

**FROM BARNYARDS TO BEDSIDES TO BOOKS AND BEYOND:
THE EVOLUTION AND PROFESSIONALIZATION OF
REGISTERED PSYCHIATRIC NURSING IN MANITOBA, 1955-1980**

Beverley Clare Hicks

A Dissertation

Submitted to the Faculty of Graduate Studies

in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

Faculty of Education

University of Manitoba

Winnipeg, Manitoba

May 2008

© Beverley C. Hicks

ABSTRACT

FROM BARNYARDS TO BEDSIDES TO BOOKS AND BEYOND:
THE EVOLUTION AND PROFESSIONALIZATION OF REGISTERED
PSYCHIATRIC NURSING IN MANITOBA, 1955-1980

In the 1950s, psychiatric nursing in Canada was developing into two models. East of Manitoba, psychiatric nursing was a part of general nursing. To the west of Manitoba, it was evolving into a distinct profession. Manitoba, during the 1950s, did not fit either the eastern or western model. But in 1960, it achieved the same distinct professional status, through legislation, as its neighbours to the west.

This study is an examination of the factors that swayed Manitoba to adopt the western psychiatric nursing model and achieve the legislation which governed its first twenty years. The factors are: male collegiality with the leaders of the other three western psychiatric nurses associations, the support of the western based Canadian Council of Psychiatric Nurses, the encouragement of medical superintendents of the provincial mental hospitals in the formation of an alternative workforce, and the lack of interest by general nurses in working in the provincial mental institutions.

The legislation achieved in 1960 gave some authority to the Psychiatric Nurses Association of Manitoba to govern its own affairs, but it was not entirely effective in bestowing full professional status on psychiatric nurses. This was especially true of the control over education which was placed in the hands of a committee, dominated by medical superintendents.

This study also examines the evolution of the profession during its first twenty years as it worked to gain control over education, develop a professional ideology, and establish a place for itself in the Manitoba mental health system. This study concludes in 1980 with the passage of full professional legislation.

A genealogical analysis was used to examine data which came from archives, oral interviews, and secondary sources. The findings suggest that registered psychiatric nursing in Manitoba is a contingent and political construction, but that it can continue to evolve and grow in unique ways through an ongoing examination of its roots, icons, practices, and philosophy.

ACKNOWLEDGEMENTS

This journey would never have been completed without the support and direction of many people. They are too numerous to mention individually and it is always difficult to leave someone out. But there are some who have invested large amounts of their professional lives who must be acknowledged.

Obviously, the chair of my committee deserves the greatest appreciation. To Dr. Denis Hlynka I owe a debt that cannot be expressed in words. His patience was endless, but his intellectual challenges and penetrating questions left no room for complacency. I will continue to be challenged by his teaching: Thank you Denis for endless hours of discussion and consultation.

The other committee members were equally, though differently, influential in the completion of this work. Dr. Yatta Kanu was always attentive to curriculum perspectives and never allowed the curriculum to be lost in the myriad of other details. Yatta it was a privilege to have you on this committee.

Dr. David Gregory ensured I stayed on track and did not stray too far down too many blind-alleys. His thoughtful comments and observations have helped to keep me focused. Thank you David.

Dr. David Creamer always reminded me of the humanistic approach, so necessary for dealing with people in distress, and encouraged me to find a way to include humanism and spirituality in psychiatric nursing education. Thank you for your guidance and blessings David.

Historical research cannot be accomplished without patient and diligent librarians and archivists. I want to thank Barb Devlin for helping me access documents at the Provincial Archives of Manitoba. There were also many helpful people at the Provincial Archives and the Legislative Library. In particular, Idelle Talbot who helped unravel the mysteries of the Brandon Mental Hospital collection and patiently answered endless questions about archival research. Thank you to Monica Ball who found obscure documents in the Legislative Library. At Brandon University Tom Mitchell was always available to ensure access to the Brandon Mental Hospital School of Nursing records. The library staff at Brandon University, especially in government documents, were generous with their time and energy. Dr. Linda Ross, who was Dean of Health Studies at Brandon University when this project started, accommodated and supported this scholarly undertaking in numerous ways. Also thanks to other colleagues from Brandon University.

Each of the four western Canadian psychiatric nurses associations took great interest in this project and I had generous assistance from each provincial executive director and office staff. The Manitoba College of Registered Psychiatric Nurses office staff and executive director, Annette Osted were, of course, particularly helpful.

Many individuals have also been generous such as early presidents of the Registered Psychiatric Nurses Association and family members of those deceased. There were many people who participated in interviews and conversations and shared their documents. Friendly colleagues in the Manitoba Association for the History of

Nursing have provided support and intellectual stimulation, especially those who have already been down this path or are traveling it simultaneously on their own history projects.

To the external examiner Dr. Michel Tarko, I thank you for agreeing to undertake the review of my thesis and providing thoughtful feedback.

One last person who must be thanked is Joyce Smith. She did endless editing and kept documents and papers organized. Finally, thanks to my family and to Luke who was born during the last stages of this project.

Thank you to the Registered Psychiatric Nurses of Manitoba Foundation, the Manitoba Association for the History of Nursing and the Canadian Association of the History of Nursing for financial support.

DEDICATION

This thesis is dedicated to all the men and women who worked to achieve
distinct professional status for psychiatric nurses in Manitoba.

TABLE OF CONTENTS

Abstract	ii
Acknowledgements	iv
Dedication	vi
Table of Contents	vii
Abbreviations	xiii
Pivotal Events	xvi
Chapter One: Positioning the Study	1
Introduction	1
A Note on Names	1
Introduction to Psychiatric Nursing	3
Manitoba Background	4
The Early Psychiatric Nursing Schools in Manitoba	7
Rationale for the Study	12
Research Approach	16
Writing History	16
Writing Nursing History	19
Writing Psychiatric Nursing History	25
Conceptual Framework of the Study	26
Data Sources	29
Records	29

Oral Data	31
Significance of the Study	33
Outline of the Chapters	34
Endnotes	37
Chapter Two: From Barnyards . . .	44
Introduction	44
Asylum Studies	45
British and American Asylum Studies	49
Eastern Canadian Asylum Studies	58
Western Canadian Asylum Studies	64
International Psychiatric Nursing Studies	69
A Study of Psychiatric Nursing in the United States	72
A Study of Psychiatric Nursing in Great Britain	76
A Study of Psychiatric Nursing in Holland	78
A Study of Psychiatric Nursing in New Zealand	80
Canadian Psychiatric Nursing Studies	82
Veryl Tipliski's Study	82
Saskatchewan Psychiatric Nursing Studies	92
Manitoba Psychiatric Nursing Studies	95
Conclusion	97
Endnotes	98
Chapter Three: . . . To Bedside . . .	108
Introduction	108

Socio-political Status of Psychiatric Nursing 1955-1960	109
The Culture and Therapeutic Strategies of the Mental Institutions	114
Portage	114
Selkirk and Brandon	121
Nursing Procedures	129
The Knowledge and Values Underpinning the Training	134
Milieu	135
Content and the Licensed Practical Nurses Curriculum	136
Teachers and Learners	140
The Male Attendants in Manitoba Institutions	142
The Canadian Council of Psychiatric Nurses	147
Manitoba Legislation	151
Conclusion	156
Endnotes	158
Chapter Four: . . . To Books . . .	173
Introduction	173
The First Two Presidents (1960-1966)	174
The Barnett Years (1960-1965)	174
The Psychiatric Nurses Association Act	176
The Psychiatric Nurses Training Act	178
Professionalism in Nursing	193
The End of the First Five Years	196

The Russell Year (April 1965-June 1966)	199
The Elusive Curriculum and Curriculum Makers	204
Psychiatric Nursing Knowledge 1960s	209
The Martyniw Years (1966-1971)	211
The Minister's Report on the Supply of Nurses 1967	213
The Emerging Curriculum and Curriculum Makers	233
Curriculum Concepts in the 1960s	236
A New Curriculum Sub-committee	237
A Licensing Crisis	238
The End of the First Decade	245
Conclusion	247
Endnotes	248
Chapter Five: . . . More Books . . .	265
Introduction	265
The Holleman Years (1971-1979)	266
The Clarkson Report	267
The Move to the Community	272
Philosophy and Objectives of Psychiatric Nursing Education	278
A Substantial Curriculum	284
Proposals and Counter Proposals	288
The Breen Report	290
Challenge and Change	294
The Task Force	295

A Bigger and Better Curriculum	306
Tom Street The Final Year: Are We Ready?	312
Conclusion	319
Endnotes	320
Chapter Six: . . . And Beyond . . .	333
Introduction	333
The Framework	335
The Questions of the Study and Synthesis of Findings	336
Post 1980 Developments	349
Directions for Future Research	353
Endnotes	355
Appendix A Ethics Approval University of Manitoba	359
Appendix B Provincial Archives of Manitoba Agreement	360
Appendix C Consent Letter and Consent Form	371
Appendix D Interview Guide	375
Appendix E Curriculum: Three and Half Year Combined Course 1952-1957	377
Appendix F Curriculum: Male Attendants 1958-1961	379
Appendix G Curriculum: Psychiatric Nursing 1961-1963	380
Appendix H Curriculum: Psychiatric Nursing 1968	381
Appendix I Suggested Topics for Community Course	382
Appendix J Recommendations PNAC Education Committee	384
Appendix K Curriculum Model and Explanation 1979	387
Appendix L Standards of Practice	390

Appendix M	Code of Ethics	395
Appendix N	Psychiatric Nurses Pledge	396
Appendix O	Psychiatric Nurses Poem	397
Bibliography		398

ABBREVIATIONS

ANA	American Nursing Association
APA	American Psychiatric Association
APNA	Alberta Psychiatric Nurses Association
AWA	Asylum Workers Association
BGH	Brandon General Hospital
BGS	Bachelor of General Studies
BHMD	Brandon Hospital for Mental Diseases
BMH	Brandon Mental Hospital
BMHC	Brandon Mental Health Centre
BScN	Bachelor of Science in Nursing
BScMH	Bachelor of Science in Mental Health
BScPN	Bachelor of Science in Psychiatric Nursing
BSW	Bachelor of Social Work
BU	Brandon University
CCF	Co-operative Commonwealth Federation
CCPN	Canadian Council of Psychiatric Nursing
CHEU	Canadian Hospital Employees Union
CNA	Canadian Nurses Association
CNCMH	Canadian National Committee for Mental Hygiene
CRNM	College of Registered Nurses of Manitoba
CRPNM	College of Registered Psychiatric Nurses of Manitoba

GNAO	Graduate Nurses Association of Ontario
LPN	Licensed Practical Nurse
LPNA	Licensed Practical Nurses Association
MARN	Manitoba Association of Registered Nurses
MGEA	Manitoba Government Employees Association
MCSA	Manitoba Civil Service Association
NAWU	National Asylum Workers Union
NDP	New Democratic Party
NEPS	Nursing Education Programme of Saskatchewan
PAM	Provincial Archives of Manitoba
PNAC	Psychiatric Nurses Association of Canada
PNAM	Psychiatric Nurses Association of Manitoba
PSB	Psychiatric Services Branch Saskatchewan
RN	Registered Nurse
RNAO	Registered Nurses Association of Ontario
RPN	Registered Psychiatric Nurse
RPNAM	Registered Psychiatric Nurses Association of Manitoba
RPNABC	Registered Psychiatric Nurses Association of British Columbia
RPNAS	Registered Psychiatric Nurses Association of Saskatchewan
SHMD	Selkirk Hospital for Mental Diseases
SMH	Selkirk Mental Hospital
SMHC	Selkirk Mental Health Centre
SNAO	Senior Nursing Administrative Officer

SRNA	Saskatchewan Registered Nurses Association
TPH	Toronto Psychiatric Hospital
U of W	University of Winnipeg
WGH	Winnipeg General Hospital

PIVOTAL EVENTS

- 1946-1950 Selkirk Mental Hospital and the Manitoba School for Retardates at Portage commence combined LPN/mental nurse training programmes.
- 1948-1950 The provinces of Saskatchewan, Alberta, and British Columbia each have psychiatric nurses associations. In Manitoba, The Licensed Practical Nurses Advisory Council of Manitoba forms a good relationship with the nursing instructors from the three provincial institutions. They assist in establishing a coherent format for the psychiatric nursing curriculum, although the superintendents still basically control the education of the nurses and attendants in the mental institution.
- 1951 First meeting of the three western associations of psychiatric nurses who formed the Canadian Council of Psychiatric Nursing (CCPN) is held in British Columbia. Dave Gibson Jr. and Alf Barnet from Manitoba attend as observers.
- 1952-1957 Brandon Mental Hospital is conducting a unique combined RN and mental nurse training programme in cooperation with the Brandon General Hospital.
- 1956 British Columbia tries to establish a programme similar to the one already in Brandon.
- 1952-1957 CCPN encourages Manitoba to form an association similar to the ones in the other three western provinces.

- 1957 Gladys Fitzpatrick comes to Brandon as Director of Nursing from North Battleford, Saskatchewan. The combined RN/mental nurse training programme is discontinued at Brandon and replaced by a combined LPN/mental nurse programme. The male attendants are receiving a three year training programme.
- 1957 Max Schreder and Duke Leflar, two CCPN executive members from Weyburn, visit Manitoba.
- 1958 Art Russell in Brandon holds an organizing meeting. Selkirk and Portage are encouraged to do the same.
- 1959 All three Manitoba provincial institutions have psychiatric nurses organizations. The superintendents have legislation drafted.
- 1960 Legislation is passed forming the Psychiatric Nurses Association of Manitoba (PNAM). A second act, The Psychiatric Nurses Training Act gives control of psychiatric nursing education to a committee of nursing administrators and medical superintendents; the Advisory Committee.
- 1960-1965 Alf Barnett is first president of PNAM. During this time a three year training programme approved by the Advisory Committee is conducted at each institution. The curriculum is a one page list of courses. Approximately 600 hours of instruction.
- 1965-1966 Art Russell is president.
- 1966-1971 John Martyniw is president. During this time the educational processes and the Advisory Committee are challenged.

- 1966 The Minister of Health, Witney commissions a report. *The Ministers Committee on the Supply of Nurses*. The Manitoba Association of Registered Nurses (MARN) recommends discontinuation of separate psychiatric nurses training.
- 1967 A summer of crisis. Both the PNAM and the Advisory Committee consider what to do about psychiatric nursing education.
- 1968 A curriculum sub-committee is established to consider curricular issues. The training programme is changed to two years and the LPN portion is dropped. Curriculum content is reorganized. Student rotations to clinical areas are based on learning needs not service. Approximately 900 hours of instruction.
- An amendment to the act allowed the use of the term *registered* with the title psychiatric nurse
- 1969 The Advisory Committee interferes with the responsibility of the PNAM to control membership. Students begin taking some course at university.
- 1971-1979 Jack Holleman is president. Talks are conducted among Brandon University, Brandon General Hospital and Brandon Mental Hospital regarding university nursing education in Brandon.
- 1972 The Psychiatric Nurses Association of Canada (PNAC) which was formerly the CCPN begins the process of developing a philosophy and objectives for psychiatric nursing education. Manitoba follows this lead.

- 1973 *Clarkson Report* published.
- 1974 The first curriculum developed by psychiatric nursing educators in Manitoba is published. It is based on a philosophy and objectives. Over 1100 hours of instruction.
- 1976 The RPNAM commissions the *Breen Report*.
- 1976 The MARN publishes *Challenge and Change*. Minister of Health, Desjardin establishes a task force under Justice Joseph O'Sullivan to study all nursing education in the province. The RPNAM is represented by John Kellie. The RPNAM hires its first Executive Director, Annette Osted.
- 1977 *Task Force Report* published. Psychiatric nursing continuance is assured for the present. National Standards of Practice are established by a committee of PNAC.
- 1978 Work proceeds on a curriculum based on the Standards of Practice.
- 1979 A more comprehensive curriculum developed. Utilizes a model.
- 1979-1983 Tom Street is president.
- 1980 The government wants all nursing legislation reviewed. Comprehensive review conducted and the Registered Psychiatric Nurses Association of Manitoba receives new legislation which gives them control over psychiatric nursing education. A building is purchased by the Registered Psychiatric Nurses Association of Manitoba.

CHAPTER 1

POSITIONING THE STUDY

Introduction

This study is an examination of the evolution and professionalization of registered psychiatric nursing in Manitoba, Canada, from 1955 to 1980. In Manitoba, registered psychiatric nursing is a distinct profession with its own legislation, standards of practice, and code of ethics. The evolution of the profession, as well as the strategies to educate and professionalize psychiatric nursing in Manitoba, are the foci of this study.

The title of this study, *From Barnyards to Bedside to Books and Beyond: The Evolution and Professionalization of Registered Psychiatric Nursing in Manitoba, 1955 -1980*, reflects the fact that the art and science of attending to the mentally disordered has evolved from custodial care in farming asylums, to medicalized bedside nursing, to complex interpersonal care requiring a substantial knowledge base. The title also suggests that psychiatric nursing can continue to evolve in new and unexplored directions.

A Note on Names

The terms used to describe mental illness, the places in which the mentally ill have been cared for or contained, and the titles of those who have cared for or controlled them have changed over time. These changes ostensibly reflect more enlightened attitudes towards the mentally ill although there is little to support the fact that name changes made much difference to the situation of the mentally ill. In

Manitoba, the first institution especially constructed to house the mentally ill in 1886 was called the *Selkirk Insane Asylum*.¹ The first facility established for the mentally challenged in 1890 in Portage La Prairie was called the *Portage Home for Incurables*. The institution built in Brandon in 1891 was called the *Brandon Insane Asylum*.² A fire destroyed the Brandon asylum in 1910 and a new state-of-the-art asylum replaced it in 1912. Superintendent, Dr. J. J. McFadden, took the opportunity to showcase not only the new building, but also a new approach to mental illness. This new approach was part of a movement to medicalize insanity and was reflected in a name change. The Brandon Insane Asylum became the *Brandon Hospital for the Insane*.³ Those who were deemed insane, however, received no new title at that time.

The next institutional name change was also the result of a crisis. A scathing report on the condition of the Manitoba insane hospitals at Selkirk and Brandon was submitted in 1919 to the Manitoba government. The Liberal government of the day, headed by T. C. Norris, was spurred into making numerous changes to the care of the mentally ill, one of which was another name change for the institutions. The Brandon and Selkirk insane hospitals became known as Hospitals for Mental Diseases, BHMD and SHMD respectively, although they were most commonly known as BMH and SMH. It is remarkable that the institutions became places for diseases, rather than people with the diseases. The inmates were to be called *patients* from then on.⁴ These institutional names lasted for fifty three years, until 1972, when the both the SMH and BMH were changed to mental health centres, that is, Selkirk Mental Health Centre (SMHC) and the Brandon Mental Health Centre (BMHC). Brandon retained this name until its closure in 1997.⁵

The name changes of the buildings are better recorded than the name changes of the staff. At one time the individuals who managed the insane in the asylums were called *keepers*, a title that obviously reflects the attitude of the time towards those with mental illness.⁶ In Brandon it seems the title *attendant* was more commonly applied to the male staff and *nurse* to the female staff. The term *nurse* is ambiguous in the mental health field. The female staff were called nurses, not because of their credentials, but because of their gender. The term *nurse* also served another purpose. It implied a medical model of mental illness, a movement which flourished in the 1920s and continued to govern views of mental illness.

The use of the title nurse became contentious in the professionalization of the mental hospital attendants. The term was supposedly reserved for those who were registered by a general nursing licensing body.⁷ Name changes for the insane, the institutions, and the attendants were sometimes subtle and not always well recorded. The terms commonly in use in a particular era will be adhered to in this study.

Introduction to Psychiatric Nursing

In Canada, contemporary care of patients with mental illness is provided by two categories of nurses. East of Manitoba, registered general nurses (RN), who may or may not have specialized training, provide psychiatric nursing care. They are often assisted by psychiatric aides. In the western provinces, psychiatric nursing care is provided by a distinct profession, registered psychiatric nurses (RPN). In Manitoba, psychiatric nursing became a legal entity on March 26, 1960 when *An Act Respecting The Psychiatric Nurses Association of Manitoba* (PNAM) was proclaimed. However, for forty years prior to this legislation, *asylum attending* and *mental nursing* had been

practiced in some form or another in the three provincial institutions. Training programmes had been run at the asylums in Selkirk and Brandon since 1920 and 1921 respectively, and at the Home for Incurables in Portage La Prairie since 1936.⁸ The programmes at Selkirk and Brandon were the first psychiatric nursing training programmes west of the Great Lakes. However, Manitoba was the last of the four western provinces to achieve legal status for psychiatric nurses. An association of psychiatric nurses had been formed in British Columbia in 1947 although it had no regulatory function.⁹ The first legislation governing psychiatric nursing occurred in the Province of Saskatchewan in 1948. Alberta and British Columbia psychiatric nurses received legal status in 1950.¹⁰

Manitoba Background

When the Province of Manitoba was incorporated in May 1870, it assumed responsibility for care of the apparently mentally ill who were wandering the western Canadian prairies. Later, the most intractable cases were housed at the penitentiary at Lower Fort Garry and following that at Stony Mountain Penitentiary. Manitoba soon followed the North American trend of creating specialized institutions for the feebleminded and insane. Three large institutions were built in Manitoba in a five year period. A lunatic asylum was built at Selkirk in 1886, a home for incurables at Portage La Prairie in 1890, and in 1891 a second provincial asylum was established in Brandon. This second asylum had been built a year earlier as a reformatory for delinquent boys. However, it seems that delinquency was not a problem in Brandon in 1890. During its one year of operation only one small boy, Billy Mulligan, was housed there.

This ridiculous situation of a huge building, a staff of six, and a budget of \$30,000 to care for the sole inmate resulted in the political decision to turn the building into a second asylum for the insane. A physician, Dr Gordon Bell, was hired and he retained Mrs. Campbell (the reformatory matron), and her husband who had been Billy's guard, as the Matron and Chief Attendant of the new asylum. It seems that the qualities necessary for guarding delinquent boys were equally well suited to caring for the insane.¹¹

During the thirty years following the establishment of the three provincial institutions, the primary purpose was to keep the insane and feeble-minded contained. Custodial care and control were implemented by well-meaning medical men assisted by a variety of keepers or attendants. There seems to have been no particular qualifications or education for the keepers or attendants during this time and about equal numbers of men and women were employed. By the early 1900s, knowledge of the functioning of the nervous system and speculation on the functioning of the mind was progressing; and medical, social, and political consciousness stimulated greater concern for the conditions of the asylums and the inmates.

