that the reluctance to embrace life-informed knowledge originates in a positivist bias that recognizes only knowledge that results from empirically tested theories. This view is shared by Newman (1992). She states that, despite a 30-year shift away from the scientific medical model towards a more holistic model, "we seem to be hedging. Are we afraid to give up the certainty in knowing that the positivist view offers?" (p. 13).

The third assumption is that this positivist bias is in part a consequence of nursing's quest for professional status. There is substantial evidence in the nursing literature of a history of such status-seeking.

Turkoski's (1992) 80-year review of the *American Journal of Nursing*, published by the American Nurses' Association, is particularly revealing. "Professionalism is referred to as 'rank', 'an elevated position', a symbol of 'social status' that is normally and naturally higher than that accorded to 'mere trades', 'commerce', or 'manual labour'" (p. 155). Further, Turkoski's review identifies two primary assumptions that still hold today: professions are superior in status to non-professions, and recognition as a profession is desirable for nursing (p. 154). On the basis of these assumptions, nursing has spent the better part of half a century attempting to achieve professional status.

In this quest for professional status, nursing has accepted the premises of a trait-based model of professionalism (Carter, 1994; Larson, 1977; O'Neill, 1992; Rafferty, 1996; Witz, 1992). One of these premises is that occupations to which society ascribes professional status feature essential traits, and when other occupations adopt these traits they will necessarily achieve professional status (Witz). As medicine has achieved virtually unparalleled success as a profession (Larson; Witz), it is medicine's unique traits that nursing has actively sought to adopt. Consistent with the medical model, the development of nursing knowledge has been grounded in the empirico-deductive or positivist paradigm, emphasizing reductionism and empirical validation (Kidd & Morrison, 1988; O'Brien & Pearson, 1993). Many nurses, however, reject these assumptions of positivism, perhaps believing that when human experiences are reduced to theory "the subject has become the object, the person has become the statistic, the creative has become constrained, the human being has become the abstraction" (Plummer, 1983, p. 77).

In the late 1970s, nurses examining knowledge embedded in clinical practice (Benner, 1984; Benner & Tanner, 1987), intuitive knowing (Agan, 1987), aesthetic, personal, and ethical knowing (Carper, 1978), and nursing epistemology in general (Kidd & Morrison, 1988; Schultz & Meleis, 1988) began to challenge the positivist status quo and to call for the inclusion of multiple sources of knowledge in nursing. "There are different ways of knowing, different unknowns to be known, different propensities of knowers for knowing and different aspects to be known about the same phenomenon" (Schultz & Meleis, p. 220).

Interest in multiple ways of knowing in nursing has surged. Clinical knowledge, particularly, has been extensively examined, but inquiry into other ways of knowing has primarily been theoretical, and life-informed knowledge is apparently being taken for granted. It is acknowledged not in the form of direct reference to nurses' non-clinical life histories, but in references to experiences that cannot possibly be limited to clinical practice. Reed (1996), for example, states that "building knowledge entails observation of human processes...and observation of human patterns" (p. 30), and Benner and Tanner (1987) suggest that nurses come to recognize subtle trends in patients' experiences by incorporating into their expert practice in-depth knowledge of the human world. Silva, Sorrell, and Sorrell (1995) state that lived experiences are "profoundly felt...but often inexplicable, and to those who have never experienced it, unknowable" (p. 10). These authors are clearly referring to knowledge acquired outside the domain of clinical practice and understand knowledge to be life-informed, as does Drew (1997), in seeking to illuminate the meaning of experiences that nurses identify as significant in their clinical practice. While Drew's focus is meaningful caregiving experiences, she acknowledges that "the experiences which [nurses] found meaningful reflected what they considered important in their non-professional lives" (p. 417). What is important, however, has only been alluded to, particularly by Benner (1984), Benner and Tanner, and Carper (1978), in her seminal discussion of personal knowing. Life-informed knowledge has yet to be fully developed in relation to nursing knowledge.