The First World War had a major impact on interest in mental illness with the identification of *shell shock*. Previously, insanity had been viewed as some sort of inherent weakness or degeneracy, but here were the finest and bravest young soldiers crumbling like infants. This stimulated an even greater interest in those suffering from mental illness and also resulted in closer scrutiny of the institutions in which these shell-shocked young soldiers were housed. Both Manitoba asylums fell short of the military expectations. It is reported by Christopher Dooley, "The military had

insisted that all Dominion War Veterans be housed at the Selkirk facility instead of at Brandon.”¹² However, Veryl Tipliski reports that the asylum at Selkirk was also considered inadequate by the federal government’s Department of Militia.¹³ The poor reports of the Canadian military were not the only indictments at the time.

The Canadian National Committee for Mental Hygiene (CNCMH), which had been formed in 1918 in Toronto to promote *mental hygiene*, also became the watchdog of the asylum system in Canada. Its prestigious leaders were Dr. Charles (C.K.) Clarke and Dr. Clarence Hincks of the Toronto Psychiatric Hospital (TPH).¹⁴ In 1918, the Public Welfare Commission of Manitoba invited Clarke and Hincks to study the provincial asylums. The Toronto doctors were critical of mental health care in Canada generally, but the Manitoba asylums were singled out for their particularly poor conditions. The report is labeled as scathing by Kurt Refvik, but as a success by David MacLennan. Refvik reported that Clarke and Hincks found “The conditions in Manitoba’s two mental institutions were appalling and they recommended sweeping reforms.”¹⁵ MacLennan, on the other hand, viewed the report a success as it clearly placed the responsibility for the conditions in the asylums on the political masters, rather than the hapless asylum managers. Whichever way the report is viewed, it forced an embarrassed Norris Government into action. The report also singled out for particular comment the lack of *trained nurses*.

These events: increasing knowledge and research into the human nervous system and mind, the casualties of the First World War, public opinion, a report which highlighted abuse and moral decay in the asylums, and the lack of trained

nurses, not only ushered in a new era of psychiatry in Manitoba, they also laid the foundation for the initiation of psychiatric nursing in the province.

The first step taken by the government was the appointment of a provincial psychiatrist in 1919. The first physician to hold this post, Dr. Alvin Mathers, had little experience in psychiatry, but he spent time at the Boston Psychopathic and Bloomingdale hospitals to gain the most up-to-date knowledge.¹⁶ One of Mather's first tasks was the appointment of new superintendents to the two hospitals for mental diseases, Dr. Edgar Barnes to Selkirk, and Dr. Charles Baragar to Brandon. Although there had always been medical superintendents employed at the Selkirk and Brandon asylums, their role was administrative rather than clinical.¹⁷ But these new superintendents had vision and ambition. They saw the care of the insane becoming a medical specialty, and the role of the superintendent as a clinician rather than a custodial manager. This new vision was to turn the asylums into hospitals, inmates into patients, and keepers into nurses. Having *trained nurses* was vital to the vision. Over the next forty years, various models of mental nurse training, gender issues, and political decisions permeated the history of psychiatric nursing in Manitoba.

The Early Psychiatric Nursing Schools in Manitoba

Between 1920 and 1960, the three institutions in Manitoba which cared for the mentally ill or intellectually handicapped ran training schools for psychiatric nurses. The training programmes instituted at the Selkirk and Brandon hospitals for mental diseases were initially only for female pupils. The training programme which was started in 1936 at the *Portage Home for Incurables* represented another facet of psychiatric nursing. The institution at Portage La Prairie cared mainly for mentally

handicapped, chronically ill, and debilitated people rather than the mentally ill.¹⁸ The inclusion of this group of patients, and their attendants, in the practice of psychiatric nursing is not uncontested.

The nurses' training programmes of the 1920s, at Selkirk and Brandon, were organized by the medical superintendents and were designed, ostensibly, to improve the care provided to the inmates. No doubt they also improved the image of the institutions as well as the superintendents. The programme in each institution operated independently of the other without any consistent standards and, as often as not, the educational needs of the students were subverted to service needs in the institutions. The students were expected to attend classes on their own time and there was no recognition for this training outside the particular institution.

Short local chronologies have been written about the Selkirk and Portage training schools which are useful for identifying changes in the training practices, although they offer little in the way of explanation for the changes. An important event at both Selkirk and Portage was the introduction of the newly formed Licensed Practical Nursing (LPN) programme in 1946 and 1950 respectively.¹⁹ The BMH School of Nursing has been the subject of more substantial studies, two of which will be examined in greater detail to reveal critical insights into psychiatric nursing in Manitoba. Two other works, those of Cornelia Johnson and Kurt Refvik, refer to the school of nursing within the overall context of the mental hospital, a theme common to most psychiatric nursing studies.²⁰

The two major studies on psychiatric nursing in Manitoba are those of Christopher Dooley and Veryl Tipliski.²¹ Both scholars used sources related to the

training school at BMH. Tipliski addressed the unique Canadian situation of the evolution of two different categories of psychiatric nurse in Canada. The focus of Tipliski's work was on the struggle for control of psychiatric nursing education between the medical psychiatrists and organized general nursing. She examined in detail the historical, philosophical, and political underpinnings of this dual system of psychiatric nursing in three Canadian provinces, Ontario, Manitoba, and Saskatchewan, from 1909 to 1955. Ontario, to the east, maintained the general nursing model with psychiatric nursing being a specialty of general nursing. Saskatchewan, to the west, followed the distinct profession model. Tipliski concluded that Manitoba in the 1950s could have tilted to the east or to the west.²²

Dooley, utilizing a labour history approach and the analytical general nursing framework of Kathryn McPherson,²³ explored the development of an intellectual and occupational identity of the female mental nurses of BMH from 1919 to 1946. This period encompasses one of the first training programmes for nurses in asylums west of the Great Lakes in 1921, until after the inauguration of a joint programme with the Winnipeg General Hospital (WGH) in 1942.

The *combined program* (sic) as the latter was called, provided the opportunity for nurses training at the BMH to affiliate at the WGH in order to gain the experience, knowledge, and skills necessary to write the licencing exams to become RNs. Following the termination of this agreement with the WGH in 1951, the programme continued in conjunction with the Brandon General Hospital (BGH) for a further six years. This programme, which was similar to those in some parts of Ontario and the United States, was identified by Tipliski as incorporating the best of both kinds of

nursing. Such a programme had been a dream of Baragar, who had initiated training for nurses in 1921 at Brandon. The rise and fall of this *combined program*, which ended in 1957, is identified by both Dooley and Tipliski as a critical event in the history of psychiatric nursing in Manitoba.

Dooley concluded that the female nurses who participated in the *combined program* carved out for themselves an intellectual and occupational identity based on their unique ability to handle difficult behaviour, and this identity was a critical factor in the evolution of the separate profession in Manitoba:

They (the nurses) combined the ideology of general nursing with that of mental nursing . . . [A]lthough further research is required, preliminary evidence . . . suggests this dual affiliation played a role in the adherence in Western Canada to the system of freestanding training schools.²⁴

Tipliski also identified the termination of the *combined program* as critical to the emergence of the separate profession in Manitoba. She argued that the failure of the Manitoba Association of Registered Nurses (MARN), the regulatory body of general nursing in the province, to come to an agreement with the provincial psychiatrists of Manitoba regarding affiliation for general nurses in mental hospitals, altered the political climate and created the opportunity for the legal recognition of psychiatric nursing:

Undoubtedly the MARN's refusal to become involved in psychiatric affiliations had some bearing on the government's decision to initiate the province-wide mental hospital training program a few months later.²⁵

In fact, the mental hospital superintendents had already decided to discontinue the *combined RN programme* and replace it with the LPN programme.²⁶

Dooley and Tipliski argue from different perspectives. Dooley argued that the distinct intellectual and occupational identity which the *mental nurses* of the 1930s and 1940s forged for themselves influenced the development of the separate profession, whereas Tipliski argues from a power and political perspective. Her contention is that lack of leadership in the MARN resulted in the opportunity for the emergence of the separate profession.

Dooley and Tipliski have greatly furthered the understanding of the factors which impacted *mental nursing* in Manitoba up to the 1950s. However, both authors focused on female nurses and chose not to take into account the large number of male attendants, and their role in the formation of psychiatric nursing. Nor did they challenge the general nursing framework, although Dooley hints at a unique epistemological basis for psychiatric nursing. Dooley's work concluded in 1946, just before the *combined program* in Brandon shifted from WGH to BGH. Tipliski's study ended in 1955, just as the *combined program* at BGH faltered. It will be argued in this study that the emergence and maintenance of the new profession was probably more complex than either Dooley or Tipliski suggest.

Psychiatric nursing arose, not only because of the failure of the negotiations with the MARN, but also because there were male attendants poised to fill the gap, there was an alternative model of psychiatric nursing in western Canada, and a national group the Canadian Council of Psychiatric Nursing (CCPN) located in the west who provided support and encouragement to their colleagues in Manitoba. Finally, there was already government action underway to establish a psychiatric nursing body under an act.

The era preceding the pivotal legislation of 1960 and the local, contextual, and gender influences which had an impact on this event are unexamined. This is the starting point for the present study.

Rationale for the Study

Registered psychiatric nursing in Manitoba arose within a particular historical, socio-political, legal, intellectual, and gender context that was shaped by the nursing, educational, and psychiatric beliefs of the day. Analyzing this context and the way in which the human agents and events interacted to form a distinct profession, as well as laying the groundwork for the continuing evolution of the profession, is the rationale for this study.

The specific socio-political context resulted from a number of factors including the ongoing medicalization of insanity, the postwar trend of greater understanding of the mentally ill, and the drive for professionalization by asylum workers. The male and female attendants in Manitoba were also influenced by their peers in neighbouring Saskatchewan, who had acquired legal status in 1948, and the support of the CCPN which had formed in 1951.²⁷ The unique situation which existed at BMH in the *combined program* added another dimension to the emergence of the profession in Manitoba. The female nurses who participated in the *combined program* were eligible for licensure with the MARN, and the fact that they had access to a legal recognition, may partly account for the lateness of Manitoba in achieving distinct legislation for psychiatric nurses relative to the other western provinces.

The mental hospital attendants and nurses were further encouraged by superintendents who had instituted a number of *scientific* labour intensive treatments

in the 1940s and 1950s which required a skilled labour force. Because of difficulties in attracting general nurses to work in the mental hospitals, the superintendents encouraged the development of a new class of mental hospital worker. The superintendents recognized the value, not only of improved physical conditions and medical treatments in the mental hospitals, but also a professional staff. Exploring the impact of the mental hospital culture on the evolution and professionalization of psychiatric nursing is part of this study.

Developments in the conceptualizations of mental illness, and its treatment, in the 1950s, 1960s, and 1970s also influenced psychiatric nursing. Procedures performed in the name of therapy included leucotomies, insulin coma, and electro-convulsive treatment. A major event was the serendipitous discovery, in 1952 in France, of drugs which had an impact on the behaviour of those deemed mentally ill.²⁸ As a result, difficult behaviour, often encountered in mental hospital wards, became managed pharmacologically. At BMH, Largactil was introduced in April 1954.²⁹ This development must have had an impact on the attendants and mental nurses whose identity had been formed by their ability to manage difficult behaviour and perform the *nursing tasks* associated with treatments such as insulin coma, and electro-convulsive treatments.

The 1950s also saw new publications related to psychiatric nursing. An American nursing leader, Hildegard Peplau, wrote *The Nurse Patient Relationship*. This book is considered to be one of the first to identify the therapeutic possibilities of the psychiatric nurse.³⁰ The National League for Nursing published proceedings from a conference on *Aspects of Psychiatric Nursing*.³¹ Maxwell Jones of Great

Britain wrote *The Therapeutic Community*, a book about the method of making a ward environment and daily interactions with nurses and attendants the major therapeutic tool of mental hospitals.³² The 1970s saw the rise of behaviour modification as an important method of management and treatment of patients in mental hospitals.

Psychiatric nursing was also shaped by gender, but not in the way in which it customarily shapes nursing, which is usually considered a *woman's profession*. In Manitoba in the 1960s, almost fifty percent of the students graduating from the psychiatric nursing training programme were male and a significant portion of the leadership of the new profession was male. Men had been particularly influential in forming the professional associations in the other western provinces, as well as the national body of psychiatric nurses, the CCPN.³³ Identifying the role of men in the evolution and professionalization of psychiatric nursing is part of this study.

The new profession of *psychiatric nurse* in turn changed the psychiatric and nursing landscape in Manitoba as it set about defining a unique role for itself and sought more autonomy over its own affairs, especially education. Along with *The Act Respecting The Psychiatric Nurses Association of Manitoba*, a second act, *An Act to Provide for the Education of Psychiatric Nurses* was proclaimed. This gave authority for the education of the new psychiatric nurses to a committee comprised of superintendents and nursing administrators, not to the newly formed psychiatric nurses' association. The strategies to gain control of the education of psychiatric nurses are a distinguishing feature of the evolution of the profession during its first

twenty years. The passage of these two acts in 1960, imperfect as they were, was a clearly visible and publicly documented event and is the pivotal point of this study.

The factors leading to the legislation and the men and women involved in bringing it about are less visible. In fact, Tipliski concluded “The era from the mid twentieth century onwards requires a separate study.”³⁴ This study will follow Tipliski’s lead and examine the political events and human agency factors immediately preceding the pivotal legislation of 1960, and the consequences of that legislation for the evolution and professionalization of psychiatric nursing in Manitoba. The two acts of 1960 governed psychiatric nursing until July 1980 when they were replaced by a single act, *The Registered Psychiatric Nurses Act*, which is the endpoint of this study.

This study is designed to address the following questions and identify how these factors influenced the evolution and professionalization of registered psychiatric nursing:

- What socio-political factors of the late 1950s led to the legislation of March 1960, in the Province of Manitoba, that created the new professional group, Psychiatric Nursing Association of Manitoba (PNAM), and who were the men and women involved in bringing it about?
- How did the legislation influence the evolution, education, and professionalization of Registered Psychiatric Nursing in Manitoba?
- What role did men play in the development of psychiatric nursing when nursing is generally considered *women’s work*?

- How did the disciplinary frameworks and traditions of general nursing influence the education and professionalization of psychiatric nursing?
- What educational processes and curriculum models guided the education of the new profession?
- What foundations were laid for the continuing evolution of the profession?

Research Approach

Writing History, Writing Nursing History, Writing Psychiatric Nursing History.

The questions of this study will be explored through an historical approach, in particular a genealogical analysis. This section provides a brief overview of general historical practice and how scholars have adapted these practices to suit nursing history. A conceptual framework suited to the study of psychiatric nursing education history is introduced.

Writing History

The focus of the scholarly practice of history is the past. Social or political institutions, events, persons, or ideas from the past may become the objects of historical study. Historical knowledge is constructed about past events or institutions from traces that are available and accessible. Some of the traces are selected and some rejected by present day historians who assemble them into a coherent and plausible narrative. The uses of these narratives and the manner of their construction have changed through fashion, necessity, or challenge. In the nineteenth century, history was viewed as heroic and was represented in literary narratives of progress and the accomplishments of political and social leaders, usually men. In the early twentieth century the style shifted to a scientific model and historians made claims to

truth about the past, based on their adherence to scientific principles and documentary evidence. The historical narratives from this period were believed to be true and valid representations of past events. But, as concerns changed, as the needs of society shifted, and as methodological strategies were refined, doubts surfaced about the accuracy, usefulness, and universality of historical narratives.

By the mid twentieth century, new questions were being asked by those whose experiences did not resonate with the histories they read and heard. Certain groups such as women, blacks, gays, blue collar workers, rank-and-file nurses, and the mentally ill were excluded. Sometimes labeled as marginalized or oppressed, these groups and their supporters rallied sufficiently to demand a place in history. Just as historical knowledge had been used to glorify past events or people, it was discovered it could also be used to expose human frailties, to keep alive memories of past neglect or injustice, or to illuminate the accomplishments of forgotten groups. Questions also arose about historical representation. Not only were questions raised about how the representations were constructed, but also by whom, and why particular representations of the past, rather than others, came to be in history books. Many of these challenges were flamed by the intellectual movement generally called *postmodernism*.

Postmodernism is a slippery term that has many meanings, therefore, it is difficult to give one definition. Denis Hlynka's view is that it is a condition we cannot escape and it permeates all aspects of contemporary life.³⁵ Julianne Cheek notes, "Given the highly contestable nature of . . . the term postmodern . . . it is not possible to arrive at 'a' or 'the' definition."³⁶ Nevertheless, the most frequently used statement

to describe *postmodernism* is the one ascribed to Lyotard as, “incredulity towards meta-narratives.”³⁷ Postmodernism has challenged more than the overarching grand narratives of modern history. It also rejects epistemological assumptions and refutes methodological conventions. It challenges claims to truth, the nature of knowledge, and the stability of language.³⁸ Postmodernism also challenges “epistemological certainties, ontological groundings, rhetorical protocols, and existential authenticities.”³⁹ Although the term may be contested, its impact on various scholarly undertakings cannot. It has spawned new positions and analytical frameworks, frameworks which question established protocols and ask daring questions. Basically, as Cheek observes, “postmodern (approaches) question the assumptions embedded in modernist thought.”⁴⁰ For historical practice, postmodernism undermined the basic assumption that the past could be recovered and represented as it actually happened. Historical practice changed from writing about the past to asking how the past was written about.

New objects, and new perspectives on old objects, became the focus of postmodern historical practice. *New History*, as it is called by Peter Burke, created the opportunity for different voices to be heard and different perspectives to be offered. Even characteristics once believed to be fixed, such as race and gender, became historicized.⁴¹ Pauline Rosenau says the new history seeks to unravel texts, raise new questions about texts, and invent micro narratives.⁴² Historian Keith Jenkins contends there is a mass of historical genres and many uses of history. Revisionism, nostalgia and presentism, the use of the past to justify present actions or behaviour, have become popular uses of history. Jenkins suggests that there may be numerous

histories about the same event and that different historians will “interpret the same phenomenon differently through discourses that are always on the move . . . always positioned and positioning.”⁴³

Writing Nursing History

The shift in historical practice also affected the writing of nursing history. Narratives of progress, professionalization, and the accomplishments of great women leaders which had characterized nursing history were challenged on both sides of the Atlantic. In 1980 in Great Britain, Celia Davies assembled a book of ten essays, each of which challenged the self-congratulatory, chronological, nursing history as progress approaches which masked power, gender, and class discourses. The authors of the ten essays offered alternative perspectives and asked why nurses should accept one particular account of their history over another.⁴⁴ Seven years later, Christopher Maggs observed that the challenges put forth by the authors in Davies’ book had been answered by a flood of works which charted new paths, reassessed conventions, and asked new questions.⁴⁵ Nearly ten years later, Anne Marie Rafferty asked penetrating questions about the shaping of nursing knowledge by politics and social attitudes towards class and gender. Rafferty concluded that the development of professionalism in nursing in Great Britain had less to do with the agency and initiative of nursing leaders and more to do with government policy which was often fanned by some political crisis. The appearance of sympathetic government action towards nursing often served the governments as well as the nurses.⁴⁶

Likewise, in the United States, changing approaches to nursing history were evident in the increasing number of articles appearing in nursing journals. As early as

1965, Mildred Newton observed that nursing history was more than accounts of leading personalities and that trends and themes in nursing practice and education were legitimate areas of study.⁴⁷ Other developments followed. Teresa Christy⁴⁸ wrote on historical methodology in 1975, and in 1977 the *Annual Stewart Conference on Research in Nursing* was devoted to sharing the products of historical enquiry in nursing.⁴⁹ The classic tales of great women nursing leaders and the triumphs of professionalization were challenged. Instead, gender, race, class, labour, and economics became the lenses through which nursing was examined. Barbara Melosh, in 1982, explored the experiences of rank-and-file nurses and found their work-related goals to be quite different from the professionalization agenda of the nursing leaders.⁵⁰ In 1987, Susan Reverby identified the dilemma experienced by nurses who were placed in the position of having to care, in a society that does not politically or legally value caring.⁵¹

The year 1987 also saw the thirty-fifth anniversary issue of the journal, *Nursing Research*, devoted to nursing history. This was repeated again five years later. The articles in the fortieth anniversary issue showed continuing diversity in historical topics and included Canadian scholarship.⁵² The trend continued with special issues of *Advances in Nursing Science* devoted to nursing history in 1990, and again in 1999. The 1999 issue included two articles by Canadian nursing scholars about Canadian nursing issues.⁵³ As new challenges and new methods evolved, a journal dedicated to nursing history was founded. The first volume of *Nursing History Review* was published in 1993, giving historians of nursing a dedicated scholarly voice.

Canadian nursing history also evolved from classic narratives of progress and triumph, and developed perspectives based on its own unique characteristics which emphasize regional and religious differences. The evolution of psychiatric nursing into two models within one country is an example of a regional difference. The role of French religious women in health care is another distinguishing feature of Canadian nursing history. Nursing as women's work in the Canadian context was examined by Judi Coburn in 1974.⁵⁴

In 1991, Veronica Strong-Boag identified two major genres in the writing of Canadian nursing history with a third emerging genre. The first genre is the long and distinguished tradition of nurses preserving their own history through the classic *Three Centuries of Canadian Nursing* by John Gibbon and Mary Mathewson⁵⁵ to a variety of biographies of nursing pioneers and laboriously compiled accounts of training schools.⁵⁶ While there is little analysis in these accounts, Strong-Boag commends nurses for saving many records and artifacts and maintaining a chronology which identifies critical points of departure for further study. One of her conclusions is that these narratives demonstrate that “nursing is not uncharted territory: there may be disagreement about the meaning of its initial mapping but nursing is already ‘women’s country’.”⁵⁷ This statement clearly positions nursing history in women’s studies, but at the same time excludes men.

Strong-Boag identified the second genre as revisionist. Despite the record of caring and accomplishments left by early nursing leaders and their historians, the next group of nurse historians, in typical revisionist fashion “were stern critics . . . of earlier generations of women.”⁵⁸ This revisionist trend considered the lives of

ordinary rank-and-file nurses and deconstructed the image of nursing as a white middle class profession. These revisionist nursing historians found a place for marginal female carers and healers, such as midwives. They also identified strengths garnered through training and sisterhood, rather than the professionalization efforts of elite leaders and their historians.

The emerging genre identified by Strong-Boag was just developing in the early 1990s. She suggested that Canadian nursing history should be integrated into broader discussions of Canadian development. She identified differences between French and British settlements in their health-care management. She also wanted more women included, such as informal and unpaid caregivers, native healers and religious women, lay and nursing sisters who accompanied soldiers to battle, and the many health evangelists who struggled to bring health care to the poor in the face of political indifference. For example, Marion McKay describes the work of the voluntary sector in bringing care to immigrant and poor women in the early twentieth century in the Winnipeg, but when public health became a political, rather than an evangelical activity, the control of the programmes was usurped by male bureaucrats.⁵⁹ Despite such new areas to be explored, Strong-Boag overwhelmingly viewed care-giving in all forms as women's work.

Three years later, in 1994, Kathryn McPherson and Meryn Stuart, guest editors for a special edition of the *Canadian Bulletin of Medical History*, identified new questions, new themes, and new methods arising from the papers written for this special issue.⁶⁰ They suggested, as did Strong-Boag, that the term nurse should be broadened to include a variety of caregivers, but they also succumbed to the position

that nursing is women's work. They emphasized the role of gender as both a facilitating and a constraining factor in nursing leadership. However, it was assumed the gender was female, and because of this conflicts arose with male doctors.

Arising from this assumption was the tension between science and caring. Women were assumed to be *carers* while medical men were *scientific*. The scientific approach to knowledge was considered to carry more weight hence, in the drive for professional status, nursing leaders wanted a more scientific approach to nursing education and research. Revisionist nursing historians suggested this alienated them from the bedside nurse. The tensions in nursing history between leaders and bedside nurses, and nurses and doctors has been made explicit through a more critical examination of primary sources such as diaries and personal letters rather than official documents.

In 1995, *The Canadian Journal of Nursing Research* devoted an issue to nursing history. The guest editor, Ina Bramadat, observed that Diana Mansell, author of the methodological essay in the issue, challenged the integrity of historical nursing research based only on the documents and activities of its leaders, thus highlighting the influence of postmodern approaches on nursing history. The experiences of rank-and-file nurses and the influence of class, race, and gender argued for by Mansell were reflected one year later in the work of Kathryn McPherson.⁶¹

In her landmark book, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*, McPherson developed an analytical framework through which she viewed ninety years of bedside nursing in Canada. She argued that nursing has customarily been analyzed through one of three frameworks: professionalization,

proletarianization, and gender. Each has contributed to an understanding nursing's past, but none alone is satisfactory. She located her study at the intersection of three interrelated bodies of scholarly literature: labour, women's, and medical history and argued that a nurse's position was simultaneously affected by class and gender and complicated by race, all within in the context of a male medical system. By nursing, however, she clearly meant women and general nursing.

McPherson acknowledged that her study did not extend to other groups such as Black and Asian nurses, licensed practical nurses, or midwives. She identified the challenges to mainstream nursing posed by some other marginal groups, such as men. She recounts the legal sanctions against male nurses in Quebec and the special status afforded them in Nova Scotia. However, she does not offer any explanation of how the particular philosophical and knowledge perspectives of men may be articulated in an occupation that has unabashedly declared itself *women's work*. Likewise, McPherson excluded psychiatric nursing, not to privilege the general nurse, but out of recognition "of the need for further detailed studies of practitioners such as psychiatric nurses."⁶²

More detailed studies of psychiatric nursing have begun to appear. In 2004, in a second special issue of the *Canadian Bulletin of Medical History*, guest editors Cynthia Toman and Meryn Stuart observed the increasing diversity and complexity in understanding nursing and the new directions in analyzing practice, "In particular within the field of mental health nursing which seems to be burgeoning." They go on to note, "There are two pieces in mental health nursing in this issue and more waiting to be published."⁶³

Writing Psychiatric Nursing History

Despite the recent trend identified by Toman and Stuart towards more studies on mental nursing, they have not figured prominently in works on nursing history. The lack of scholarship on psychiatric nursing may spring from one or the other of two positions. On one hand, psychiatric nursing may be considered a subset or particular kind of *nursing* and therefore the assumptions and theoretical frameworks of general nursing will also explain psychiatric nursing. On the other hand, it may be so different that a unique framework needs to be developed. The latter position is adopted in this study.

Psychiatric nursing has been studied as a distinct profession,⁶⁴ as a specialty of general nursing,⁶⁵ or as a particular kind of labour force which evolved as a response of medical superintendents to meet asylum needs and the medicalization of insanity.⁶⁶ These different approaches to the study of psychiatric nursing's past reflect the ambivalence and ambiguity which have dogged not only the history of the profession, but the profession itself. From these approaches, the most persistent themes which have emerged are the roots of psychiatric nursing in asylums, the ambiguous place of men and the comparisons and conflicts with general nursing.

Can a profession which arose in asylums and a unique socio-political and gendered milieu utilize the same concepts to explore its past, present, and future as those used in general nursing historical practice? Not only are the gender and environmental contexts distinct, so are the concepts of illness. Madness became mental illness based not so much on *scientific* explanations of pathological processes, but on social contingencies and philosophical speculation. Psychiatric nursing was

constructed in asylums to provide nursing care to individuals whose nursing needs were as poorly defined as their illness. The position adopted here is that in order to understand psychiatric nursing, it is necessary to construct a new framework, one which highlights its contingent and ambiguous nature.

Conceptual Framework of the Study

Psychiatric nursing was constructed within a particular socio-historical, political, and gendered context. Understanding the unique, specific, and local contingencies which coalesced to form the profession of *Registered Psychiatric Nursing* in Manitoba implies a history of the present⁶⁷ or a genealogical approach. Genealogy, in this study, is taken to mean the uncovering of hidden connections and unlikely events of the past that have resulted in the present. Genealogy refutes the belief in history as an inevitable progression of events, but rather seeks to illuminate the particular conditions under which those events occurred.

Genealogy is a postmodern approach to historical practice and is described by Rosenau as “a substitute for more modern versions of history.”⁶⁸ It differs from traditional history in that it does not seek to locate the origins of institutions or the truth of particular kinds of knowledge nor does it, as C. G. Prado observes “claim to mine a continuous vein in which determinants of later events can be found.”⁶⁹ Genealogy considers the present as the product, not of a grand design, but rather the result of a series of decisions and contingencies, of happy and unhappy events. In genealogy there are no grand designs or determinative continuities rather there is the tracking of a series of particular accidents, complexity and disparity. and “the jolts

and surprises of history.”⁷⁰ In genealogy there are no causal antecedents rather there are casual antecedents.

This does not mean that genealogies are constructed on flimsy evidence. In fact, Foucault says, “Genealogy is gray, meticulous, and patiently documentary.”⁷¹ Genealogy focuses on minute details and marginal items and “it needs archives, diaries, journals, logbooks, memoirs, official records and registries.”⁷² In other words it uses the same raw material as traditional histories but, unlike traditional history, genealogy does not seek evidence to support a belief in inexorable progress but rather offers alternatives by “unearthing the obscure and ignored.”⁷³

Genealogy has no fixed theory but it is not atheoretical. Gutting states that “the theories are not permanent structures. . . . [T]hey are temporary scaffoldings erected for a specific purpose.”⁷⁴ Thomas Popkewitz employs the concept of *scaffolding*:

As a grid or overlay of historically formed ideas whose pattern gives intelligibility to today’s debates.⁷⁵

Today’s debates are often the result of uneven and multiple historical trajectories. The temporary grid or framework directs attention to the various trajectories, breaks and ruptures, as well as the continuities with the past. Popkewitz argues that history is not only the locating of breaks, but also the identification of relational and conditional continuities.⁷⁶ This approach offers the opportunity for perspective taking and demonstrating the constructed and contextual nature of particular social institutions. By revealing the contingent nature of an institution, genealogy also offers hope for the future:

Not one that is foreordained . . . or predictable but one that will exceed--in undetermined and contingent ways--the limits of the present.⁷⁷

Psychiatric nursing in Manitoba arose from a contingent context. The literature on psychiatric nursing reveals that it has taken different forms in different times and places, sometimes a specialty of general nursing and sometimes a distinct profession. It also has links to earlier forms of providing care to the mentally ill such as asylum attending. The form taken has never been dependent on any overarching truth or the superiority of one form over another, but rather has resulted from local and particular decisions made at particular moments. The temporary scaffolding constructed for this study reveals the contingent nature of those decisions, but it also offers the opportunity to envisage many possible futures. It offers the possibility that psychiatric nursing can reinvent itself.

Three interrelated themes form the scaffolding of this study. The first theme concerns the political and historical evolution from asylum attendant to the legal designation Registered Psychiatric Nurse. This includes an examination of the social, political, intellectual, and gendered contexts from which psychiatric nursing arose, and the way in which these constrained or facilitated the evolution of the new profession in its first twenty years.

The second theme concerns the decisions made regarding the content, context, and control of the curricula and the knowledge and assumptions that underpinned psychiatric nursing education.

The third theme concerns the politicized and gendered strategies employed to gain professional recognition. This includes an examination of unexpected events and contingencies which affected the professionalization of psychiatric nurses. These

themes direct and guide the study and become the scaffolding which will inform the analysis and interpretation of how these factors coalesced to form a distinct profession, and established a context for the continuing evolution and professionalization of psychiatric nursing in Manitoba.

Data Sources

In this section, the collection and analysis of data is discussed, along with the limitations of the data-gathering and analysis. The data came from three sources, primary texts, secondary texts, and oral data. Primary texts included official reports and records, official correspondence, and minutes of meetings. Secondary texts included textbooks and curriculum documents.⁷⁸

Records

The major reports in the public domain included *The Hall Report*, *The Minister's Report on the Supply of Nurses*, and *The Task Force Report*. These reports provided the official political stances regarding psychiatric nursing, against which psychiatric nursing often had to define itself.

The annual reports of the Manitoba Department of Health were an important source of information and easily located at the Manitoba Legislative Library. Even more useful were the hospital annual reports. During the 1950s, 60s and 70s at BMH, the practice was to have each hospital department compile its own annual report. These were then modified and distilled into the official annual report of the Manitoba Department of Health. The official reports, therefore, had lost much information during the compilation. Locating the original reports, called the hospital copies, was fortuitous. They provided a much richer and more detailed source of information.

Other primary sources included relevant records located in the Provincial Archives of Manitoba (PAM) and a number of institutional and organizational archives such as College of Registered Psychiatric Nurses of Manitoba (CRPNM), College of Registered Nurses of Manitoba (CRNM), archives of the psychiatric nurses associations of Saskatchewan, Alberta, and British Columbia, the records of the CCPN, and McKee Archives at Brandon University. Some information was also located at the institutional museums at Portage La Prairie and Brandon.

The Provincial Archives of Manitoba is the official repository of the Manitoba government records. For almost sixty years psychiatric nursing education in Manitoba fell under government control. Records of the early evolution of psychiatric nursing are often found in government records. That the control of the superintendents was so pervasive is evidenced by the fact that many references to psychiatric nursing education are found in the minutes of medical superintendents' meetings. Internal memos, amongst government officials, regarding psychiatric nursing education and practice, also reflect the extent of government control of this profession. Even after the establishment of the Education Advisory Committee (hereafter the Advisory Committee) in 1960, which was to have been the official body in control of psychiatric nursing education, references to psychiatric nursing education occur in the minutes of the meetings of medical superintendents and other government programmes. The minutes of the Advisory Committee meetings, and the sub-committees it established, were an important source of data. Other official records located at PAM were the minutes of the LPN Advisory Council meetings, and records of the University Grants Commission.

The records accessed at the CRPNM included minutes of all the council meetings held since the inception of the organization in 1960. Other documents in this location included notes kept of the earliest organizing meetings held in Brandon in the late 1950s, before the association was officially formed. Official correspondence of the association was also available at the CRPNM. The minutes of board meetings of CRNM were also examined. The records of the CCPN were accessed at the Saskatchewan Psychiatric Nurses Association located in Regina, Saskatchewan. McKee Archives has a collection related to the school of nursing at BMH as well as the records of Brandon University Senate.

Minutes of meetings are an important source of information regarding decisions made by the officers of an association. These provide the official view of events, but many of the nuances of the discussions and personal tensions and conflicts are not captured in official documents. These are often captured in personal papers, but only a few personal items were discovered. This is unfortunate as such papers are usually a rich source of data. This is a limitation of the study.

Oral Data

Collecting the oral data presented the most challenges in this study and is also the most limited source of data. First, the participants were neither randomly nor self-selected. They were approached directly and invited to participate because of their particular involvement in specific events. In addition, a number of them were known to the interviewer/researcher. This at times made interviewing difficult. Although an interview outline had been developed, the interviews often became conversations and reminiscences of shared memories.⁷⁹ It was not always easy to keep on topic.

The interviews were conducted over a period of time and were interspersed with the collection of the documentary evidence. They were not intended to capture precise codifiable data. Rather the aim was to gather participants' impressions of the events and to provide an opportunity to explore what psychiatric nursing meant to them.

The third, fourth, and fifth presidents of the Psychiatric Nurses Association were interviewed and family members of the first two presidents, both now deceased, also provided information. Other key people included male and female psychiatric nurses, members of the early Advisory Committee, members of the early PNAM council, and the executive director of the CRPNM.

Most participants signed the consent form, although those who provided information electronically gave permission via e-mail. Most allowed their names to be used although some preferred to remain anonymous and some chose not to have their interviews recorded. Participants were given the opportunity to review and refine the transcript of their interview although most chose not to. In one particular case, where the participant wanted to reword some statements, the resulting data was improved and became more of a negotiated text.

Field notes and transcripts of the interviews were examined for key points and insightful comments and excerpts from the interviews were used to highlight particular points. The most potent data was the emotion expressed when the participants tried to capture and articulate what psychiatric nursing meant to them. The intensity of their expressions coupled with the body language is not easily put

into words but emphasizes the struggle of trying to state what psychiatric nursing means.

Significance of the Study

This study evolved out of a need for the profession of psychiatric nursing in Manitoba to specify more clearly its uniqueness in terms of its evolution and place in Manitoba. No previous studies have been conducted into the internal evolution of the legal profession of *Registered Psychiatric Nursing* in Manitoba.

The role of men in the development of registered psychiatric nursing has been neglected. At the legal inception of psychiatric nursing in Manitoba in 1960, almost fifty percent of those providing care as psychiatric attendants were male, but their contribution had never been examined. Likewise, the role of male leadership in the legalization and professionalization of psychiatric nursing in Manitoba has not been explored.

One of the characteristics of a profession is the claim to a unique body of knowledge. The knowledge base of psychiatric nursing as a distinct profession in Manitoba needs to be more clearly articulated. In particular, in what way did medical psychiatric knowledge and general nursing knowledge form a basis for new intellectual content for psychiatric nursing? What educational processes and curriculum frameworks formed the basis for the education and professionalization of the newly registered psychiatric nurses?

This study will contribute to the body of knowledge regarding psychiatric nursing in the following ways:

- Increasing the understanding of the evolution of psychiatric nursing as a distinct profession in Manitoba from 1955 to 1980.
- Adding not only to local knowledge of psychiatric nursing in Manitoba but also to the understanding of psychiatric nursing as a unique profession.
- Identifying the role of men in psychiatric nursing.
- Identifying systems of curriculum control which had an impact on psychiatric nursing education and professionalization in Manitoba.
- Identifying the curriculum frameworks which guided psychiatric nursing education.

Outline of the Chapters

Chapter 1. The two kinds of psychiatric nurses in Canada and Manitoba's position between the two in the 1950s have been described. Nursing history methods have been reviewed and a unique conceptual framework has been constructed which reflects the uniqueness of psychiatric nursing and will provide an analytical framework.

Chapter 2. The asylum environment from which psychiatric nursing arose is described. Major studies on psychiatric nursing from the United States, Great Britain, Holland and New Zealand are reviewed. These studies highlight how the asylum environment became the context for the evolution of psychiatric nursing in different countries. Psychiatric nursing arose, as much out of the effort to medicalize asylums and professionalize attendants, as to provide care for patients. Yet this factor has often been neglected in favor of demonstrating how psychiatric nursing modeled itself on general nursing and became either a specialty of general nursing or a distinct

profession. Part of the reality of the asylum environment as a context of care, was that a significant number of men were employed. Although they were called attendants, and at times were not treated well, they frequently provided care to male patients similar to that provided by female mental nurses to female patients. In Manitoba, men were a significant factor in the evolution of the profession. Men have often been neglected in the analyses of psychiatric nursing.

Tipliski's work, the only one to describe and analyze the evolution of two psychiatric nursing systems in Canada, is reviewed. This is followed by an examination of the Saskatchewan literature. Saskatchewan became the leader in the development of the separate profession in Canada and played an important role in supporting Manitoba in gaining its legislation. The chapter concludes with a review of the Manitoba studies of Dooley and Tipliski to identify gaps that exist in the history of psychiatric nursing in this province and highlight the need for the present study.

Chapter 3. The work and training of the nurses and attendants, and the socio-political, and intellectual climate of the Manitoba mental hospitals in the 1950s are described. How the newly formed LPN Advisory Council became the vehicle for developing *nursing* standards for psychiatric nursing education is discussed. During this time, conversations were also occurring amongst male and female attendants regarding the establishment of a separate professional association for mental hospital nurses. The leadership role of the male attendants in the three institutions of Manitoba, and their counterparts in Saskatchewan is explored. The role of the newly

formed CCPN is highlighted. The chapter concludes with the passage of the legislation in Manitoba in 1960.

Chapter 4. This chapter is an examination of how the legislation impacted the emerging professional consciousness of the new psychiatric nurses during the first decade, 1960-1971. Having attained legal status and the necessity of passing a licensing exam, certain educational standards were required for the students. But who established these standards? The content, context, and control of the curriculum and training were put into the hands of a committee controlled by the superintendents. The superintendents therefore, continued to influence psychiatric nursing education just as they had in older mental hospital contexts. This decade was characterized by a growing self-consciousness of the need for a professional ideology and more control over education. During this time the use of the term *registered* was added to the psychiatric nurse designation and to the association..

Chapter 5. The second decade, 1971-1980, is described. During this time, the Registered Psychiatric Nursing Association of Manitoba (RPNAM) came into public focus as the result of political changes to the mental health system and challenges from the MARN. There was a maturing of the association during this decade as it consulted and conflicted with other mental health professionals in the province. There was a slow erosion of the medical control over the curriculum. A number of political factors influenced the evolution of the profession.

Chapter 6. The findings are synthesized to reveal how the factors coalesced to form the new profession in Manitoba. Post 1980 developments are briefly reviewed and future research directions are suggested.

Endnotes Chapter 1

1. Kurtland I. Refvik, *History of the Brandon Mental Health Centre 1891-1991* (Brandon, Manitoba, Canada: BMHC Historical Museum, 1991).

2. *Ibid.*, XI.

3. *Ibid.*, 40.

4. *Ibid.*, 45.

5. *Ibid.*, 148.

6. James E. Moran, "Keepers of the Insane: The Role of Attendants at the Toronto Provincial Asylum, 1875-1905," *Social History* 28 (55) (1995): 51-75.

7. In Saskatchewan this became an issue and optional titles were suggested. Angela Y. Martin, "Determinants of Destiny: The Professional Development of Psychiatric Nurses in Saskatchewan 1914 to 2003" (master's thesis, University of Regina, 2003), 55. F. H. Kahan, *A Different Drummer (The History of the Saskatchewan Psychiatric Nurses' Association)* (Published for the Saskatchewan Psychiatric Nurses' Association, 1973). See Chapter 4.

8. Annette Osted, "40th Anniversary Tribute," *Update* (The Registered Psychiatric Nurses Association of Manitoba, March 2000). The Annual Report of Selkirk Mental Hospital, 1920, identified the start of a programme to educate *trained nurses*. The Annual Report of Brandon Mental Hospital, 1921, identified the start of a training programme. There has always been uncertainty as to which hospital started their training programme first, but these annual reports seem to confirm that it was Selkirk.

9. In British Columbia a general meeting of the Provincial Mental Hospital Employees Association was held May 22, 1947, at New Westminster. A committee of eight men and women was elected to discuss ways and means of forming an Association of Psychiatric Nurses. An impromptu meeting was held May, 27, 1947, and the names Wilfred Pritchard and Richard Strong, two male attendants, were prominent in the proceedings. These men subsequently became leaders of organized psychiatric nursing in western Canada. The organizational meeting was held June 2, 1947, and the group reviewed their purpose. They observed that various titles were used to identify personnel in mental hospitals. They believed themselves to be specialists of a kind but they had no organization and powerful opposition from the Registered Nurses Association. They established aims and objects and interestingly their first goal, "To promote, improve and maintain an enlightened and progressive standard of psychiatric nursing" was the same wording used thirteen years later when Manitoba established their objectives. Source. Handwritten minutes of first meeting located in the offices of the Registered Psychiatric Nurses Association of British

Columbia in May 2007. A box of memorabilia had been donated by the family of a well known psychiatric nurse Miss Catherine Murray.

10. Author Unknown, *Dear Bill, Let's Start an Association . . . A Tribute to the Psychiatric Nurses Association of Canada on the Occasion of Its 25th Anniversary* (British Columbia: Registered Psychiatric Nurses Association, 1976).

11. Refvik, 2.

12. Christopher Dooley, "When Love and Skill Get Together: Work, Skill and the Occupational Culture of Mental Nurses at the Brandon Hospital for Mental Diseases, 1919-1946" (master's thesis, University of Manitoba, 1998), 23.

13. Veryl Margaret Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing in Three Canadian Provinces, 1905-1955" (Ph.D. diss., University of Manitoba, 2002), 85.

14. David MacLennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1938*," *Canadian Bulletin of Medical History* 4 (1987): 7-23.

15. Refvik, 45.

16. Tipliski, note 21, 146.

17. Refvik. Chapter One, passim. Refvik describes the role of early superintendents including their responsibilities for managing all aspects of the asylum including the farm.

18. Barry Edginton, "Moral Treatment to Monolith: The Institutional Treatment of the Insane in Manitoba, 1871-1919," *Canadian Bulletin of Medical History* 5 (1988): 167-188.

19. College of Registered Psychiatric Nurses of Manitoba Archives (hereafter CRPNM Archives). John Kellie, "A History of the School of Nursing: The Manitoba Developmental Centre," (unpublished manuscript, 1988). CRPNM Archives, Della Narfason, "Historical Perspective, School of Psychiatric Nursing, Selkirk," (unpublished manuscript, 1986).

20. Cornelia Johnson, "A History of Mental Health Care in Manitoba: A Local Manifestation of an International Social Movement" (master's thesis, University of Manitoba, 1980). Refvik.