Contemplating Life Experience

Each and every encounter with another human being provides nurses an opportunity to reflect on our own experience of an event or to imagine it happening to ourselves or a family member. In this process we draw not only on our clinical experiences, but also on our myriad life experiences. As Moch (1990) says, "nursing contexts are replete with encounters in which...knowledge can be gained through imagining or *experiencing* events such as surgery, the death of a loved one, or even being a hospital patient" (p. 157; italics added). Nurses have even used their homes as experimental ground, "where emotional management can be tried out, sometimes unconsciously, before confronting a similar situation at work" (Staden, 1998, p. 151).

Meleis (1987) champions the consideration of life experiences. She argues that an examination of nursing knowledge must consider nurses' experiences, perceptions, and personal meanings, *and* the contexts in which they are understood. "Personal meanings are understood in the nursing situation within the context of societal and cultural meanings. Meanings attributed to multiple realities create the context for understanding of responses" (p. 13). Despite Meleis's contention, few authors explicitly contemplate the ways in which nurses' non-clinical life experiences inform nursing knowledge.

Life-Informed Knowledge

I am aware that many nurses may intellectually reject the notion that life-informed knowledge is integral to nursing knowledge. Kikuchi's (1992) argument for the adoption of philosophical inquiry in nursing is a case in point. Having differentiated scientific and philosophical questions, Kikuchi turns to the matter of what kinds of questions constitute philosophical questions. Of particular importance to a discussion of life-informed knowledge are epistemological questions. Kikuchi argues that exploration of questions of this nature has failed to make an important distinction — that between "the knowledge nurses use in order to nurse" and "the knowledge that comprises the body of nursing knowledge" (p. 33). She suggests that the latter is part of the former. Her words concede that the knowledge nurses use to nurse is broader than an evident, recognizable "body" of knowledge. This belief is echoed in Chinn and Kramer's (1999) claim that "as nurses practice, they know more than they can communicate symbolically or justify as knowledge" (p. 2).

Kikuchi (1992) goes on to suggest that it is only the body of nursing knowledge that members of the profession are responsible for developing. She dismisses what she calls preclinical knowledge as taken on assumption and outside the discipline. And she dismisses personal knowledge as subjective, incommunicable, and *publicly unverifiable*. Here she parts company with Chinn and Kramer (1999), who do believe that much of what nurses are unable to communicate has the potential to be formally expressed. Kikuchi's articulate argument against knowledge gained outside the discipline is a powerful barrier to explicit articulation of life-informed knowledge. It is also a paradox.

Kikuchi (1992) argues that because a nurse's ontological and epistemological perspectives are private, subjective, and exclusively her possession, they cannot be shared, and therefore educators are not responsible for them. This is the paradox. Members of the nursing profession are responsible for its body of knowledge, but not for the knowledge used by its practitioners to nurse. Philosophical inquiry, exploring ontological and epistemological questions, is fundamental to creating and understanding the nature of that body of knowledge. Yet inquiry that explores the very nature, scope, and object of any nurse's nursing knowledge, her own ontological and epistemological perspectives, is not perceived as nursing's responsibility.

Life-informed knowledge is precisely what Kikuchi (1992) argues against. It is knowledge that is intensely personal, private, and subjective, an implicit form of knowledge by Mayeroff's (1971) definition, because it cannot be easily articulated. It is each nurse's way of being in the world, and the manner in which that way of being finds expression in her practice. Life-informed knowledge does not suggest pride or arrogance. It is not one nurse's resolute insistence that her way of knowing is the "right" way. It is knowledge acquired during a lifetime of non-clinical as well as clinical experience, a well-established personal ontology. We cannot disregard it, and it is naive to suggest that we can. As Mayeroff states, "restricting the meaning of knowledge in this way [to that which can be verbalized] is as arbitrary as assuming that only words can be communicated and restricting the meaning of communication to what can be put into words" (p. 10).