21. Dooley. Tipliski.

22. Tipliski, 484.

23. Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996).

24. Dooley, 214.

25. Tipliski, 470.

26. Provincial Archives of Manitoba (hereafter PAM), GR 157, H-14-21-1B, Schultz to Elliott, Oct 10, 1952. The Advisory Council for Licensed Practical Nurses wishes to recommend that a combined course leading to a Diploma in Psychiatric Nursing and a License as a Practical Nurse be held at the Brandon Hospital for Mental Diseases.

27. Author Unknown, "Dear Bill," 8.

28. Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

29. Refvik, 122-123.

30. Hildegard Peplau, *Interpersonal Relations in Nursing* (New York: G.P. Putnam & Sons, 1952).

31. National League for Nursing. Aspects of Psychiatric Nursing Considered at the 1956 Regional Conference. (1957). There had also been a Report of the Conference on Advanced Programs in Psychiatric Mental Nursing (May 14-18, 1951).

32. Maxwell Jones, *The Therapeutic Community: A New Treatment Method in Psychiatry* (New York: Basic Books, 1953).

33. Note on source of information regarding number of students who participated in the various training programmes at Brandon. Throughout the years, 1920-1995, at Brandon Mental Hospital School of Nursing, neat handwritten lists of every class of students who went through any of the training programmes were maintained. Lists of male and female students were kept separately until 1971. Every affiliate student and postgraduate student is also listed. When the programme of psychiatric nursing education was transferred from the Centre for Psychiatric Nursing Education at the BMHC to Brandon University in 1995, these registers were saved. Any reference to number of students are from this source. (hereafter The Register).

Author Unknown, "Dear Bill," 8. This early history of the CCPN identifies the male leaders.

34. Tipliski, 13.

35. Denis Hlynka, "Postmodern and Poststructural Theory," Chapter 10 in ed. D.H. Jonassen, *Handbook of Research for Educational Communications and Technology* (New York: Simon & Schuster Macmillan, 1996), 255.
36. Julianne Cheek, *Postmodern and Poststructural Approaches to Nursing Research* (Thousand Oaks, CA: Sage Publications, 1999), 3.
37. Jean Francois Lyotard, "The Postmodern Condition: A Report on Knowledge," in W Godzich & J Schulte, *Theory and History of Literature Vol. 10* (G. Bennington & B. Massumi, Trans) (Minneapolis: University of Minnesota Press, 1984). (Original work published in 1979).
38. Pauline M. Rosenau, *Postmodernism and the Social Sciences: Insights, Inroads, and Intrusions* (Princeton, NJ: Princeton University Press, 1992).
39. F. Barker, P. Hulme, and M. Iversen, eds., *Uses of History: Marxism, Postmodernism and the Renaissance* (Manchester, England: Manchester University Press, 1991), 2.
40. Cheek, 5.
41. Peter Burke, ed., *New Perspectives of Historical Writing* (University Park, Pennsylvania: The Pennsylvania State Press, 1992).
42. Rosenau, 66.
43. Keith Jenkins, *Re-thinking History* (London: Routledge, 1991), 11.
44. Celia Davies, ed., *Re-writing Nursing History* (London, England: Croom Helm, 1980).
45. Christopher J. Maggs, ed., *Nursing History: The State of the Art* (London: Croom Helm, 1987).
46. Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996).
47. Mildred Newton, "The Case for Historical Research," *Nursing Research* 14 (1) (Winter 1965): 20-26.
48. Teresa E. Christy, "The Methodology of Historical Research: A Brief Introduction," *Nursing Research* 24 (3) (1975): 189-192.
49. M. Louise Fitzpatrick, ed., *Historical Studies in Nursing: Papers Presented at the 15th Annual Stewart Conference on Research in Nursing March 1977* (New York: Teachers College Press, 1978).

50. Barbara Melosh, *The Physicians Hand: Work Culture and Conflicts in American Nursing* (Philadelphia: Temple University Press, 1982).
51. Susan Reverby, *Ordered to Care: The Dilemma of American Nursing 1850-1945* (New York: Cambridge University Press, 1987).
52. Meryn Stuart, "Half a Loaf is Better Than No Bread: Public Health Nurses and Physicians in Ontario, 1920-1925," *Nursing Research* 41 (1) (1992): 21-27.
53. Adeline R. Falk Rafael, "The Politics of Health Promotion: Influences on Public Health Promoting Nursing Practice in Ontario, Canada from Nightingale to Nineties," *Advances in Nursing Science* 22 (1) (1999): 23-39. Susan M. Duncan, Beverley D. Leipert and Judy E. Mill, "Nurses as Health Evangelists: The Evolution of Public Health Nursing in Canada, 1918-1939," *Advances in Nursing Science* 22 (1) (1999): 40-51.
54. Judy Coburn, "I See and Am Silent: A Short History of Nursing in Ontario, in *Women at Work in Ontario, 1850-1930* (Toronto: Canadian Women's Educational Press, 1974).
55. John Murray Gibbon & Mary Mathewson, *Three Centuries of Canadian Nursing* (Toronto: Macmillan, 1947).
56. Veronica Strong-Boag, "Making a Difference: The History of Canada's Nurses," *Canadian Bulletin of Medical History* 8 (1991): 231-248.
57. Ibid., 233.
58. Ibid., 237.
59. Marion Lynne Clark McKay, "Saints and Sanitarians: The Role of Women's Voluntary Agencies in the Development of Winnipeg's Public Health System, 1882-1945" (Ph.D. diss., University of Manitoba, 2005).
60. Kathryn McPherson and Meryn Stuart, Guest Editors, "Writing Nursing History in Canada: Issues and Approaches," *Canadian Bulletin of Medical History* 11 (2) (1994): 3-22.
61. Ina Bramadat, Guest Editorial, "Focus: History of Nursing, Nursing History: Some Issues and Insights," *Canadian Journal of Nursing Research* 27 (3) (1995): 3-14. Diana Mansell, "Designers Corner, Sources in Nursing Historical Research: A Thorny Methodological Problem," *Canadian Journal of Nursing Research* 27 (3) (1995): 83-86.
62. McPherson, 21.

63. Cynthia Toman and Meryn Stuart, Guest Editors, "Emerging Scholarship in Nursing History," *Canadian Bulletin of Medical History* 21 (2) (2004): 223-227. Christopher Dooley, "They Gave Their Care But We Gave Loving Care: Defining and Defending Boundaries of Skill and Craft in the Nursing Service of a Manitoba Mental Hospital During The Great Depression," *Canadian Bulletin of Medical History* 21 (2) (2004): 229-251. Tipliski, "Parting at the Crossroads: the Emergence of Education for Psychiatric Nursing in Three Canadian Provinces, 1909-1955," *Canadian Bulletin of Medical History* 21 (2) (2004): 253-279.

64. Geertje Boschma, "Creating Nursing Care for the Mentally Ill: Mental Health Nursing in Dutch asylums, 1890-1930" (PhD. diss., University of Pennsylvania, 1997). Susan T. Wood, "Changing Times: A Historical Review of Psychiatric Nursing in the Province of Saskatchewan," (master's thesis, University of Regina, 1998). Catherine Mary (Kate) Prebble, "Ordinary Men and Uncommon Women: A History of Psychiatric Nursing in New Zealand Public Mental Hospitals, 1939-1972," (Ph.D. diss., University of Auckland, 2007).

65. Olga Church, "That Nobel Reform: the Emergence of Psychiatric Nursing in the United States 1882-1963," (PhD. diss., University of Illinois, 1982). Tipliski.

66. Dooley, "When Love and Skill Get Together," Peter Nolan, "Psychiatric Nursing, Past and Present: The Nurses Viewpoint," (Ph.D. diss., University of Bath, UK, 1989).

67. Gary Gutting, *The Cambridge Companion to Foucault* (Cambridge, England: Cambridge University Press, 1994), 12.

68. Rosenau, 67.

69. C. G. Prado, *Starting with Foucault: An Introduction to Genealogy* (Boulder, CO: Westview Press, 1995), 34.

70. Gutting, 33.

71. Michel Foucault, "Nietzsche, Genealogy, History," (D, F, Bouchard and S. Simon, Trans.) Reprinted in Paul Rabinow, ed., *The Foucault Reader* (New York: Pantheon Books, 1984). (Original work published in 1971).

72. Prado, 40.

73. Ibid., 153.

74. Gutting, 16

75. Thomas S. Popkewitz, "A Changing Terrain of Knowledge and Power: A Social Epistemology of Educational Research," *Educational Researcher* 26 (9) (December 1997): 18-29:18.

76. Ibid., 24.

77. Joan Wallach Scott, *After History?* Paper presented at the History and the Limits of Interpretation Symposium (Rice University, March 15-17, 1996). Accessed http://cohesion.rice.edu/humanities/csc/conferences.cfm?doc_id=371.

78. Ian Hodder, "The Interpretation of Documents and Material Culture," chapter 26 in eds. Denzin and Lincoln *Handbook of Qualitative Research* (2nd ed.) (Thousand Oaks: Sage Publications, 2000). Hodder makes a distinction between records and documents. Records include marriage certificates and drivers licences. Documents are prepared for personal reasons such as diaries, memos, and letters. Minutes of meetings are not classified by Hodder.

79. See appendix D for interview guide.

CHAPTER 2

FROM BARNYARDS . . .

Introduction

The history of the evolution and professionalization of registered psychiatric nursing falls uneasily between nineteenth century asylum history and twentieth century nursing history, and is influenced by both. The impact of the asylum environment on the evolution of psychiatric nursing is an important aspect of an historical understanding of the roots of psychiatric nursing. This chapter is divided into three sections. The first section is an overview of asylum studies and a discussion of the asylum context from which psychiatric nursing arose. The second section is a review of selected international classic scholarly works on psychiatric nursing in the United States, Great Britain, Holland, and New Zealand. The third section is a review of Canadian psychiatric nursing studies. These studies illustrate how psychiatric nursing in different countries disassociated itself from its asylum roots and developed an identity either as a part of general nursing or as a distinct profession. This review of the asylum and political themes, and unexplored themes, establishes how the framework for this study was constructed.

* * *

Psychiatric nursing has been studied as a distinct profession,¹ as a specialty of general nursing,² or as a particular kind of workforce,³ but one of the most persistent themes is its roots in asylums. Psychiatric nursing arose in asylums, usually at the

behest of the superintendents, in response to service needs of the institutions and the medicalization of insanity. Its history is intimately tied to this asylum context. When the medicalization of insanity and the shift in the purpose of the asylums gave rise to the need for a new class of skilled workers, the superintendents of most asylums determined that *nurse* was the most appropriate category of worker to fill this need.

The evolution of psychiatric nursing is being explored in a growing body of literature. Some of the themes which have emerged from this literature include: its intellectual basis and professional affiliation, the political tensions around the control of psychiatric nursing, and the factors which influenced whether or not it would be a distinct profession or a specialty of general nursing. There are also themes which have not been fully explored, for example, the place of gender in psychiatric nursing, the uneasy comparisons between general nursing and psychiatric nursing, and the identification of a distinct philosophical perspective.

Asylum Studies

Asylums of the nineteenth century have come under considerable scrutiny in the last forty years and a lively literature has developed about the social and medical meaning of asylums. As the major nineteenth century tool in the containment, care, and treatment of the mentally ill, asylums have also been linked to the history of psychiatry and the changing concepts of mental illness. However, there is no consensus on the nature of this past or on the historical interpretations of its meaning. In 1994, Mark Micale and Roy Porter, reflecting on the many histories of psychiatry, concluded that “in no branch of the history of science or medicine has there been less interpretive consensus.”⁴ This lack of consensus is evident in the histories of

nineteenth century asylums wherein the roots of psychiatric nursing lay. The conflict surrounding the social and medical meaning of asylums and psychiatry is also reflected in the history of psychiatric nursing.

The literature on nineteenth century asylums is considered by Thomas Brown to have evolved through three genres, each in response to changes in historical practice and altered philosophical attitudes towards mental illness. In 1985, Brown described the impact of Michel Foucault's 1965 provocative critique of nineteenth century lunatic asylums on current asylum studies.⁵ Foucault is known for his challenge to the popular notion that asylums were places of human benevolence and medical progress in the treatment of the insane.⁶ Before Foucault's challenge, the history of nineteenth century asylums and psychiatry had usually been written by well-intentioned medical men with an historical bent. They wished to convey the notion that care of the insane had progressed, from the dark days of chains and imprisonment, to enlightened humanitarianism and scientific understanding. This first genre, identified by Brown as *whigish*, is characterized by a self-congratulatory, progressive tone. While these works were useful in identifying changes in asylum systems, they offered little explanation of the political, social, or medical meaning of the asylums. The next generation of asylum historians believed these authors had missed the point, although David Rothman, in discussing asylum practices, noted, "It is easier to describe the fact of change than to explain it."⁷

Flamed by the general social critique of the 1960s, the second genre or *revisionist* trend of the 1970s challenged the whigish asylum histories. The anti-psychiatry rhetoric of R. D. Laing, Thomas Szasz, and Erving Goffman also

contributed to the general cynicism towards psychiatry and asylums.⁸ Laing hypothesized that schizophrenia was not a mental illness, but was the result of distorted family communication. Szasz asserted that because no biological basis could be found for mental illness, it was not a true disease. Goffman claimed that the mental hospitals themselves caused *mad behavior*. The voices of Foucault, Laing, Szasz, and Goffman were joined by those of sociologist Andrew Scull and historian David Rothman.⁹ The good intentions of the well-meaning psychiatrists and social reformers were called into question by these revisionists and were reframed as *social control*.

Social control became the central concept of the 1970s critiques of the nineteenth century asylum movement. Originally used by sociologists to describe the ways in which society functioned to instill commonly held values into its members, social control later became viewed as the way in which the state imposed authority over the lower classes. The term social control was appropriated by asylum historians who also found it a useful concept in questioning the *benevolence* view of asylums. Perhaps it was not benevolence that motivated the reformers, the revisionists argued, but the desire to keep the disorderly off the streets. Rothman suggested that this concept encouraged a group of historians to investigate the meaning and purpose of the purported social reforms, rather than the reforms themselves.¹⁰

Brown argued that this new orthodoxy, one which imputed sinister motives to asylum reformers, was itself too simplistic. It reduced society to two classes, those with power and those without. This opinion was shared by the third genre of asylum historians who were emerging in the mid 1980s. The *counter-revisionists*, as they were called, offered an alternative to the strident voices of the revisionists. Brown

posited that these more nuanced and balanced accounts, which were firmly anchored in archival research, would result in a new synthesis and declared:

It seems highly unlikely that the decade of the 1980s will close without seeing the production of some new more synthetic overviews of nineteenth century psychiatry to match those produced by David Rothman and Andrew Scull in the 1970s.¹¹

When Brown revisited this assumption in 1994, he concluded that there had been no new synthesis in the 1980s. The counter-revisionists, in their bid to examine in detail the daily life of asylums, had failed to account for the formation of asylums in the first place:

These richly detailed microanalyses may contain many insights into the insane and their world . . . but what is missing . . . is any meaningful analysis of the realities of power in the asylums or the wider society of which they were a part.¹²

While the counter-revisionist historians may not have succeeded in arriving at any more synthetic view, what they did accomplish was to open the doors of the asylums and move away from the incarceration/treatment dichotomy. These historians considered the social control hypotheses too simplistic and “too pregnant with ideological significance . . . and more theoretically compelling than factually demonstrable.”¹³ The asylums, the counter-revisionists said, were viewed from the outside by the revisionists as social and political institutions. Their view was from the inside as a set of negotiated relationships:

Within the dark internal world of the asylum . . . a world that was ‘contested terrain’ shaped by the needs of and imperatives of patients, keepers and physician-administrators alike.¹⁴

Daily life, the retrieval of silenced voices, and rich description of particular asylums put a human face on the insane and their keepers. It is in this examination of

daily life, who structured it, and how it was managed that the roots of psychiatric nursing will be found.

British and American Asylum Studies

Studies which opened the doors of American and British nineteenth century asylums include those of Gerald Grob, Anne Digby, Nancy Tomes, Patricia D'Antonio, and Ellen Dwyer.¹⁵ Grob's 1966 work, although somewhat earlier than the movement called counter-revisionist, represents one of the first efforts to provide a balance between the self-congratulatory progressive view of asylum medicine and the social control theories. Although the studies of Digby, Tomes, and Dwyer are identified as representative of the counter-revisionist movement, they are, in fact, detailed case studies of the inner life of particular institutions. Furthermore, the focus of the Digby and Tomes studies were small, private asylums run on a particular religious philosophy, Quakerism. The study of D'Antonio, a psychiatric nurse, although not always identified in the counter-revisionist asylum literature, is included here because of its similarity in style and substance to the works of Digby, and Tomes. Ellen Dwyer's study, like Grob's, concerns state asylums. Her focus was on two of New York's earliest state asylums, Utica and Willard.

If *social control* was the key concept of the revisionists, *domesticity* was the central concept of the counter-revisionists. The private religious asylums, and the state asylums which modeled themselves after them, were designed to replicate an orderly family. The Quaker philosophy of *moral treatment* was the background against which the institutional studies of Digby, Tomes, and D'Antonio were constructed.

The development of moral treatment is credited to William Tuke, an English Quaker. In France, Philippe Pinel also developed a humane approach to care of the insane. According to Grob, “Kindness was the fundamental ingredient in Pinel’s therapeutic approach . . . Moral treatment involved the creation of a total therapeutic environment, social, psychological, physical.”¹⁶ William Tuke argued that patients could be rational “provided that they were not alienated by cruelty, hostility or harsh and unreasonable methods of restraint.”¹⁷ As well as kindness, the structure of daily life and domestic rhythm was an important part of moral treatment. Grob says “it meant individualized care in a small hospital with occupational therapy, religious exercises, amusements and games, and in large measure a repudiation of all threats of physical violence.”¹⁸

The description of moral treatment, with its attention to the social and emotional environment, is similar to that of the therapeutic community put forth one hundred years later by Maxwell Jones, and of importance to psychiatric nurses in the 1950s.¹⁹ Although moral treatment may not be considered by all as *medical*, the order and industriousness of the moral community was an improvement over the disorder found in many asylums. It also engaged the attendants in a meaningful way. The role of attendants in the day-to-day life of the institutions and the patients is one of the continuities between attendants and psychiatric nurses.

There was no clear distinction between the status of male and female attendants in these moral communities and as many men as women were employed. In fact, the male attendants were particularly important to the aspects of moral treatment which often included farm work for the male patients. This required male

attendants skilled in farming. The female attendants were sometimes referred to as nurses, although this seems to have been based on gender rather than credentials. The domestic tasks of female patients and their female attendants paralleled the gender specific tasks of the male side of the asylums. Gender seems only to have become an issue when formal training programmes were established in asylums and *nursing*, with its feminist connotations, was the selected occupational category.

* * *

The major counter-revisionist histories of Grob, Digby, Tomes, D'Antonio, and Dwyer share similarities and differences. What they have in common is the concern with internal life in asylums. However, they are different kinds of asylums, private and state. The private asylums had financial and social benefits that the state asylums could not replicate. The implementation of moral treatment was probably easier in the smaller, homogeneous, private institutions than in the state institutions, although the state asylums attempted to emulate the private institutions. Grob declares that "half of the mental hospitals established in the United States prior to 1824 drew heavily on the experiences of the Quakers."²⁰

Grob's history of the Worcester State Hospital in Massachusetts covers eighty-four years, from 1833 to 1917. He describes the employment of *moral treatment* and its subsequent decline, the role of politics and economics in shaping the internal world of a state asylum, and the central role of the superintendent. Asylum literature is always characterized by the centrality of the superintendent, who was not only a medical authority but also a site-manager, usually being responsible for the physical structure, the farm, and the grounds. In the moral treatment context, he also

functioned as a father-figure to the *family* of patients, attendants, and staff; hence the domestic metaphor. As asylums changed into hospitals and served different functions, this theme of the paternalistic superintendent persisted. In studies of psychiatric nursing in the twentieth century, the superintendents remain central.

Grob described the relatively successful initial thirteen years at Worcester under a dedicated superintendent, Samuel Bayard Woodward, who believed as much in kindness as in medical care. He also believed in the importance of attendants in carrying out the precepts of moral treatment. High moral standards were expected of the attendants. In 1839, he informed the attendants that they should not be “cold or insensitive . . . or impatient . . . they were to mingle with the insane in kindness . . . respect and affection.”²¹ But for all the initial good intentions, Grob goes on to note the failure of moral therapy as the asylum became more crowded and the ability to maintain the high ideals was compromised. As the need to employ greater numbers of attendants increased, the standards dropped. Grob observes that by 1880 the comment was made, “The caliber of this group leaves much to be desired. . . . [B]ecause of the low esteem of state hospitals a position at such an institution was not a desirable one.”²² The transition from the ideal attendant, described by Woodward in 1839, to the reality of 1880, was part of the larger decline of moral treatment, but it also subsequently became the impetus for improving the skills and knowledge of attending staff. The evolution of attendants into psychiatric nurses was part of a more general early twentieth century reform movement spurred on by further medicalization of insanity, but the ideal of the good attendant persisted and became part of the philosophy of the new profession.

The York Retreat in England, the Quaker institution in which William Tuke set forth and implemented his moral treatment, is the subject of the 1985 study by Digby and spans 118 years. She describes the physical structure and moral environment of the Retreat and the role of the attendants whom she calls “the hidden dimension.”²³ In the environment of non-restraint and kindness, which was the guiding philosophy of the Retreat in the early nineteenth century, the character of the attendants was of utmost importance. In order to carry out the moral treatment, the Retreat employed attendants of the highest caliber recruited preferably from the Quaker community.²⁴ The domesticity of the Quaker environment extended to the personal lives of the attendants. They were expected to live within the asylum grounds and their marital status was an issue. Being single was an advantage, and, even if married, they had to live at the institution.²⁵

This control of the personal lives of attendants extended to Canadian mental hospitals fifty years later. *Living in* was a common requirement for single attendants as late as 1935 at Brandon Mental Hospital. A change in marital status, from married to single, seems not to have been a reason to continue living outside the hospital walls. An attendant who had divorced his wife apparently did not return to live at the institution following the dissolution of the marriage. In an anonymous letter to Superintendent Dr. Pincock, the writer, who only identified himself as a *Male Nurse*, stated:

He should have reported his case before the Medical superintendent. His living out allowance stopped also he should be living at the hospital like myself.²⁶

The economics of employing married versus single staff was an issue in another Canadian asylum. Samuel Edward Dole (SED) Shortt at the London, Ontario asylum in the late 1800s noted that it was decided that married staff were too costly and that “no married staff were to be hired in the future.”²⁷

* * *

Attention to character, behaviour, and marital status would not ensure quality care. As early as the 1860s, the lunacy commissioners of Great Britain recognized the need to train attendants. However, it was not until 1885 the well-established and powerful association of medical superintendents, *The Medico-Psychological Association*, saw the value of training and published *A Handbook for the Instruction of Attendants on the Insane*.²⁸ Digby notes:

The retreat took a lead in implementing these measures intended to transform the attendant into the professional mental nurse.²⁹

These early beginnings of training form the foundation from which a separate profession of mental nursing evolved in Great Britain.

The American view of moral treatment was articulated in the greatest detail by Thomas Story Kirkbride, who is considered one of the leading American superintendents of the nineteenth century and is the central figure in the work of Nancy Tomes. For forty-two years, from 1841 to 1883, he ran his asylum, *Pennsylvania Hospital for the Insane*, along philosophical lines based as much on his Quaker religious background as on any understanding of mental illness.

The staff was essential to the smooth running of the orderly institution and the effective implementation of moral treatment principles. Kirkbride established two levels of staff, companions and attendants. The companion’s role was to engage in

intellectual and artistic activities with the patients and to organize group activities. Today this might seem more like occupational therapy. Although the attendants had different responsibilities, they were also expected to be pleasant and cultivated. According to Kirkbride, the perfect attendant possessed “a pleasant expression . . . gentleness of tone . . . mental cultivation . . . coolness and courage.”³⁰ The attendants had the most daily contact with the patients and they preserved the physical appearance of both patients and ward, but their status was lower than that of the companions. The ambiguous position of the attendants is emphasized by the amount of responsibility they incurred, although they had little power. In their daily contact with patients, they became the eyes and ears of the superintendents and in particular were responsible for guarding against suicide.³¹

The work of Patricia D’Antonio shares similarities with that of Tomes and Digby. The institutional focus of her 1992 work was the *Friends Asylum*, a small Quaker institution in Philadelphia. Her description of the physical, social, and emotional environment differs little from that of Digby or Tomes. Steeped in Quaker philosophy and domesticity, it served primarily Quaker Brethren. The role of the attendants, as at similar institutions, was a difficult one. They had to:

Maintain the physical appearance of wards and patient, work with their patients on the farm and about the house, nurse the physically ill prevent or contain frightening physical violence.³²

D’Antonio’s study concludes in 1850 before there was any formal training of nurses, but she sets out the expectations of attendants which could be echoed today:

The lay staff at the asylum worked carefully and consciously to structure their patients’ environment in such a way as to ease their distress and disruptiveness. . . They moved patients fairly skillfully . . . between more and less restricted environments . . . using their

expertise and their personal knowledge of the patients to join with them around an intervention designed for their benefit.³³

The clinical skills and intuitive judgment suggested by this passage could well describe the knowledge, skills, and tasks of today's psychiatric nurses.

Dwyer's work differs from Tomes, Digby, and D'Antonio in that she selected two state asylums in New York, Utica and Willard, rather than private Quaker institutions, as the objects of her study. But she too focused on the internal world of the asylum, controlled by the superintendents with day-to-day life managed by the attendants. Her picture is less rosy, and it seems that attempts at moral treatment failed due to staff limitations. The calibre of the attendants differed from those described by Digby, Tomes, and D'Antonio. As state institutions they were no doubt subject to economic constraints. Dwyer identifies the ambiguity of the attendants' position. Attendants were expected to:

Make beds, scrub floors, and bathe filthy patients, they were also expected to offer moral guidance and psychological counseling.³⁴

Hiring and maintaining staff to carry out these complex tasks was a challenge. In particular, there was a lack of suitable female applicants. The matron tried to employ female attendants who could write and do simple sums, but she was often forced to "hire all those with a respectable and trustworthy appearance."³⁵

There was little effort at these state asylums to educate the attendants, despite a legislative investigation in the 1880s which recommended better trained staff.³⁶ The superintendents of Utica and Willard seemed less willing than their Quaker counterparts to implement training programmes:

Despite the obvious need for formalized instruction, asylums in New York State hesitated to establish formal training schools . . . while the Utica and

Willard doctors never openly discussed the reasons . . . one superintendent commented he might sponsor ‘simple lectures in which no attempt is made to take the nurse beyond her depths.’³⁷

Such ambivalence around the content, context, and control of psychiatric nursing education did not end in the nineteenth century in the United States. Similar attitudes continued in Manitoba well into the twentieth century.

* * *

The debate around the meaning of asylums was never conclusively resolved in this literature. Brown argues the debate between the traditionalists and the revisionists grew stale and the counter-revisionists failed to accomplish any new synthesis.³⁸

Whatever the theoretical meaning of asylums, at the core were the insane and how they spent their days. Whether the insane were incarcerated, entertained, or involved in domestic chores, it was always attendants who managed and supervised these activities.

Edward Shorter also argues that the incarceration/kindness debate lost its currency when Foucault came under “withering fire and the fantastical thesis of the great confinement has been broken.”³⁹ Marxist philosophy no longer serves to explain psychiatric history and there is a new agenda. The new agenda is concerned with the growing medicalization of society and the link between patterns of mental illness and the values of society.⁴⁰ Despite Shorter’s insistence that we are now freed of Marxist explanations, he still links the values and structures of society to individual patterns of behaviour.

The debate over the political meaning of asylums may have waned, but it certainly has not over the political uses of psychiatry. Micale and Porter note, “In few professions . . . has it been more difficult to demarcate the scholarly enterprise from

urgent, present day debates.”⁴¹ Micale and Porter identify the issues to be explored in psychiatric history today which they call “the peculiar, complex and powerful interplay between psychiatry, historiography, and social, cultural and political ideology.”⁴² It could be added that these issues also impact psychiatric nursing history.

Eastern Canadian Asylum Studies

The shift away from asylums as the focus of psychiatric studies is reflected in Canadian literature. There are fewer Canadian asylum studies, and Edward Shorter notes, “An overview of the history of psychiatry in Canada remains unwritten.”⁴³ Cheryl Krasnick Warsh suggests that there are fewer because of the smaller Canadian population, less diversity in the types of asylums, and the Canadian tradition of providing more social services to the poor and indigent.⁴⁴ There is less discussion in the Canadian literature of the social meaning of asylums, but more about provincial psychiatric systems. There is less discussion of moral treatment than there is in the English and American literature, no doubt because it was falling into disfavour by the time Canadian asylums were being established.

The first asylum in English Canada was established in 1836 in an old cholera hospital in New Brunswick. The first permanent asylum was opened there in 1848, and Nova Scotia’s first asylum was opened in 1859.⁴⁵ Previously, the insane of the Maritimes were either imprisoned or permitted to wander at will, if they were considered harmless. This pattern of either incarcerating or ignoring the insane was common to most Canadian provinces until the mid to late nineteenth century when each province developed a system of management. Management at that time often

meant the building of asylums in which to incarcerate the insane. Life inside the walls received less attention than the walls themselves.

Daniel Francis reports that moral treatment was tried in the two Maritime asylums, but by the 1880s both were hopelessly overcrowded and poorly staffed. His description of the attendants and their behaviour seems more like the poorhouses of Europe in the eighteenth century rather than the nineteenth century institutions which were trying to improve care. Patients were neglected, even murdered, and women were stripped and bound.⁴⁶ Francis does not describe any attendant action in a positive light and concludes, “Given the intolerable conditions of the asylum, the humane aspect of moral treatment had been sacrificed to the requirements of the system.”⁴⁷

* * *

The Ontario asylum system commenced in 1850 with the opening of the 250 bed Provincial Lunatic Asylum in Toronto.⁴⁸ By 1900 there were six asylums in Ontario including the Hamilton and Kingston asylums which subsequently became important in the establishment of psychiatric nursing. Particular aspects of the Kingston Asylum have been the focus of individual studies. For example, Danielle Terbenche argues that while Kingston may have been a fairly typical nineteenth century asylum, it also served a curative function in certain situations.⁴⁹ In part, Terbenche credits the treatment successes with the implementation of a training programme designed to improve the status and working conditions of the attendants:

The program benefited patients by providing them with more knowledgeable attendants whose job dissatisfaction was somewhat decreased by professional recognition of their duties.⁵⁰

Kingston was also the focus of a study by Patrick Connor who describes a number of aspects of the attendants' lives in that institution between 1877 and 1905. He highlights the training programme as one of the significant events of this period, but observes that this was only extended to women. Dr. Charles Kirk Clarke, the superintendent who established the training:

Considered the nurses training school one of his greatest successes, but he repeatedly lamented in his annual reports that the same training could not be extended to male attendants.⁵¹

This resulted in one of the ambiguities that plague psychiatric nursing, the role of gender and the difficulty of using a female nursing model when it does not fit. As the new female nurses were not permitted on the male wards, the male patients gained no benefit from the improved training. Connor speculates, "One can only surmise that male patients suffered from a . . . poorer standard of care."⁵² Not only did the male patients suffer, the increased status of the professional female nurses disadvantaged the male attendants. Connor argues that any authority the male attendants had:

Was further undermined by the presence of trained female nurses whose professional qualifications and middle class status encouraged them to identify with the medical staff.⁵³

This lower status of the male attendants cannot be explained simply by the professionalization of female nurses. As will be seen from the literature of the prairie provinces, it was male attendants who headed the drive for professional recognition.

The mental asylum at London, Ontario, which opened in 1877, was the background of a study by Samuel Edward Dole (SED) Shortt.⁵⁴ Rather than institutional history it is more about Superintendent Dr. Richard M. Bucke. Bucke's idiosyncratic medical beliefs guided the asylum at London for twenty-five years, from

1877 to 1902. Shortt argues that late nineteenth century institutional psychiatry did not necessarily reflect any medical doctrines but were more often autonomous institutions fashioned by the mindset of the individual superintendents.⁵⁵ Shortt describes in great detail the mindset of Bucke who developed a complex theory of mental illness based on a curious blend of physiological and spiritual views.⁵⁶ His treatment included strange surgical interventions to stop masturbation in males. He also permitted a number of gynaecological procedures to be performed on women beset by mental illness, despite the fact the provincial inspector disapproved of such practices and there was little evidence they had any curative effect.⁵⁷

Shortt distinguishes between attendants and nurses at the London asylum. He notes that in the United States there were twelve training schools for nurses in asylums by the end of the nineteenth century, but also observes, “This professionalization process scarcely influenced Canadian asylums in the nineteenth century.”⁵⁸ He describes desirable qualities in attendants, one of which was musical ability “so as to ensure participation in asylum entertainment.”⁵⁹ This resonates with the Brandon experience almost eighty years later when, under Superintendent Schultz, an orchestra and choir were formed which seemed to have had a better reputation than the treatment provided at BMH.⁶⁰ Shortt also describes another activity which was echoed later in Brandon. The London Asylum boasted a cricket team which participated in local tournaments. Brandon had the *Mentals*, a football team of some note in the area in the 1940s. These anecdotes provide examples of the total institution in which all aspects of the lives of the attendants and patients were managed as well as the control exerted by superintendents.

* * *

There was one exception to the Ontario public system. *The Homewood Retreat* established in 1883 in Guelph was a venture in corporate health care. This asylum is the subject of Cheryl Krasnick Warsh's study and, like Shortt's work, is as much a study in the practices of particular superintendents as it is an institutional case study. The first superintendent, Stephen Lett, had no illusions that insanity could be cured and devoted his attention to the treatment of alcoholism.⁶¹ The second superintendent, Alfred Hobbs, who had studied and worked at the London Asylum, continued the gynaecological surgeries he had practised with Bucke.⁶²

Along with Hobbs and Bucke another participant in the medical practices of the London Asylum was Dr. Edward (Edgar) Barnes, the assistant superintendent.⁶³ He subsequently became superintendent of the Selkirk Mental Hospital in Manitoba where he is credited with starting a training programme for nurses.⁶⁴ The surgical interventions of Bucke and Hobbs would have required nurses skilled in working with surgical patients although neither Shortt nor Warsh discuss this issue.

Warsh discusses the establishment of training schools in asylums and records that the first training school for nurses in asylums was established at the Kingston Asylum in 1888 followed by others in Toronto, Brockville, London, and Hamilton.⁶⁵ The Homewood Retreat also established a training school for nurses in 1906. Conflicts with general nurses, both within and outside the asylum, surfaced soon after. Apparently, Inspector Bruce Smith suggested the nurses in the Homewood Retreat were inferior to nurses in general hospitals although Hobbs asserted they were equally well prepared:

My nurses undergo a training of two years . . . they undergo a strict course . . . and pass a very strict severe standard for their examinations.⁶⁶

Despite continuous upgrading, including an affiliation at a general hospital,

the “professionalizing initiatives by the general nursing establishment left

Homewood’s nurses in the cold.”⁶⁷ The professionalizing efforts to which Warsh

refers was the establishment of a Graduate Nurses Association of Ontario (GNAO).

Although this preceded their licensing legislation by twenty one years, this body still

wielded some power.⁶⁸

Although the training may not have met with approval from the general nursing body, Warsh observes that the efforts to upgrade asylum nursing had immediate benefits for the institution. It provided labour, but as it involved female students, it also meant cheap labour. This economic windfall was philosophically justified as young women were associated with a natural and benevolent *calling*, whereas the male attendants were associated with brutality.⁶⁹ Warsh touches on two issues which subsequently became of major importance in the evolution of psychiatric nursing in Canada. First, the tension exhibited, even at this early date between general nurses and asylum nurses, and second the role of gender. The assumption that only females made good asylum nurses has never been challenged. In fact, the dilemma described by Connor at the Kingston Asylum where it was assumed only females could be nurses, although they could not nurse male patients, is illustrative. These two factors, conflicts with general nurses and gender issues, are central to the studies of psychiatric nursing in Canada and Manitoba.

* * *

Another major study of the Ontario psychiatric system is a work edited by Shorter. The centre-piece of this study is the *Toronto Psychiatric Hospital* (TPH) established in 1925. This psychopathic hospital was attached to the general hospital and the university and was to be the centre of research and teaching. Written more as a celebration than a critical analysis, Shorter claims TPH mirrored the larger trends in psychiatry in the first half of the twentieth century. Since the history of psychiatry has moved beyond the analysis of nineteenth century asylums and the early days of psychoanalysis, Shorter states “more recent periods are largely a blank.”⁷⁰ Shorter suggests more recent trends should be studied to include the use of psychosurgery and electro-convulsive therapy in the 1930s and 1940s, the rise of other mental health professionals, and societal forces such as individual rights. The rise of mental health professionals to which Shorter refers includes psychiatric nurses. It was during this period that the two different kinds of psychiatric nursing emerged in Canada, a general nursing specialty east of the Manitoba-Ontario border and a distinct profession in western Canada.

Western Canadian Asylum Studies

British Columbia established its first dedicated asylum in a converted building in 1872. This was followed by other western asylums in Manitoba, Saskatchewan, and Alberta. In Manitoba, the Selkirk Asylum was opened in 1886 and the Brandon Asylum in 1891. The first Alberta asylum was located at Ponoka in 1911. In Saskatchewan, the first asylum was built at North Battleford in 1914. Each of these provinces established psychiatric nursing education programmes in these asylums.

Tipliski argues that the battle for control of psychiatric nursing education was waged in Saskatchewan.⁷¹

There are few works on the psychiatric systems in British Columbia and Alberta. In 1973, Ian Clarke described the development of the asylum system in Alberta. He:

Was concerned with the problems engendered by the eastern standards to the legal characterization of insanity, the form of the asylum, and the power of the medical superintendent in the development of Alberta's mental health system between 1907 and 1936.⁷²

Clarke's study covers the period in which Baragar, formerly of the BMH, became the Alberta commissioner for mental institutions and director of mental health. In this capacity, as he had done in Brandon, he instituted a training programme for mental nurses at Ponoka. He was successful in securing affiliation at the general hospital, ensuring these nurses were trained in both general and mental nursing. Baragar had not been so successful in Manitoba in gaining the desired general affiliation.⁷³ Ronald LaJeunesse studied the psychiatric system in Alberta and identified political decisions which impacted the care of the mentally ill in that province. Despite the importance to the mental health system of psychiatric nursing, LaJeunesse does not discuss the formation of psychiatric nursing in that province.⁷⁴

* * *

Of particular importance to the present study is the Saskatchewan and Manitoba asylum literature. There is a rich literature on the Saskatchewan provincial psychiatric system and Saskatchewan psychiatric nursing. For example, Paul Nishida studied the Saskatchewan provincial system from the establishment of the two mental hospitals, one at North Battleford in 1914 and the other in Weyburn in 1921, to 1940.

This was just prior to the major reforms of the Co-operative Commonwealth Federation (CCF) Government of Tommy Douglas.⁷⁵ This period was characterized by building programmes, containment of the insane, and overcrowding. Although there are charges of political patronage and hints of eugenics, Saskatchewan also received positive reviews from Clarence Hincks of the CNCMH. Hincks, in 1921, surveyed North Battleford and gave the institution and its staff a glowing report, “In many cases the finest we have seen in the Dominion . . . Saskatchewan is the most progressive province of the whole lot.”⁷⁶ Saskatchewan continued to lead in social and psychiatric reforms and the North Battleford Mental Hospital was the site of the first group registered psychiatric nurses in Canada.⁷⁷

Two other studies provide additional perspectives on psychiatric practice in Saskatchewan, including psychiatric nursing. Harley Dickenson, in 1989, analyzed the transformation of psychiatric work from 1905 to 1984. In 1990, Duane Mombourquette analyzed the policies of the CCF in Saskatchewan between 1944 and 1964 and their impact on mental health care.⁷⁸ Dickenson argued that there had been a major transformation in the nature and organization of psychiatric work since World War II which was characterized by an institutional bifurcation.⁷⁹ Dickenson identifies this bifurcation as the *two psychiatries*, one a medically dominated, private sector system and the other a public non-medical system. His thesis includes an analysis of the political and social factors which underpinned the shifts in the philosophy of care and also the establishment of psychiatric nursing. Both Dickenson and Mombourquette highlight the policies of Tommy Douglas and the CCF in the Saskatchewan mental health system.

One of the first initiatives of this new socialist government was a survey of mental health services. This was again conducted by Hincks who had completed the first survey in 1921. His 1944 report was less glowing than his 1921 report. From his numerous recommendations, two had a profound impact on the evolution of the profession of psychiatric nursing four years later. The first was the appointment of Dr. Donald McKerracher as Commissioner of Mental Health Services; the second concerned the need for properly trained asylum nurses. The task of ensuring properly trained nurses was aggressively undertaken by McKerracher and his work in this area is central to Tipliski's study. The reform efforts of 1944 resulted in improved management strategies in the mental hospitals of Saskatchewan and the professionalization of the mental hospital workers. Dickenson, however, observes that not everyone was pleased with the professionalizing efforts:

The Psychiatric Nurse Training Program, organized by the PSB [Psychiatric Services Branch] management as part of its process of creating the occupation of psychiatric nursing, was also the object of intense conflict.⁸⁰

There were conflicts with the union, with the Saskatchewan Registered Nurses Association, and even with the older attendants who "opposed these developments because it was felt, justifiably, that the transition from custody to cure would threaten their jobs."⁸¹ Nevertheless, this political decision has become a key event in the history of registered psychiatric nursing in Canada.

* * *

The provincial asylum system in Manitoba has been the subject of a number of studies. In 1961, J. Matas wrote an overview of progress in the traditional whigish genre. This was followed, in 1970, by a similar self-congratulatory article by Thomas

Pincock.⁸² A more critical thesis was the 1980 work of Cornelia Johnson who compared the rise of asylum psychiatry in Manitoba with similar trends in other countries. Likewise, in 1988, Barry Edginton described the establishment of the two large asylums in Manitoba in the late nineteenth century. Designed as therapeutic tools in the moral treatment mold, they quickly deteriorated into custodial and morally bankrupt monoliths. By 1918, when Hincks conducted his dominion wide survey, Manitoba was given one of the worst reports in the country.⁸³ The most comprehensive work on the Brandon institution is that of Kurt Refvik. Written to celebrate its one hundredth anniversary, Refvik's purpose was to keep alive the history of the men and women who worked in the institution for ten decades.

The asylum studies reviewed here illustrate that there have always been workers who attended to the insane. In all cases, politics and medical power influenced the way in which the workers and the work have been articulated and controlled and has resulted in a series of contrasts. In some places the attendants were seen as special companions, in others as little more than keepers. In most places both men and women provided care, companionship, or control. In some places little attention was paid to the moral character of the attendants, whether they were male or female; while at other places character was the most important criteria for employment. In some places the improvement of care was accomplished by enhancing the skills of existing staff through training programmes; in other places a new category of worker was created who displaced former workers. In many instances the new workers were referred to as *psychiatric nurses*. This title has often been a source of tension and conflict. The evolution of this new group of *psychiatric*

nurses and how they related to attendants and general nurses is an important component of the psychiatric nursing literature to be reviewed.