It is, admittedly, difficult to reveal life-informed knowledge. But it is not impossible. Every nurse's clinical practice illustrates her way of being with people. "Human reality is understood as conversation and action, where knowledge becomes the ability to perform effective actions" (Kvale, 1999, p. 101). Reflection on relationships, and examination of actions, can, therefore, illuminate our understanding of nursing knowledge. Reflection can be undertaken individually and introspectively, in diaries or journals, or collaboratively, as in the context of a research relationship. I describe elsewhere (Will, 2001) how the life-history research method can be used to reveal life-informed knowledge, through one nurse's interpretation of another nurse's personal, introspective, and contextual story.

Life-Informed Knowledge and Nursing Knowledge

Current conceptualizations of nursing knowledge, while providing a wealth of information on its character and scope, do not explicitly recognize and affirm life-informed knowledge. This failure perpetuates a spurious distinction between nurses' personal and professional lives. It widens the chasm between knowledge that is verifiable and communicable and the knowledge that nurses use to nurse. It sustains a division between an academic elite and thousands of bedside nurses who are not encouraged or supported to "behold themselves as experts" (Maeve, 1994, p. 14). Its implicit acceptance, and its explicit absence from our discourse, serves to prevent fuller understanding of what it means to know and of how knowledge is expressed.

I suggest that nursing knowledge has multiple sources, including life experiences outside the clinical realm, artfully blended together to create a mindful whole. The key word is mindful. A focus on empirical knowing alone could, for example, result in a preoccupation with cure and technological intervention. By the same token, a focus on life-informed knowledge alone could result in a nurse believing that her experience, in and of itself, provides nursing knowledge and competence. Each, without consideration of the other, could be perceived as an incontestable form of knowledge.

Rubin's (1996) study of impediments to the development of clinical knowledge reveals the notion of "patterns gone wild" (Chinn & Kramer, 1999), the dilemma created when ways of knowing exist in isolation from one another. In Rubin's study, a nurse who is a recovering alcoholic leaves her assigned responsibilities to care for a patient admitted for treatment of alcoholism. The nurse sees nothing wrong in this, perhaps believing that her life experiences enable her to contribute something unique and important to the patient's care. Rubin interprets her actions as indicating a lack of clinical knowledge. My perspective is somewhat different. I see the nurse's life experience as informing her nursing knowledge in a manner that she views as acceptable and others view as lacking. I also see, in this instance, evidence of "patterns gone wild," wherein the nurse acts on life-informed knowledge in a manner that is not responsible or particularly mindful. It is interesting to speculate on how different the example might be had the nurse been enabled to reflect on her experience of alcoholism. Had she understood the particular way in which her life experiences informed her nursing knowledge, she might have used that knowledge differently in her nursing practice.

Conclusion

The women and men who seek to become nurses, and those who are nursing and/or pursuing post-basic education, have vast reservoirs of unarticulated knowledge acquired in life experience that informs how they know nursing, and therefore how they practise their art. It is no longer acceptable to assume that who they are can be held at arm's length, where it will have no impact on their nursing care. Life-informed knowledge, by its very nature, demands that we attend to it, not once, but on an ongoing basis over the course of our nursing careers. I propose that every nurse commit to lifelong reflection and analysis in response to the overarching question "Who am I as a nurse?"

Nursing knowledge is extraordinarily complex. In our effort to explicate just how complex, members of the profession have invested time and energy into articulating the "core" of nursing. In doing so, we have focused on process, on the act of caring. We have failed to consider that it is what we know that is the core of nursing, and we have failed to reveal all aspects of our knowledge, in all of its richness and depth.

The "core" of nursing is nurses, who we are and what we bring to each and every encounter with other human beings. I recently encountered Walker (1994), who suggests that the concept of caring resists representation because it "resides in the flesh and sinews of nurses" (p. 53). The idea that the essence of nursing resides in our flesh and sinews is a captivating one. It suggests that we must attend in a more mindful way to understanding nurses and their lives, and to exploring, in nursing education, practice, and research, how knowledge acquired in life experience contributes to nursing knowledge.

References

Agan, R.D. (1987). Intuitive knowing as a dimension of nursing. *Advances in Nursing Science, 10*(1), 63–70.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley.