International Psychiatric Nursing Studies

The link between asylums and psychiatric nursing is clearly evident in writings on the profession of psychiatric nursing. The rise of psychiatric nursing in early twentieth century asylums was an important strategy, implemented as much to improve the image the asylums as to improve patient care. In 1991, Peter Nolan suggested, “Training may have been a response more to political and professional pressures than to the need to improve patient care.”⁸⁴ Geertje Boschma also argues:

Training was not only an attempt to uplift the morality and class basis of asylum personnel, but also one of the efforts of psychiatrists to place asylum care on the same footing as counterparts did in general medicine.⁸⁵

In one way or another all psychiatric nursing studies credit the asylum superintendents, and their ambitions, for the evolution of the profession. For example, Linda Richards is generally considered to be the first trained psychiatric nurse in America, yet Olga Maranjan Church notes that the first training programme for nurses in asylums was established by Dr. Cowles, *with the help of Linda Richards* (italics added).⁸⁶

The uniqueness of the asylum environment and the needs of the insane were often ignored in favour of establishing psychiatric nursing in the same mold as general nursing. The *hospitalization* of the asylums and the *medicalization* of insanity may have limited the ability of the early advocates of psychiatric nursing to consider alternative models of care. For example, in a 1949 article on psychiatric nursing, Elvin Santos and Edward Stainbrook of Cornell University stated, “Psychiatric

nursing by 1900 had become an organized discipline, with its own body of knowledge and techniques.”⁸⁷ Nevertheless, they go on to describe psychiatric nursing as managing incontinence, applying poultices, participating in forced alimentation, and administering chemical restraint. Of this last procedure Santos and Stainbrook note, “Present nursing procedures concerned with the administration of sedatives, hypnotics, and prolonged narcotics have their historical basis in this period.”⁸⁸ They also quote the classic British Medico-Psychological Association syllabus of essential knowledge in the training of psychiatric nursing personnel, including a variety of physical procedures:

Managing beds and bedding to . . . wet compresses . . . to lifting and carrying. . . . [B]y the end of the (nineteenth) century . . . there existed, therefore a definite body of knowledge and specific skills and procedures constituting the special discipline of psychiatric nursing.⁸⁹

But there is little in this list that could be considered uniquely psychiatric nursing. This emphasis on physiological procedures highlights not only the ongoing dilemma regarding the nature of psychiatric nursing, but also its knowledge base. Is it the application of physiological procedures to psychiatric patients or is it the application of these procedures by nurses trained in the asylums? What is it that makes this body of knowledge unique? What is it that makes psychiatric nursing distinct? Despite the differences between hospitals and asylums on a number of levels, schools of nursing were established in asylums. Many of these training schools did not celebrate the differences, but modeled themselves on the policies and practices of general hospitals and general nurses. The suitability of the general nursing model for psychiatric nursing is questionable.

Another early article highlights this constant push and pull in the search for uniqueness. In 1961, Alexander Walk outlined the struggle of psychiatric nursing in England to gain suitable knowledge. He too referred to the syllabus of the Medico-Psychological Association. He declared that by 1908 *heresy* led to the mental nursing qualifications being divorced from the real work:

The syllabus, was arranged along speciously logical lines . . . beginning with anatomy and physiology and only reaching care of mental patients after everything else has been exhausted. First aid and bodily diseases were the concerns of the first and second year examinations and the little psychiatry and mental nursing was relegated to the final year.⁹⁰

He blamed this unsound arrangement on following general nurses' training and the approximation of asylums to general hospitals, "Every feature peculiar to the asylum was regarded as suspect and some hospital method was substituted."⁹¹ Walk concludes with an observation made by one superintendent of the early twentieth century:

An asylum trained nurse must learn to do much more . . . she has to deal with all the patients vagaries of talk and conduct, calm the restless, guide the perverse, rouse the apathetic, comfort the desponding.⁹²

Apart from the obvious gender bias in referring to nurses as *she*, this statement captures some of the dilemma. Psychiatric nursing is about more than the application of techniques. It is also about engagement with patients whose ability to engage is often severely compromised. The philosophical perspective expressed by Walk, that there was something distinct about asylum nurses because of the uniqueness of their patients, continues to be a central, though poorly articulated, concern.

In 1980, Mick Carpenter, in a frequently quoted article, made a similar observation:

Nursing historians need to be more ‘reflexive’ and self-consciously aware of half buried assumptions that . . . need to be prised out. . . . One of these (assumptions) is that nursing history is the history of general hospital nursing. [H]istorians confirm rather than question the dominance of hospital nursing. To describe other forms of nursing we use prefixes such as psychiatric. When the term nurse is used everyone knows a general hospital nurse is signified. They have claimed propriety rights over the title.⁹³

These early articles, on the development of psychiatric nursing, raised issues which were expanded upon and explored in an emerging body of scholarship. In particular, where should psychiatric nursing *fit* in relation to nursing in general? Should it maintain an identity as a distinct profession, or is it a logical part of general nursing? Could psychiatric nursing develop a distinct body of knowledge, or would it adapt and utilize general nursing concepts? The following studies address how some of these questions have been resolved in the United States, Great Britain, Holland, and New Zealand and how other questions have been left unaddressed.

A Study of Psychiatric Nursing in the United States

It is generally acknowledged that the first critical study of the development of psychiatric nursing in the United States is the 1982 work of Olga Maranjan Church. Her purpose was, “To identify and examine the critical social forces which gave rise to the emergence of the psychiatric nursing movement during the years 1882-1963.”⁹⁴ This long timeframe provides a comprehensive view of how changing perceptions and needs of society have had an impact on psychiatric nursing in the United States. Boschma describes Church’s study as “a transitional style of writing nursing history.”⁹⁵ She appears to mean that while it is a chronicle of significant events in the traditional *history as progress* genre, it also has a revisionist tone in that it highlights conflicts between nursing leadership and the medical superintendents of the asylums.

Boschma observes that “the study’s emphasis on professionalizing strategies prevents an analysis of the construction of nursing’s work or nurse-patient dynamics.”⁹⁶ In the United States, the professionalizing strategy was to develop psychiatric nursing as a specialty of general nursing, not a distinct profession.

Tipliski views Church’s work not only as a professionalizing chronicle but also as a critical examination of “eternal societal forces such as the economy, politics and war, all of which had a role in shaping the specialty in the United States.”⁹⁷ Tipliski observes that the students and nurses are missing from Church’s work, thereby suggesting that it is not a grassroots history. Nevertheless, Church’s study represents the first significant effort to address the question of psychiatric nursing as a specialty of general nursing in the United States.

Church describes how Dr. Edward Cowles, superintendent of the McLean Asylum for the Insane, established a training school for nurses in 1882. Cowles viewed the training and employment of nurses as serving two purposes:

First the nurse was important . . . as a symbolic manifestation for medicalizing the asylum . . . second the nurses as women provided a moral and curative influence.⁹⁸

This statement reflects the assumptions that asylums should become hospitals and that nurses should be women. But Cowles also believed:

The nurses should be prepared in general, or ‘bodily nursing’ . . . and that an asylum school should teach all the principles of general nursing . . . not only for the sake of the asylum but for the public good.⁹⁹

To this end, he arranged affiliation experiences for the asylum nurses in general hospitals. Cowles’ insistence that these nurses learn all forms of nursing may be the reason that the question of a separate profession was never as intense in the

United States as it had been in Great Britain or that it became in Canada. Yet the general nursing body in the United States at first showed little interest in the asylum nurses. Church, referring to the early organization of nurses in 1893 argued, “The newly emerging organized group of nurses was in no position to take on the responsibility of asylum training.”¹⁰⁰ This failure to take on the responsibility may have played a role in the formation of a *Committee on Training Schools for Nurses* by the Medico–Psychological Association at its annual meeting in 1906. This committee, comprised of medical men, had a significant influence on the early formation and education of psychiatric nursing in the United States and foreshadowed the same role played in Manitoba fifty-four years later by a similar committee.

By the second decade of the twentieth century nursing leaders in the United States were taking a greater interest in mental hospital nursing. This may have been fostered by the establishment of clinics attached to general hospitals which provided opportunities for training nurses in psychiatry as part of the general programme. In particular, Euphemia Taylor worked to establish psychiatric nursing training at the Phipps Clinic of the Johns Hopkins Hospital Medical Centre. This demonstrated the commitment of the general nursing body to the integration of psychiatric nursing with general nursing.¹⁰¹ Taylor observed, “The mental institutions and the policies which guided them confined and restricted opportunities for development for the nurse and the care she might provide.”¹⁰²

Church describes the continuing evolution of psychiatric nursing as a specialty of general nursing and the role played by the committee on nursing education of the American Psychiatric Association (APA) (formerly the Medico-Psychological

Association). There was increasing cooperation between the APA and the National League for Nursing Education (later the National League for Nursing), and ultimately the general nursing body assumed control for psychiatric nursing. In the end it became a specialty of general nursing rather than a distinct profession.

There are important links between psychiatric nursing in Canada and the United States in the 1930s and 1940s described by both Church and Tipliski. The chairman of the APA Committee on Psychiatric Nursing in 1938 was a Canadian, Dr. George Stevenson, superintendent of the London Mental Hospital, in Ontario. In that capacity he would have been familiar with the philosophy of the American nurses. In 1945, he promoted the inclusion of mental health concepts into general nursing education and supported the idea of affiliation for all students.¹⁰³ Stevenson would also have been familiar with Laura Fitzsimmons, a nurse consultant, who had been hired in 1943 by the APA to survey mental hospitals in America and Canada. One of her recommendations was that every student nurse should have an affiliate experience in a mental hospital. She also recommended the discontinuation of training schools in mental hospitals.¹⁰⁴ How much Fitzsimmons' survey influenced the evolution of psychiatric nursing in Canada is unclear, but her recommendation that mental hospitals discontinue training programmes was certainly not popular with Dr. McKerracher of Saskatchewan.

Fitzsimmons' survey had been financed by the Rockefeller Foundation. This foundation also helped finance some of the mental health programmes which McKerracher was in charge of in Saskatchewan. The Rockefeller Foundation was committed to "improving the effectiveness of psychiatric theory and the efficiency of

psychiatric practice as part of an effort to rationalize the process of social reproduction.”¹⁰⁵ This commitment extended to Saskatchewan in 1944 when the new premier, Tommy Douglas, who had promised better health care to the people of Saskatchewan, applied to the Rockefeller foundation for funds. Although this was a socialist government bent on the eradication of capitalism, the conditions of this highly capitalist fund were:

Acceptable to the CCF, for over the course of the next decade the Rockefeller foundation and other large American philanthropies became involved in several aspects of the province’s mental health system.¹⁰⁶

One of the major thrusts of the reformed and refinanced mental health system in Saskatchewan was the training of specialists in psychiatric care, including nurses.

A Study of Psychiatric Nursing in Great Britain

In contrast to the specialty of psychiatric nursing in the United States, Great Britain had established a separate profession in 1891. The Medico-Psychological Association (MPA) began lectures for attendants, set examinations, and wrote a textbook. The textbook, the *Handbook for the Instruction of Attendants on the Insane*, was published by the MPA in 1885 and became “a milestone in the history of the education of mental nurses.”¹⁰⁷ Peter Nolan has explored several aspects of the profession in Great Britain from the late nineteenth century to the present. One of his studies focused on how mental nurses formed an identity for themselves outside the auspices of general nursing. He argued that the roots of the separate profession go back to the beginning of professional nursing in England. Florence Nightingale and the early general nursing leaders, especially Mrs. Bedford-Fenwick, were not merely indifferent to asylum nurses they were, in fact, outright hostile. In response to a

request from a member of parliament that the asylum attendants who had passed the examination set by the MPA be allowed to be registered as nurses, Bedford-Fenwick vigorously claimed that “asylum workers could not be called nurses and that the training of the MPA was inferior to that of general nurses.”¹⁰⁸

Not welcomed into the general nursing fold the value of an association was, however, recognized by the asylum attendants and so they formed their own, the Asylum Workers Association (AWA), which later evolved into the National Asylum Workers Union (NAWU).¹⁰⁹ Many asylum superintendents supported this move:

They saw it as beneficial to the respectability of psychiatry as a whole if the attendants of the mentally ill received greater recognition. Well respected nurses could but add to the prestige of the doctors who controlled them.¹¹⁰

This group was primarily concerned with working conditions, but also recognized the value of education. In 1923 they joined with the newly formed Mental Hospital Matrons Association and “both organizations recognized the primary importance of training in improving patient care and working conditions.”¹¹¹

Twenty years later a new group, the *Society of Mental Nurses*, formed and fell under the auspices of the Royal College of Nursing, an umbrella group for all nurses. Even this was controversial. When the mental nurses were placed on a supplementary register, not the main register, several matrons took exception, “Supplementary they felt, meant inferior.”¹¹² Controversy continues in Great Britain.

Nolan recounts the implementation of a new syllabus in 1982, “The first in the history of psychiatric nursing to be introduced without consultation with the Royal College of Psychiatrists.”¹¹³ However, the new found autonomy has another **side**, “The debate of the 1980s . . . concerns the very continuation of the profession of

psychiatric nursing”¹¹⁴. Direct entry into psychiatric nursing was to cease by 2000 and it was to become a branch for those who choose psychiatric nursing. Nolan, in his 1989 dissertation pondered:

It may also be that it is the first move in the eventual phasing out of psychiatric nursing if it proves to be a specialization unsuitable to the contemporary needs of clients and health professionals. . . . [I]t may be appropriate to ask whether . . . there is a long-term intention to look to a new type of professional person or agency to deliver care to the mentally ill in the community.¹¹⁵

Nolan’s study of psychiatric nursing in Great Britain places the evolution and education of different generations of psychiatric nurses into historical and socio-political context:

With specific reference to those periods when psychiatric nursing found itself under considerable pressure to change itself in some way. . . . [T]he 1980s he describes as a climate . . . when psychiatric nursing finds itself under threat.¹¹⁶

Nolan’s study is unique. He goes beyond an analysis of the socio-political factors that impacted the development of the profession to an examination of how an understanding of past concepts of psychiatric nursing can illuminate the present.

A Study of Psychiatric Nursing in Holland

A third major English language study of psychiatric nursing outside Canada is that of Boschma.¹¹⁷ Boschma analyzed the development of psychiatric nursing in four asylums in Holland between 1890 and 1920. She argued that as mental illness became conceptualized as a brain disease:

Mental patients should receive the same care and treatment as physically ill patients . . . and the asylum doctors argued they needed better trained personnel . . .that would have the same qualities as trained hospital nurses.¹¹⁸

She conceded that the model of training in the asylums closely followed the general nursing training in terms of gender, uniforms, and curriculum. The general nursing model was emphasized by the treatments the physicians employed, which included bed rest. Based on emerging views of the somatic causes of mental illness:

The new generation of psychiatrists considered bed rest therapeutic for both physical and mental exhaustion, and employed it widely for all sorts of psychotic patients.¹¹⁹

This form of therapy also required monitoring of vital signs and nursing care to prevent decubitus ulcers. These tasks are usually associated with treatment in general hospitals, but their application in the mental hospitals gave legitimacy to the psychiatrists, as well as the mental nurses. It also further reinforced the concept that mental illness was very similar to physical illness and mental nursing was a particular kind of nursing.

Boschma employed a social history analytical framework to examine life inside the asylums. In this way she highlighted not only the socio-political and medical context of mental nursing, but also the tensions caused by the introduction of a new class of worker, particularly for the male attendants. Boschma is one of the first researchers to highlight the dilemma of the male attendants in this new context. She identified their distress at being replaced by female nurses whose professional status made them eligible for promotion over male attendants. Attendants also lost social prestige, but one of the more poignant losses was that they were treated “as if they did not have the same level of civilization and compassion as a female nurse; some institutions did not even train male nurses.”¹²⁰ Boschma notes the importance of the male attendants in working with patients whose primary therapy was work. Although

this reflects the earlier days of asylum care, when the main form of therapy *was* moral order and work, the newer forms of treatment based on the medical model were only applicable to a limited number of patients. There was still a need for this kind of care.

Boschma asks the very important questions:

Should he be a nurse experienced in the care of the sick or should he be an artisan overseeing patients in work? Was the latter a nursing role or an artisan role? Or was the new nurse an artisan?¹²¹

This reflects two of the dilemmas of psychiatric nursing. First, the female gendered model of nursing discredits the large number of caring male attendants who performed many important tasks with patients and second, the medical model of mental illness has limited use in many situations. Many people suffering from mental disorder often need assistance with work and life skills that goes beyond the management of illness. This echoes Nolan's question of whether there will be a new kind of professional to work in the community.¹²² Boschma's description of the special role of male artisans was echoed thirty years later in Brandon when male attendants, with skills in woodworking and crafts, were selected to work in a new industrial therapy programme.

A Study of Psychiatric Nursing in New Zealand

In New Zealand, psychiatric nursing followed a similar pattern to the British model. Catherine Mary Prebble explored the changing context, culture, and identity of psychiatric nurses in that country from 1939 to 1972.¹²³ Her study shares a number of characteristics of other psychiatric nursing studies such as the ambiguous place of men, the ambivalent relationship with the general nursing body, and conflict between union values and the goals of professionalization. As was the case in the United

States and Holland, the male attendants were excluded from participating in nursing physically ill patients, a situation which caused “umbrage” amongst the attendants. The male attendants were as offended in New Zealand, as were the attendants in Holland, at the suggestion that they could not provide good care.¹²⁴ Unlike western Canada, a successful separate system of psychiatric nursing did not prevail in New Zealand. Despite the fact that there had been training and registration in the older asylum-type hospitals, eventually the separate system was discontinued. It was the female nurses who viewed absorption into the general nursing body as desirable. In 1972, the separate profession disappeared from New Zealand.

The works of Church, Nolan, and Boschma have become the models for psychiatric nursing history although each has contributed to the literature in a different way. Church has provided a long view of the evolution of psychiatric nursing as a specialty of general nursing in the United States. Nolan’s work considers not only the development of the distinct profession in the asylums of Great Britain, but also how psychiatric nursing education must adapt to meet changing needs or be replaced. Boschma, in her study of the development of mental nursing in Holland, highlights the dilemma of the male nurses in the newly feminized profession. Prebble’s study shares many similarities with those of Nolan and Boschma, and the dilemma of men in psychiatric nursing is highlighted in her study. The loss of psychiatric nursing as a distinct profession was as political in New Zealand as it was in eastern Canada. Each of these issues has relevance for the Canadian literature on psychiatric nursing.

Canadian Psychiatric Nursing Studies

Canada, geographically closer to the United States but ideologically closer to Great Britain, shares aspects of psychiatric nursing from both countries. There is the general nursing model of the United States in eastern Canada as well as the distinct model of Great Britain in western Canada. There are, therefore, two perspectives in the literature on Canadian psychiatric nursing. The first concerns the evolution of two forms of psychiatric nursing and the second focuses on the separate system in western Canada.

Undoubtedly, the most significant work, to date, on Canadian psychiatric nursing is that of Veryl Tipliski. Using extensive archival material, she explored in-depth the socio-political and gendered processes that resulted in the emergence of two systems of psychiatric nursing in Canada. Other Canadian studies have examined the emergence and development of the distinct profession in Saskatchewan.¹²⁵ There is a single study on the occupational and intellectual identity of psychiatric nurses in Brandon, Manitoba.¹²⁶

Veryl Tipliski's Study

The focus of Tipliski's study was on the struggle between the general nursing hierarchy of the Canadian Nurses Association (CNA) and the medical superintendents, particularly in Saskatchewan, to gain control of psychiatric nursing education in the 1940s and 1950s. As well as exploring the political and power perspective, Tipliski also employed a social historical approach and was "interested in students' and nurses' perceptions of their training and work, and nursing leadership viewpoints about education for psychiatric nursing."¹²⁷ Her research "focuses on

psychiatric nursing in the context of general nursing, medical psychiatry, and broader social, political and economic influences.”¹²⁸

Tipliski compared the development of psychiatric nursing in three provinces, Ontario, Saskatchewan, and Manitoba, each with different outcomes. Ontario followed the American route and made psychiatric nursing a specialty of general nursing. Saskatchewan became the first Canadian province to have a separate licensing body for psychiatric nurses in 1948. Manitoba, at the conclusion of Tipliski’s study, was teetering between the eastern Canadian model and the western Canadian model. She explained these different outcomes as the result of different administrative structures, different strengths and philosophical perspectives of the three provincial nursing bodies, and the gender and personality differences of the actors involved.

* * *

In Ontario, the general nursing body began taking an interest in the asylum nurses as early as 1905, just after the GNAO was formed. Some mental hospitals had superintendent-initiated programmes similar to those in the United States. The GNAO hoped to improve the calibre of all nursing education, including that conducted in asylums, and announced it would be establishing new standards when its proposed legislation was passed. Unfortunately its legislation was not passed, leaving it powerless to enforce its proposed standards. Tipliski supports the claim that the mental hospital superintendents, who did not want the nurses association to become too powerful, had a hand in scuttling the third reading of the bill. This proposed act

would have given the GNAO legal responsibility for nursing education in all hospitals, general and mental.

When the GNAO's legislation was finally passed in 1922, the inclusion in the register of the graduates of mental hospitals and other specialty hospitals was considered. Eventually, this registration became dependent on the length of affiliation in general hospitals and the meeting of particular standards. Over the next thirty years, through collaboration with the Ontario Department of Health and the medical superintendents, and the insistence on standards, the Registered Nurses Association of Ontario (RNAO) gradually gained control of psychiatric nursing education.

* * *

In Saskatchewan, the first efforts to provide an affiliation experience for the pupils from the mental hospitals had occurred in 1938 between the Saskatchewan Registered Nurses Association (SRNA) and the new student advisor/registrar, Kathleen Ellis. Despite a fair report on the mental hospitals from Ellis, nothing was concluded regarding affiliation, perhaps because of the intrusion of WWII.

Following the election of the CCF government in Saskatchewan in 1944, discussions regarding mental hospital nursing resumed. As already described by Mombourquette and Dickenson, the CCF government and Commissioner of Mental Health Dr. McKerracher were eager to reform the mental health system. The training of mental hospital staff was a part of the reform. Tipliski describes the negotiations and political maneuvering between McKerracher and Ellis around the issue of trained staff for the mental institutions. Despite a belief that affiliation for general students and a combined programme of some kind for the mental hospital students was the

ideal, the outcome was a separate training programme in the mental hospitals and no affiliation for the general students. Tipliski argued that Ellis appeared to defer to McKerracher and suggested, “Ellis’ leadership was limited by her gender.”¹²⁹ It also seems apparent that the SRNA was not as involved as the RNAO. Tipliski added “organized nursing in Ontario had a long-standing formal relationship with mental hospital training.”¹³⁰

Tipliski’s assessment of McKerracher was that he was manipulative and controlling, but he also subscribed to the view that mental nursing is very different from general nursing, and that psychiatric nursing knowledge derived from general nursing may not be the most appropriate for care of individuals in mental hospitals. He protested the use of the title *nurse* for the new professional, not only on the grounds that it would be confused with general nurses, but also:

The term psychiatric nurse is an unfortunate selection. In the first place the training programme is fitting the ward staff for a *therapeutic function rather than nursing function* (italics added)¹³¹

His choice of words may have been unfortunate, but he was no doubt trying to articulate the difference between *nursing*, as the “hands-on” approach to a patient’s physical needs, and *therapeutic function*, as the engagement with a patient with no obvious physical needs, in a relationship in which there are no physical tasks to perform. Six years later, Chief of the Mental Health Division of Health and Welfare Canada, Dr. Roberts, at the Canadian Nurses Association (CNA) conference at Banff, made a similar statement, “It is now believed that psychiatric nursing is inherently different from general nursing.”¹³² Both these statements reflect the opinion of Dr. Walk regarding the suitability of general nurses training for psychiatric nurses.¹³³

Tipliski interprets the views of McKerracher and Roberts as the wish for control over psychiatric nursing, whereas their statements may reflect the ongoing dilemma of how to articulate the distinctiveness of psychiatric nursing.

Nevertheless, once the training programme was in place at the provincial institutions in Saskatchewan, the next step was to gain professional status for the graduates through legislation. Tipliski describes how this was achieved in 1948. She argued that the process was as surrounded with politics and intrigue as the implementation of the training programme had been. The swift accomplishment of the legislation Tipliski described as a “stunning victory.”¹³⁴

Two years later news of this *victory* reached Ottawa. By then, Saskatchewan had been joined by British Columbia in the formation of an Association of Psychiatric Nurses and Alberta had made enquiries concerning the formation of an association.¹³⁵

The CNA also reported:

In the latter part of 1950 a director of nursing service in one of our mental hospitals expressed her concern over two related developments. . . . The increasingly strained relations between the few registered general nurses in the hospital and the greater number of other personnel participating in the nursing care.¹³⁶

Tipliski identifies the nursing director as Edith Pullan, and the provincial mental hospital as Essondale in British Columbia. Clearly, there was an emerging self-consciousness amongst the burgeoning associations in the three western provinces of their importance to mental health care.¹³⁷ These developments in the west alarmed the CNA and Tipliski argued that at the heart of this reaction was the lack of involvement of the general nursing bodies in psychiatric nurse training and the

control by medical psychiatrists. Therefore, at the biennial convention of the CNA in 1952, a resolution was put forward:

A special committee be appointed to study the problem of the preparation of non-professional psychiatric nursing personnel, and that provision be made for bringing the committee together to work on this problem.¹³⁸

One of the statements leading to this decision reads, “Whereas the nursing profession has a responsibility for the standard of nursing care in psychiatric hospitals.” This is somewhat ironic as there were few general nurses working in mental hospitals and most were reluctant to do so. It seems as though there was little interest in the care of mental patients until a new group decided to call themselves *nurses*. In early 1954, this special committee also met with representatives of the newly formed CCPN. It is notable that the three representatives of the CCPN were all men. Tipliski reported that this caused concern for Dr. Roberts, who was also at the meeting. But the presence of these men at this meeting reflects the fact that the leadership of the emerging profession in western Canada was primarily male.

A further source of tension between the two groups was also related to gender. The female dominated CNA was concerned that the untrained men were frequently paid as much as the female general nurses even though they had less education. But, as many asylum policies prevented women from attending to the male patients, there was little option but to staff the male wards with male attendants.¹³⁹

The report of the special committee was presented at the June 1954 Biennial CNA meeting in Banff. The preamble stated, “The problem of how to provide more adequate nursing care for the patients in our mental hospitals is very complex and very difficult.”¹⁴⁰ A survey of the mental hospitals revealed such low numbers of

registered nurses that, “Little more than custodial care is possible.”¹⁴¹ “Many workers are carrying nursing responsibilities for which they have had little or no preparation.”¹⁴² Certainly there may have been low numbers of registered nurses, but that may well have been because they chose not to work at the mental hospitals, therefore, the tasks had to be carried out by others. The assumption underlying this statement is that the attendants and nurses trained in the mental hospitals were not capable of providing care to mental patients, yet the general nurses to whom this was addressed had little or no experience in working with such patients. It was a classic dilemma of preparation versus experience.

This, of course, is one of the reasons that the staff working in the mental institutions were striving to improve their own credentials, so that better care could be provided. So while the CNA was discussing the issue, the attendants and nurses in the mental hospitals were improving their skills. That they were aided and abetted by the western provincial mental hospital medical superintendents was not popular with the CNA. The CNA recommended that the inclusion of more psychiatric concepts in the general nursing curriculum was one of the solutions. However, this would not necessarily guarantee that the general nurses would seek employment in the mental hospitals.

The competing views came to a head at the CNA convention in 1954 in Banff, Alberta. This is titled by Tipliski, “The Battle in Banff.”¹⁴³ The report of the CNA was presented by the male Chief of the Mental Health Division, Dr. Roberts. He favoured the emerging western Canadian model, and “hoped that the Canadian nursing profession will support this new approach.”¹⁴⁴ The assembled delegates

resolved to study how best to provide nursing care to psychiatric patients.¹⁴⁵ The CNA saw the solution, not in a separate profession, but in offering the western psychiatric nurses the opportunity to become registered nurses with a psychiatric specialty.

Despite efforts by the CNA to establish a programme which would combine mental and general nursing, the project failed, just as the medical superintendents of western Canada failed to impose their model of a distinct profession on the whole country. Tipliski concludes:

This project's failure, together with the imposed halt in the psychiatrists' eastward movement of western style psychiatric nurse training at the Manitoba-Ontario border, signified a 'parting at the crossroads' in Canadian education for psychiatric nursing.¹⁴⁶

Manitoba was caught in the crossfire.

* * *

Located geographically between Ontario to the east and Saskatchewan to the west, Manitoba straddled the two provincial psychiatric nursing systems ideologically. There were three schools of psychiatric nursing in Manitoba during the period studied by Tipliski but, because of its unique *combined programme*, Brandon was the only site included in her work. In 1942, BMH Superintendent Dr. Stuart Schultz, had successfully negotiated a *combined programme* in which female students could train for two years at BMH followed by two years at WGH. This enabled the students to write the provincial general licensing exams and to be registered with the MARN. They also received a diploma in psychiatric nursing from BMH. In 1947, a decision was made to reorganize this course and to have the general affiliation portion

of the programme with BGH rather than WGH. A note in the 1947 annual report of the training school reads:

It has been decided to reorganize the affiliate course. Affiliation with the Winnipeg General Hospital is to be discontinued. Affiliation with the Brandon General is to commence on September 1, 1948. It is suggested that this be a three and half year course instead of four years and that classes be admitted in January and September.¹⁴⁷

The course is outlined and it is noted that the students from both Brandon hospitals were to take the basic sciences together. The BMH students were also to affiliate at Ninette Sanatorium for tuberculosis nursing, Grace Hospital in Winnipeg for obstetrical nursing, and Children's Hospital for paediatric nursing. It is not documented how or why this decision was made, but Tipliski views this programme as superior to the "two plus two" being offered in conjunction with the WGH. It was a "true affiliation and six months shorter."¹⁴⁸

But the same year the first students graduated from this new *combined programme* in 1952, it is noted in the annual report of the BMH training school, under a heading entitled *Improvements*, "A thirty-month course for Psychiatric Nurses combined with training leading to a license in Practical Nursing is being organized. We are hoping to institute this course in January 1953."¹⁴⁹ In what way it was an improvement is not stated. The minutes of the MARN board meeting of May 31, 1954 record that Mrs. Hannah, the superintendent of nurses of BMH, notified the MARN that the *combined programme* was to be discontinued and the last class had enrolled in August 1953. The MARN board thanked Mrs. Hannah for this information without any recorded discussion.¹⁵⁰ The affiliation programme with the BGH had only just commenced, the first ten nurses had graduated in 1952, and already plans

were underway to replace it. By doing away with the general nursing training, this decision brought Manitoba closer to the distinct profession model of western Canada. As the Selkirk and Portage institutions already had a combined programme with the Licensed Practical Nurses, this would bring the three facilities into line.

In the 1953 annual report of the Manitoba Department of Health and Welfare, Superintendent Schultz of BMH states that amongst the visitors to the institution in that year was “Miss Winnifred Barratt, Reg. N., Registrar-Consultant for Licensed Practical Nurses.”¹⁵¹ The purpose of Barratt’s visit is not identified in the report, but it may well have had to do with the fact female students were now going to be able to pursue a combined Licensed Practical Nurse (LPN) diploma in conjunction with their Mental Nurse diploma. Perhaps she wished to see the facilities of the institution. The Executive Secretary of the MARN also visited that year, as well as Miss Frances McQuarrie, nursing education secretary of the CNA. McQuarrie was one of the authors of the report on psychiatric nurses training of 1954.¹⁵²

Informal speculation as to the reason for the demise of the successful *combined programme* is offered by some of the participants. “They (the doctors) didn’t want us to get too smart!” Another explained that the nurses with the RN had more job mobility and they left the employ of the mental hospital when other opportunities arose. This seems a more likely explanation. But, for whatever reason, the hopes of a *combined programme* in the mold of eastern Canada seemed to be slipping away at Brandon.¹⁵³

The Manitoba situation is viewed by Tipliski as having elements of both the eastern and western models. She argues that Manitoba could have followed either the

eastern model of psychiatric nursing as a specialty of general nursing or the distinct profession model of the west, “Manitoba bridged the two regions, tilting first to the east and then to the west.”¹⁵⁴ She argues that the opportunity to follow the eastern model was lost when the MARN, concerned with the revision of its own act, refused to ensure that all general nursing students would affiliate in a psychiatric setting. This meant that while the mental nurses were away on affiliation the mental hospitals were understaffed. The superintendents were concerned with the need for service and saw the replacement students as necessary. The MARN was philosophically opposed to this position, but “it was also concerned with the lack of facilities and resources at the Brandon and Selkirk mental hospitals. Rather than taking the lead, it retreated from the issue.”¹⁵⁵

Psychiatric nursing in Manitoba continued to be ideologically ambiguous in the 1950s while its neighbour to the west was further developing its distinct character.

Saskatchewan Psychiatric Nursing Studies

The Saskatchewan studies on psychiatric nursing illustrate different perspectives on psychiatric nursing history. The political aspect has already been discussed in the work of Dickenson and Mombourquette. Tipliski views it from a gender perspective in the failure of the SRNA to wrest control away from powerful political and medical men. In 1973, Fanny Kahan, in an anecdotal celebratory style recorded the first twenty five years of the Saskatchewan Psychiatric Nurses Association (SPNA) 1948-1973. She viewed the establishment of psychiatric nursing as an accomplishment, with men playing a leading role.

A unique psychiatric nursing education programme, started in Saskatchewan in 1972, is analysed by Sandra Bassendowski. This programme moved psychiatric nursing education out of the mental hospitals and into the college system along with diploma nurses and nursing assistants. These three groups shared a common core curriculum.¹⁵⁶

In 1998, Susan Taylor Wood also examined the education of psychiatric nurses in Saskatchewan, 1930-1997. She explored the most recent change to affect the profession in Saskatchewan, the termination of any form of a separate educational programme for psychiatric nursing education. The Registered Psychiatric Nurses Association of Saskatchewan (RPNAS) joined with a Saskatchewan Nursing Education Coalition and in 1996, the Nursing Education Programme of Saskatchewan (NEPS) was launched.¹⁵⁷ The implications of this decision are still being evaluated.

Finally, Angela Martin¹⁵⁸ analysed the professionalization of psychiatric nursing in Saskatchewan from 1914 to 2003. Martin identified five *determinants of destiny* which she employed to trace the professionalization of psychiatric nurses in that province. The first determinant in her model is the changing concepts of insanity. The shift from “hopeless condition” to medical illness created the opportunity for the evolution of special personnel including trained attendants and mental nurses.

Martin identified as the second determinant the political and social conditions of Saskatchewan which governed how services would be delivered to the inmates of the provincial asylums. Convenience rather than clinical need determined how the mental nurses would be trained and deployed. Mombourquette, Dickenson and Tipliski share this view.

Martin identified the third determinant as gender. She equates the development of psychiatric nursing with general nursing. But this is an awkward fit as she deliberately omits the very significant numbers of men and the roles they played in the development of psychiatric nursing. She argued that the word nurse, and all its gendered connotations, affected the professional development of psychiatric nurses, “The most profound similarity between the two groups was the influence of gender on their professional development.”¹⁵⁹ This is arguable, however, in view of the fact that many of the initiatives towards professionalization were initiated by men.

Martin’s fourth determinant was the conflict over the entitlement to use the term *nurse*. She suggests that the tension between the two kinds of nurses were not merely turf wars:

The enduring struggles between psychiatric nurses and general nurses were the result of the general nurses’ belief that their type of nursing was superior to mental nursing.”¹⁶⁰

She observed, however, that general nurses did not want to work in asylums and this “paved the way for the establishment of the profession of psychiatric nursing.”¹⁶¹

The fifth and final determinant, and according to Martin “arguably the most important to professional development of any group is the work of its members and of its professional association.”¹⁶² As the psychiatric nurses expanded their work roles into community settings, the professional association worked to achieve more respect and higher education for the members. The professional association also worked to gain control over its educational programme. This was finally accomplished in 1972,

twenty four years after its inception. Martin also discusses the implementation of the NEPS programme in 1996.

Martin developed a useful model for examining the professionalization of psychiatric nursing, but her comparison with general nursing highlights the similarities rather than the distinctive features. Nevertheless, her analysis illustrates the numerous pressures which impact psychiatric nursing.

The Saskatchewan literature represents a number of different perspectives on psychiatric nursing education: as political expediency, as a form of post secondary education, as a professionalization history, and as a celebratory history. The Saskatchewan literature also highlights the important role of men in the evolution of psychiatric nursing in western Canada. Many of these perspectives are echoed in the small Manitoba literature. They also offer a segue into a broader philosophical discussion of the nature of psychiatric nursing.

Manitoba Psychiatric Nursing Studies

The Manitoba literature on psychiatric nursing reflects many of the features of the American, British, Dutch, New Zealand, and Saskatchewan experiences but two features distinguish the history of the profession in Manitoba. The first is how close Manitoba came to following the eastern general nursing model. The second, but related feature is Manitoba's lateness, relative to its western neighbours, in acquiring distinct legislation. Indeed, as Tipliski so aptly states, Manitoba could have swung to the east or the west.

There is a single study by Christopher Dooley in which he examines the development of psychiatric nursing at the BMH between 1919 and 1946. Dooley

concludes that the failure of the *regular nursing* hierarchy to recognize the training and skills of the psychiatric nurses resulted in their consolidation and determination to *be different*. General nurses staked their claim to proprietary knowledge in the performance of ritualized techniques, but Dooley argues, “In caring for individuals without an expectation of cure, mental nurses were able to lay claim to a specific skill set that differentiated them from the general nurses.”¹⁶³ The concept of *difference* is one of the most common in psychiatric nursing literature, yet the differences are difficult to articulate. Nevertheless, some of the subjects in Dooley’s study found unique ways to achieve this. For example, one nurse made the distinction, “They [general nurses] gave their care, but we gave loving care.”¹⁶⁴ This struggle to articulate the difference, not only in legal or political terms, but also in philosophical terms, continues.

Dooley highlights the ways in which the nurses at BMH forged an occupational and intellectual identity for themselves based on their unique ability to care in an unpredictable environment, but he drew heavily on Kathryn McPherson’s framework. McPherson developed her framework to analyze the development, organization, and ethos of general nursing in general hospitals in Canada. This framework may not reflect many of the realities of mental hospitals and mental hospital nursing. Dooley’s contribution lies in his foregrounding, not the political nature of psychiatric nursing, but its philosophical nature.

Neither Dooley nor Tipliski took their works beyond the 1950s, and the male attendants received little attention. Nevertheless, they have greatly furthered the understanding of psychiatric nursing in Manitoba, Dooley by suggesting that the very

environment and culture of the asylum setting consolidated a distinct occupational identity for the female nurses and Tipliski by suggesting that it had more to do with external factors. Tipliski argues that the failure of the MARN to show leadership opened the door for the development of the distinct profession. But psychiatric nursing did not spring up in Manitoba just because the MARN failed to seize the moment in 1953 and the CNA lost the battle at Banff in 1954. Other contingencies converged and culminated in the opportunity for its emergence. A group of male attendants at the provincial institutions were poised to seek their own recognition; there was a model of professionalization of psychiatric nursing in the other three western provinces; and there was the CCPN, albeit small and confined to three provinces, who wished to include Manitoba in its membership.

Conclusion

From the psychiatric nursing literature reviewed, three themes recur: the emergence of psychiatric nursing from the asylum context, usually at the behest of the medical superintendents; the ambiguous place of men in the profession; and the modeling of psychiatric nursing on general nursing. These themes persisted in the evolution and professionalization of psychiatric nursing in Manitoba in the 1950s and have generated the questions for the present study. In the next chapter the socio-political context of psychiatric nursing in Manitoba in the 1950s and the gradual emergence of the distinct profession are described. The work culture, therapeutic strategies, and education of psychiatric nurses are explored.

Endnotes Chapter 2

1. Boschma, "Creating Nursing Care for the Mentally Ill". Wood, "Changing Times". Prebble, "Ordinary Men and Uncommon Women".
2. Church, "That Nobel Reform". Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing in Three Canadian Provinces".
- 3 Dooley, "When Love and Skill Get Together". Peter Nolan, "Psychiatric Nursing, Past and Present: The Nurses Viewpoint,"
4. Mark S. Micale and Roy Porter, eds., *Discovering the History of Psychiatry* (New York: Oxford University Press, 1994), 4.
5. Thomas E. Brown, "Foucault Plus Twenty: On Writing the History of Canadian Psychiatry in the 1980s," *Canadian Bulletin of Medical History* 2 (1985): 23-49.
6. Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*. Translated by Richard Howard. (New York: Random House, 1965).
7. D. J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, rev. 2d ed., (Boston: Little Brown, 1990), xxi.
8. R. D. Laing, *The Divided Self* (Harmondsworth, Middlesex: Penguin Books, 1965). Thomas Szasz, *The Myth of Mental Illness* (New York: Harper and Row, 1961). Erving Goffman, *Asylums* (Garden City, NY: Anchor Books, 1961).
9. Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (New York: St. Martin's Press, 1979). Rothman, *The Discovery of the Asylum*.
10. Rothman, xxxvii.
11. Brown, 23.
12. Thomas Brown, "Dance of the Dialectic? Some Reflections (Polemic and Otherwise) on the Present States of Nineteenth-Century Asylum Studies," *Canadian Bulletin of Medical History* 11 (1994): 267-296, 277.
13. Ibid., 274.
14. Ibid., 274.
15. Gerald N. Grob, *The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830-1920* (The University of North Carolina Press:

Chapel Hill, 1966). Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985). Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1850-1883* (Cambridge: Cambridge University Press, 1984). Patricia O'Brien D'Antonio, "Negotiated Care: A Case Study of Friends Asylum, 1800-1850" (Ph.D. diss, University of Pennsylvania, 1992). Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, NJ: Rutgers University Press, 1987).

16. Grob, 10.

17. Ibid., 11.

18. Ibid., 62.

19. Jones. *The Therapeutic Community*

20. Grob, 12.

21. Ibid., 66.

22. Ibid., 248.

23. Digby, 40.

24. Ibid., 142.

25. Ibid., 155.

26. McKee Archives, Brandon University, Brandon, Manitoba Shelf Box 3, (hereafter SB) File 3, Anonymous Male Nurse to Pincock, May, 1935.

27. Samuel Edward Dole Shortt, *Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry* (Cambridge: Cambridge University Press, 1986), 46.

28. Medico-Psychological Association, *Handbook for Mental Nurses* (London: Bailliere, Tindall and Cox, first published 1885).

29. Digby, 166.

30. Tomes, 139.

31. Ibid., 185.

32. D'Antonio, 166.

33. Ibid., 175.
34. Dwyer, 164.
35. Ibid., 170.
36. Ibid., 176.
37. Ibid., 179.
38. Brown, "Dance of the Dialectic", 268.
39. Edward Shorter, ed., *TPH: History and Memories of the Toronto Psychiatric Hospital, 1925-1966* (Toronto, Ontario: Wall & Emerson, 1996), 5.
40. Ibid., 7.
41. Micale and Porter, *Discovering the History of Psychiatry* 4.
42. Ibid.
43. Shorter, 10.
44. Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Psychiatry and the Homewood Retreat, 1883-1923* (Montreal and Kingston: McGill-Queen's University Press, 1989).
45. Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces" in ed. SED Shortt, *Medicine in Canadian Society: Historical Perspectives* (Montreal: McGill-Queen's University Press, 1981), 93-114, 99.
46. Ibid., 107.
47. Ibid., 111.
48. Cyril Greenland, "Origins of the Toronto Psychiatric Hospital" in ed. Edward Shorter *TPH*: 19.
49. Danielle Terbenche, "'Curative' and 'Custodial': Benefits of Patient Treatment at the Asylum for the Insane, Kingston, 1878-1906," *The Canadian Historical Review* 86 (1) (March, 2005): 29-52.
50. Ibid., 36.

51. Patrick J. Connor, "Neither Courage nor Perseverance Enough: Attendants at the Asylum for the Insane, Kingston, 1877-1905," *Ontario History* 88 (4) (1996): 251-272, 266.

52. *Ibid.*, 266.

53. *Ibid.*, 267.

54. Shortt, *Victorian Lunacy*.

55. *Ibid.*, 3.

56. *Ibid.*, 71. Chapter 3.

57. *Ibid.*, 153.

58. *Ibid.*, 44.

59. *Ibid.*, 44.

60. Refvik, *History of Brandon Mental Health Centre* 115. An anonymous source related a story of an attendant who was let go by the chief male attendant but because he had an excellent singing voice Dr. Schultz, the Superintendent, rehired him!

61. Warsh, *Moments of Unreason* 28.

62. *Ibid.*, 29.

63. *Ibid.*, 35. In Warsh's work Barnes is identified as Edward. In the first annual report he submitted from Selkirk he is called Edgar. His obituary only identifies him as Dr. E. C. Barnes. There is no indication that Barnes practiced any psycho-gynaecological procedures when he was at Selkirk.

64. *Ibid.*, 35. Thomas A. Pincock, "A Half Century of Psychiatry in Manitoba," *Canada's Mental Health* 14 (May 1970): 4-10, 6.

65. Warsh, "Tipliski, Parting at the Crossroads: The Development of Education for Psychiatric Nursing," 37.

66. Warsh, 115.

67. *Ibid.*, 115.

68. Alice J. Baumgart and Jenniece Larsen, eds., *Canadian Nursing Faces the Future: Development and Change* (St. Louis, MO: C. V. Mosby, 1988), 412.

69. Warsh, 116.

70. Shorter, *TPH*: viii.

71. Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing," Chapters 5 and 6.

72. Ian H. Clarke, "Public Provisions for the Mentally Ill in Alberta, 1907-1936" (master's thesis, University of Calgary, 1973), 5.

73. *Ibid.*, 153.

74. Ronald A. La Jeunesse, *Political Asylums* (Edmonton, Alberta: The Muttart Foundation, March 2002). This work has no footnotes though many sources of information are identified. La Jeunesse makes no mention of psychiatric nursing in this work even though psychiatric nurses formed an association in 1950 and the Psychiatric Nurses Training Act came into being in 1955.