Benner, P., & Tanner, C.A. (1987). How expert nurses use intuition. *American Journal of Nursing, 87*(1), 23–31.

Carper, B.A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1,* 13–23.

Carter, H. (1994). Confronting patriarchal attitudes in the fight for professional recognition. *Journal of Advanced Nursing, 19*(2), 367–372.

Chinn, P.L. (1992). What does a nurse need to know? *Nursing Outlook, 40*(1), 7.

Chinn, P.L., & Kramer, M.K. (1999). *Theory and nursing: Integrated knowledge development.* St. Louis: Mosby.

Drew, N. (1997). Expanding self-awareness through exploration of meaningful experience. *Journal of Holistic Nursing, 15*(4), 406–424.

Dunlop, M.J. (1986). Is a science of caring possible? *Journal of Advanced Nursing, 11*(6), 661–670.

Kidd, P., & Morrison, E. (1988). The progression of knowledge in nursing: A search for meaning. *Image: Journal of Nursing Scholarship, 20*(4), 222–224.

Kikuchi, J.F. (1992). Nursing questions that science cannot answer. In J.F. Kikuchi & H. Simmons (Eds.), *Philosophic inquiry in nursing* (pp. 26–37). Thousand Oaks, CA: Sage.

Kvale, S. (1999). The psychoanalytical interview as qualitative research. *Qualitative Inquiry, 5*(1), 87–113.

Larson, M.S. (1977). *The rise of professionalism: A sociological analysis.* Berkeley: University of California Press.

Maeve, M.K. (1994). The carrier bag theory of nursing practice. *Advances in Nursing Science, 16*(4), 9–22.

Mayeroff, M. (1971). *On caring.* New York: Harper & Row.

Meleis, A.I. (1987). ReVisions in knowledge development: A passion for substance. *Scholarly Inquiry for Nursing Practice, 1*(1), 5–17.

Moch, S.D. (1990). Personal knowing: Evolving research and practice. *Scholarly Inquiry for Nursing Practice, 4*(2), 155–165.

Newman, M. (1992). Prevailing paradigms in nursing. *Nursing Outlook, 40*(1), 10–13, 32.

O'Brien, B., & Pearson, A. (1993). Unwritten knowledge in nursing: Consider the spoken as well as the written word. *Scholarly Inquiry for Nursing Practice, 7*(2), 111–124.

O'Neill, S. (1992). The drive for professionalism in nursing: A reflection of classism and racism. In J.L. Thompson, D.G. Allen, & L. Rodrigues-Fisher (Eds.), *Critique, resistance and action: Working papers in the politics of nursing* (pp. 137–147). New York: National League for Nursing Press.

Pinar, W.F. (1981). "Whole, bright, deep with understanding": Issues in qualitative research and autobiographical method. *Journal of Curriculum Studies, 13*(3), 173–188.

Plummer, K. (1983). *Documents of life: An introduction to the problems and literature of a humanistic method.* London: George Allen & Unwin.

Rafferty, A.M. (1996). *The politics of nursing knowledge.* New York: Routledge.

Reed, P.G. (1996). Transforming practice knowledge into nursing knowledge — a revisionist analysis of Peplau. *Image: Journal of Nursing Scholarship, 28*(1), 29–33.

Rubin, J. (1996). Impediments to the development of clinical knowledge and ethical judgement in critical care nursing. In P. Benner, C.A. Tanner, & C.A. Chesla (Eds.), *Expertise in nursing practice: Caring, clinical judgement and ethics* (pp. 170–192). New York: Springer.

Schultz, P.R., & Meleis, A.I. (1988). Nursing epistemology: Traditions, insights, questions. *Image: Journal of Nursing Scholarship, 20*(4), 217–221.

Silva, M., Sorrell, J., & Sorrell, C.D. (1995). From Carper's patterns of knowing to ways of being: An ontological philosophical shift in nursing. *Advances in Nursing Science, 18*(1), 1–13.

Staden, H. (1998). Alertness to the needs of others: A study of the emotional labour of caring. *Journal of Advanced Nursing, 27*(1), 147–156.

Turkoski, B.B. (1992). A critical analysis of professionalism in nursing. In J.L. Thompson, D.G. Allen, & L. Rodrigues-Fisher (Eds.), *Critique, resistance and action: Working papers in the politics of nursing* (pp. 149–165). New York: National League for Nursing Press.

Walker, K. (1994). Confronting "reality": Nursing, science and the micro-politics of representation. *Nursing Inquiry, 1*(1), 46–56.

Will, R. (2001). Lessons from nurses' lives. In A.L. Cole & J.G. Knowles (Eds.), *Researching lives in context: Methods, issues, and examples in life history research.* Walnut Creek, CA: AltaMira.

Will, R., & Fast Braun, V. (1997). [Nurses' professional values]. Unpublished raw data.

Witz, A. (1992). *Professions and patriarchy.* London: Routledge.

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Comments or inquiries may be directed to: Constance (Renée) Will, School of Health Studies, Brandon University, 270–18th Street, Brandon MN R7A 5Y1 Canada. Telephone: 204-727-7440. Fax: 204-726-5793. E-mail: <will@brandonu.ca>.

Ethics, Values, & Decision-Making

September 2002 (vol. 34, no. 2)

This issue of *CJNR* will focus on ethics, values, and decision-making in health and health care. Despite the rise in concern about the ethical and value dimensions of health and health care, these dimensions have received only moderate attention in the nursing literature. In particular, the significance of ethics and values in health-care decision-making has been scarcely examined. We are calling for philosophical, theoretical, and empirical research papers in these areas. *CJNR* seeks manuscripts that examine current philosophical or theoretical problems, or report empirical research, in ethics, values, and/or decision-making in health and health care. Manuscripts that effectively assert innovative implications for research, education, or clinical care are particularly requested.

Guest Editor: Dr. Frank Carnevale
Submission Deadline: January 15, 2002

Addiction & Dependence

December 2002 (vol. 34, no. 3)

In nursing and in other disciplines, addiction, dependence, and addictive behaviours and their health consequences are of growing social concern. This issue will focus on all aspects of these phenomena as they intersect with nursing practice in all health-care settings. We are interested in addiction in all its forms (e.g., tobacco, drugs, alcohol), any behaviour that results in a physiological dependency (e.g., eating disorders), the effects on individual and family well-being across the lifespan, physical and mental health outcomes, and prevention and intervention. We are also interested in individual, parental/family, and social/environmental factors that place individuals at risk or that lessen the risk of these phenomena. We are particularly interested in the testing of interventions and the factors that contribute to an intervention's success. We plan to mainly publish research reports but will consider papers on theory development and testing. We welcome investigations that use either qualitative or quantitative data or a combination of the two.

Guest Editor: Dr. Pamela Ratner
Submission Deadline: April 15, 2002

Please send manuscripts to:
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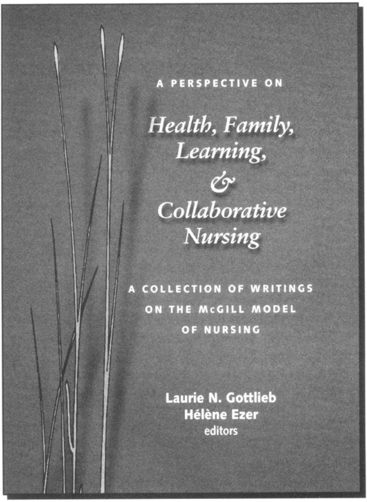

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Résumé : Un résumé d'environ 100 à 150 mots chacun doit précéder le texte. Ce résumé devrait comprendre l'objectif, la méthode, les résultats et les retombées de la recherche. Les manuscrits qui concernent la théorie et les analyses critiques doivent inclure une identification des objectifs principaux, le cadre conceptuel utilisé pour l'analyse des données et un résumé de la discussion.

Texte : La longueur totale d'un manuscrit, incluant les tableaux, les figures et les références, ne doit pas dépasser 20 pages, dactylographiées à double interligne. Les articles doivent être rédigés en anglais.

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