75. Paul Susumu Nishida, "The Establishment of Saskatchewan's Mental Hospitals 1912-1940" (master's thesis, University of Regina, 1988).

76. Nishida, 47 and 48 quoting from The Hincks Report.

77. F. H. Kahan, *A Different Drummer*. Kahan also describes the role of the male attendants in forming the Association.

78. Harley D. Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984*, (University of Regina, Regina, Saskatchewan: Canadian Plains Research Centre, 1989). Duane John Mombourquette, "A Government and Health Care: The Co-operative Commonwealth Federation in Saskatchewan, 1944-1964" (master's thesis, University of Regina, May, 1990).

79. Dickinson, xiv.

80. *Ibid.*, 103.

81. *Ibid.*, 107.

82. J. Matas, "The Story of Psychiatry in Manitoba," *The Manitoba Medical Review* (June-July 1961): 360-364. Pincock.

83. Johnson, "A History of Mental Health Care in Manitoba". Edginton, "Moral Treatment to Monolith". Refvik, *History of the Brandon Mental Health Centre*

84. Peter Nolan, "The Founding of Psychiatric Nurse Training and its Aftermath," *British Journal of Psychiatry* (159) (1991): 46-52, 46.
85. Boschma, "Creating Nursing Care for the Mentally Ill" 5.
86. Olga Church, "From Custody to Community in Psychiatric Nursing," *Nursing Research* 36 (1987): 48-55, 51.
87. Elvin H. Santos and Edward Stainbrook, "A History of Psychiatric Nursing in the Nineteenth Century, Part I," *Journal of the History of Medicine* (Winter 1949): 48-74, 59.
88. *Ibid.*, 71.
89. *Ibid.*, 73.
90. Alexander Walk, "The History of Mental Nursing," *The Journal of Mental Science* (January 1961): 1-17, 12.
91. *Ibid.*, 13.
92. *Ibid.*, 13 quoting David Yellowlees.
93. M. Carpenter, "Asylum Nursing Before 1914: A Chapter in the History of Labour," in ed. C. Davies *Rewriting Nursing History* (London: Croom Helm, 1980).
94. Church, "That Nobel Reform," 27.
95. Boschma, "Creating Nursing Care for the Mentally Ill," 11.
96. *Ibid.*, 12.
97. Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing," 7.
98. Church, 41.
99. *Ibid.*, 44.
100. *Ibid.*, 61-62.
101. *Ibid.*, 88. In particular see the correspondence between Taylor and Dr. Adolph Meyer described by Church.
102. *Ibid.*, 76.

103. Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing," 346, quoting G. H. Stevenson, "The Place of Mental Hygiene and Mental Nursing in this Reconstruction Period," *The Canadian Nurse* 41 (7) (July 1945): 519-522.
104. Tipliski, 347. Laura Fitzsimmons, "Mental Hygiene and Hospital Nursing," *The Canadian Nurse* 41 (7) (July 1945): 523-526.
105. Dickenson, 76.
106. Ibid., 75.
107. Peter Nolan, *A History of Mental Health Nursing* (London: Chapman & Hall, 1993), 64.
108. Ibid., 69.
109. Ibid., 70. F.R. Adams, "From Association to Union: Professional Organization of Asylum Attendants, 1869-1919," *British Journal of Sociology* XX (1) (1969): 11-25.
110. Nolan, 70.
111. Ibid., 78.
112. Ibid., 104.
113. Nolan, "Psychiatric Nursing, Past and Present," 37.
114. Ibid., 2.
115. Ibid., 2.
116. Ibid., 3.
117. Boschma. "Creating Nursing Care for the Mentally Ill"
118. Ibid., 5.
119. Ibid., 104.
120. Ibid., 340.
121. Ibid., 345.
122. Note 116, chap. 2, this study.

123. Prebble. "Ordinary Men and Uncommon Women"

124. Ibid., 4.

125. Sandra Bassendowski, "Development of the Core Curriculum in Nursing at Wascana Institute of Applied Arts and Sciences" (master's thesis, University of Regina 1988). Wood "Changing Times". Angela Martin, "Determinants of Destiny"

126. Dooley, "When Love and Skill Get Together".

127. Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing", 19.

128. Ibid., 19.

129. Ibid., 314.

130. Ibid., 372.

131. Ibid, quoting letter McKerracher to Ellis March 15, 1948.

132. Ibid., 448 quoting C. A. Roberts address to the Meeting of the Canadian Nurses' Association, Banff, Alberta June 10, 1954.

133. Note 90, chap. 2, this study.

134. Tipliski, 300.

135. Archives of Alberta Psychiatric Nurses' Association Historical Files. Letter from Frank Jones (Saskatchewan Registered Psychiatric Nurses' Association) to Campbell Evans (Ponoka, Alberta) September 16, 1949 suggesting they may be interested in forming an association similar to the one Saskatchewan already had. Letter from W. L. Pritchard (The British Columbia Psychiatric Nurses' Association) to C. W. Evans (Ponoka, Alberta) March 30, 1950 congratulating Alberta on their progress towards legislation and offering help.

136. Canadian Nurses Association Archives (hereafter CNA Archives), WY 160 C25. The Preparation of Nursing Personnel for the Care of the Mentally Ill, A Report prepared by the Committee on Educational Policy for presentation to the Canadian Nurses' Association at its Biennial Meeting, June, 1954, 1.

137. Author Unknown, "A Century of Psychiatric Nursing," *Canadian Journal of Psychiatric Nursing* (July-August, 1979): 5-7.

138. CNA Archives, Minutes of General Meeting June 2-6, 1952.

139. The practice of rigidly segregating male and female staff and patients was adhered to in the majority of mental hospitals at that time.

140. CNA Archives, *The Preparation of Nursing Personnel for the Care of the Mentally Ill*. 6.

141. *Ibid.*, 9.

142. *Ibid.*, 10.

143. Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing," 447.

144. *Ibid.*, quoting C. A. Roberts address to The Meeting of the Canadian Nurses' Association, Banff, Alberta June 10, 1954, 448.

145. Tipliski, 452.

146. *Ibid.*, 463.

147. Annual Report of the Training School, 1947. Records maintained by staff of the Brandon Mental Hospital School of Nursing.

148. Tipliski, 328.

149. Annual Report of the Training School, 1952. Records maintained by staff of the Brandon Mental Hospital School of Nursing,

150. College of Registered Nurses of Manitoba Archives (hereafter CRNM Archives). Minutes of MARN Board Meeting, May 31, 1954.

151. Legislative Library, Winnipeg, Manitoba. (hereafter Legislative Library) Manitoba Department of Health and Welfare Annual Report 1953, 179.

152. *Ibid.*

153. Informal discussions with participants from that programme.

154. Tipliski, 484.

155. *Ibid.*, 470.

156. Bassendowski. "Development of the Core Curriculum,"

157. Wood. "Changing Times,"

158. Martin. "Determinants of Destiny,"
159. Ibid., 143.
160. Ibid., 144.
161. Ibid., 144.
162. Ibid., 145.
163. Dooley, "When Love and Skill Get Together," 172.
164. Ibid., 175.

CHAPTER 3

... TO BEDSIDES ...

Introduction

The period 1955 to 1960 was critical to the evolution of psychiatric nursing in Manitoba. Changes to the structure of nursing education in the three provincial institutions coupled with few alternatives for the provision of care, and increasing medicalization of the mental hospitals created the space for the subsequent emergence of the western model of psychiatric nursing education. The existing psychiatric nurses associations in the three provinces to the west: Saskatchewan, Alberta, and British Columbia, along with a growing national body of registered psychiatric nurses encouraged Manitoba to seek its own legislation. This chapter is an examination of how these factors coalesced to bring about the separate legislation.

This chapter is divided into six sections. The first section is an examination of the socio-political status of psychiatric nursing from 1955 to 1960. The second section is a discussion of the culture, therapeutic strategies, and nursing work in the mental institutions. The third section reflects on the knowledge, assumptions, and curricula beliefs which guided the training programmes. The role of the male attendants is discussed in section four. In section five, the influence of the recently formed Canadian Council of Psychiatric Nurses (CCPN) is identified. The chapter concludes with the passage of the pivotal legislation of 1960 which gave legal status to the psychiatric nurses and control of their education to a committee.

Socio-political Status of Psychiatric Nursing, 1955-1960

In 1955, psychiatric nursing in Manitoba was in legal limbo. The general nursing (RN) component of the combined programme at BMH, which bore many similarities to the proposed curriculum of the CNA of 1955,¹ was about to be discontinued. The MARN seemed indifferent to this and the CNA had apparently lost the battle at Banff. The three provinces to the west already had licensing bodies for psychiatric nurses, and the CCPN, which had been formed in 1951, was eager to include Manitoba, but Manitoba had no legal recognition for psychiatric nurses.

Nevertheless, care was still being provided in some form or another to the residents and daily life went on at the three institutions at Brandon, Selkirk, and Portage La Prairie. The three institutions also ran training programmes and conferred a psychiatric nursing diploma on successful students although there was no consistency in the training. It is difficult to determine what constituted the curriculum content, or the teaching and learning strategies. At Brandon, the decision had been made to discontinue the RN training and replace it with an LPN diploma.²

The female students at Selkirk and Portage had been receiving training as LPNs since 1946 and 1950 respectively.³ As two of the three provincial psychiatric nurse training schools were already engaged with the LPN programme it is possible that the decision to replace the RN programme at Brandon was a move to bring them into alignment. Over the next thirteen years a unique relationship developed between the mental hospital nursing instructors and the LPN Advisory Council.

* * *

The relationship between the LPN Advisory Council and the mental hospital administrations had begun in 1945, shortly after LPN training was legislated into existence, and was about to start the first programme. A meeting of the new LPN Advisory Council was held in December 1945. Deputy Minister of Health Dr. Jackson, and representatives from the three mental hospitals “were present to discuss the participation of their institutions in the training of practical nurses.”⁴ The BMH Superintendent of Nurses Miss Wilkes stated that they could not participate in practical nurse training as they already had one training programme, the *combined* RN programme, and they had limited facilities. Perhaps another reason was that the LPN regulations stated, “Any hospital conducting a training school for registered nurses shall not be eligible to provide training for practical nurses.”⁵ But, it was noted that Brandon could be considered in the future.

At this meeting, Selkirk Mental Hospital (SMH) was represented by Medical Superintendent Dr. Johnson, who reported:

With a few changes in the two year course being conducted at the Selkirk Mental Hospital at the present time the minimum curriculum and requirements regarding the conduct of the course for practical nurses could be complied with and the Selkirk General was willing to provide obstetrical experience.⁶

Portage was also represented by a physician, Acting Medical Superintendent Dr. Bristow, who stated:

At the Home for Mental Defectives, Portage La Prairie a three year course with 273 hours of theory including obstetrics is given, but he doubted if they could obtain obstetrical experience in order to give a general training. Dr. Jackson suggested either Neepawa or Gladstone might provide this experience.⁷

The fact that three physicians were present at this important meeting discussing nursing education is symbolic of the times.

In the discussion which followed certain issues unique to the current mental hospital training system were identified including the length of the existing programme, remuneration for students, and the timing of examinations. The question of the status of the male attendants in the mental hospitals was also raised. It was suggested by one board member that “most graduates from mental institutions could be included under the waiver.”⁸ The waiver referred to the process that was used to deal with female practical nurses who had been practicing for a number of years prior to the enactment of a licensing body. Generally referred to as a *grandfather clause* it seems that due consideration was to be given to the male attendants who had been practicing psychiatric nursing for some time. The agreement to meet again and discuss these issues suggests that a spirit of cooperation existed between the two groups. At the February 11, 1946 meeting, it was agreed that the LPN training could commence at Selkirk and Portage in September 1946.⁹

On February 26, 1946 a conference was held attended by two members of the LPN Advisory Council, the Provincial Psychiatrist, the superintendents of Portage and Selkirk, the Civil Service Commissioner, and the Deputy Minister of Health:

To discuss what might be done so that girls now entering Selkirk and Portage La Prairie to take a course in mental nursing, could attain at the same time, a certificate of a practical licensed nurse.¹⁰

The group concluded that with four months of experience in a general hospital the students would be eligible to hold a diploma in psychiatric nursing and a

certificate in licensed practical nursing. In September 1946, therefore, a new era began in psychiatric nurses' training in Manitoba, at least at SMH.

The programme was derailed for four years at Portage. Dr. Atkinson, who had just returned from war service, may not have been aware of earlier discussions and he informed the students they did not need to go to the general hospital for affiliation. Apparently two students from the Portage School were unhappy with the general hospital experience and persuaded their classmates to request they not go on affiliation. Atkinson supported this minor rebellion by telling them they certainly did not need the general affiliation for mental nurse training. When the students were advised by the registrar of the LPN Advisory Council that without the LPN diploma their careers would begin and end in the mental hospital, they relented, but Atkinson did not. He informed the Advisory Council:

For the immediate future at least they would not be able to comply with the regulations for the training of practical nurses and would only train mental graduates.”¹¹

Atkinson must have reconsidered. In 1950 it is recorded that Portage School for Mental Defectives would now be offering the LPN diploma.¹²

In the period 1950-1955 Selkirk and Portage were strengthening their combined LPN/psychiatric nurse training, while at Brandon the combined RN/psychiatric nurse training, which had been the jewel in the crown of the Manitoba system, was slowly being eroded. There are no conclusive answers to the question as to why Selkirk and Portage did not follow the lead of Brandon in securing general nursing affiliate training, rather than Brandon aligning with Selkirk and Portage. Perhaps working with the newly formed LPN Advisory Council was easier than

working with the long standing MARN although there was also a long history in Brandon of the RNs at BGH and those at BMH working together. On the other hand, many of the graduates from the combined programme left BMH for other employment. It has been suggested it may not have been a worthwhile undertaking.¹³ There may have been other advantages to the LPN affiliation in contrast to the RN affiliation.

The relationship between the psychiatric nursing instructors in the mental hospitals and the LPN Advisory Council seemed less fraught with tension than the relationship with the MARN. The minutes of meetings suggest a spirit of cooperation. By the mid-1950s, half the students acquiring LPN diplomas were also enrolled in the combined LPN/psychiatric nurse training programmes.¹⁴ The admission requirement for both the psychiatric nurse and the LPN training was grade X. The LPN Advisory Council was willing to consider how to incorporate training for males and made efforts to accommodate them. The LPN course also provided adequate nursing skills and knowledge for psychiatric nursing in mental hospitals. The question of how much general nursing knowledge is necessary, or even appropriate, for psychiatric nursing is a contentious one. It has never been satisfactorily resolved. Many of the nursing skills taught in general (RN) training would never be used in psychiatric nursing situations.

Finally, the relationship with the LPN body provided the opportunity for the nursing instructors from the mental institutions to engage in collegial relationships with other nursing instructors who seemed genuinely interested in the students from the mental hospitals. By 1953, instructors from the three mental institutions were

actively participating in the LPN instructors meetings. They also participated with the Registrar of the LPN Advisory Council in developing policies related specifically to the combined LPN/psychiatric nurse training programme.¹⁵ This satisfactory arrangement with the LPN programme lasted for thirteen years, until one of the jolts and surprises of history terminated it.

The Culture and Therapeutic Strategies of the Mental Institutions

Brandon and Selkirk were designated as mental hospitals, whereas, the facility at Portage La Prairie was identified as *The Manitoba School for Mentally Defective Persons*, although it was generally shortened to The Manitoba School or simply Portage. Because of the differences between the nature of the patients in this facility and the mental hospitals, its inclusion in discussions of psychiatric nursing causes some difficulties, but these were largely ignored in the 1940s. Wendy Nehring states:

Prior to WWII, the writings about nurses in mental retardation primarily appeared within a discussion of ‘mental’ nursing which included mental illness or insanity and mental retardation.¹⁶

In Manitoba, no distinction was made between the mentally ill and the mentally retarded. All three provincial institutions were grouped for administrative and reporting purposes, but it is useful to discuss the Portage School separately.¹⁷ Examining the nature of the work at Portage also underscores some of the challenges of defining psychiatric nursing.

Portage

The Portage institution, built in 1890, was originally called the *Portage Home for Incurables*. As the name suggests, it was a place of refuge for those who did not fit any particular category of illness. When the Portage Home opened in 1890 the

Selkirk Asylum, built in 1886, was already overcrowded and “17 harmless lunatics were moved from Selkirk to this new facility.”¹⁸ There were few criteria for admission and a brief historical article notes:

At this time many types of patients were admitted including old people, patients with physically incurable diseases not requiring treatment in a general hospital, paralytics and mental defectives.¹⁹

This reiterates Barry Edginton’s observation:

Unfortunately, this institution became the dumping ground for the problem cases of the province. The name *Home for Incurables* is misleading. . . . Apparently any family in Manitoba which had a troublesome member, either young or old simply pressed it onto the *Home* . . . an unhappy conglomeration of idiots, imbeciles, epileptics, insane, seniles and mentally normal people suffering from incurable diseases.²⁰

During its first forty years, the facility was managed by superintendents who were not physicians, but who seemed to be good managers. It is noted that the first superintendent was interested in horticulture and landscaping, and he planted many beautiful trees. During the tenure of the second superintendent another building was added which allowed the separation of the old folks from the defectives, a new barn was built, and a fine Holstein herd was started. Under the last non-medical superintendent electricity came to the home, overcrowding continued, and the name was changed to the *Home for the Aged and Infirm*. During these forty years, medical care was provided by physicians from the town of Portage La Prairie. There did not seem to be any particular nursing care.²¹

In 1930, a new era was ushered in at the Portage Home. A colorful and energetic young physician, Dr. Henry Atkinson, came from SMH to act as the first medical superintendent. During his 35 year tenure, which only ended with his accidental death in 1965, he supervised many changes at the institution but his style

was also characterized by many ambivalences. On one hand, he recognized the differences between the patients at Portage and those at Brandon and Selkirk; on the other hand, he also embraced a philosophy of *general nurses* being essential to the running of the home. The first annual report of Atkinson provides an insight into his philosophy and also his perception of the role of psychiatric nurses.

The lengthy narrative provided in the annual report details the difficulty of sorting through previously badly kept records in order to provide, at minimum, a demographic picture of the patient population. His focus was on the advancement of care of *mentally deficient* and he urged the removal of the elderly “at the earliest possible date.”²² He clearly saw this facility not so much as a hospital, but as a home, a school, and a place for occupational training:

We believe that a policy largely new has been heralded . . . and that is the occupational training of patients.²³

Atkinson continued with a pastoral picture of the boys working industriously on the farm, in the chicken house, and even replacing the milkmaids who had retired.

Atkinson also had a plan for the girls:

No less are the girls adding their aid to make the institution a hive of industry . . . [Many] show ability in helping care for their less fortunate sisters.²⁴

His glowing picture was marred, however, by the realization that before he could proceed with his goals it would be necessary “to first instill into the staff, worthiness, humanness and practicability.” He obviously had a training programme for the staff in mind. He wanted to form the proper attitudes in those who were “sincere, kindly, and willing to serve.” For the rest of the staff he also had a plan:

To those who find understanding impossible, who lack sympathy and patience or who do not show the zeal to improve the conditions for those less

fortunate . . . [T]here should be no room in the great family of this institution.²⁵

He goes on at length about developing a playground, securing footballs for the younger boys, and skipping ropes for the little girls. He talks of the importance of spiritual worship and entertainment. Above all, he insisted on the kindness and enthusiasm of a devoted staff. He was greatly concerned that there were too few nurses to look after the epileptics, seven of whom had recently died during seizures. He believed that nursing care should be improved by the employment of graduates from the mental hospitals. He would have been referring to his experience at Selkirk where the nurses working and training there had received a *Mental Nursing Diploma*.

The optimistic report highlights the similarity with earlier asylums and the concept of the institution as a family, with everyone contributing to the best of their ability. It also highlights one of the dilemmas of the occupational identity of psychiatric nurses. Atkinson saw the value of nurses in watching the epileptic and elderly patients, hardly a uniquely psychiatric nursing task, but he saw the main work of the institution as occupational and recreational therapy, not nursing.

Nevertheless, a psychiatric nursing training programme was established at this facility in 1936. John Kellie relates, “The programme was implemented largely through the impetus of the Medical Superintendent, Dr. H.S. Atkinson, M.D. and the Matron, Miss E. Miller, R.N.”²⁶ But Atkinson’s plan was not popular with everyone. At the MARN board meeting October 1, 1937 the executive decided to call the Minister of Health to protest the establishment of training at the Portage Home. On November 1, 1937 a specially convened committee met with Health Minister Honourable Mr. Griffiths and Deputy Minister of Health Dr. Jackson. The committee

made three suggestions as to how such a programme should be conducted.²⁷ Griffiths enquired whether for registration purposes the MARN recognized the mental hospital graduate, to which the president replied that they did not. Griffiths then enquired as to why the MARN was concerned!²⁸ Jackson informed the MARN committee that it had been impossible to retain the services of graduate nurses who refused to stay for any period of time.²⁹

As had often been the case, general nurses could not, or would not, provide care in the institutions for the mentally ill or retarded. But they seemed to resent efforts by others to improve the status and skills of those who did provide care. This effort, to impose standards on the training of nurses at the Portage Home, could have been an opportunity to form a closer alliance between the MARN and the Department of Health and Welfare. The meeting concluded with the assurance of the Minister of Health that “if there were any changes in the present plan the board of the MARN would be consulted before any action was taken.”³⁰ No further meetings took place and it was a lost opportunity.

In his 1951 annual report, Atkinson reiterated the uniqueness of his facility and the care provided. In his philosophical, heartstring-tugging rhetoric, with quotes from Goethe, the Earl of Lytton, and the Bible he presented his plan for, “A New Way of Life” at the Portage School. At the outset he observed, “We are not in fact a hospital but only have medical and nursing service attached to our school. Our population is not sick.”³¹

He proceeded at length on the rationale for implementing his carefully thought-out plan to construct a “miniature” society which “will produce the most

beneficial results temporally and spiritually.”³² The core of his programme was training, not nursing, yet he reports:

Our three year course in Psychiatric Nursing for both men and women has been maintained. The appointment . . . of an Instructress of Nurses (RN) . . . allowed us to offer the standard curriculum for Licensed Practical Nurses.³³

He failed to add that the LPN training was only for female students; neither did he add that initially he had stalled the implementation of this programme

But Atkinson’s loyalty to his own nurses is questionable. In a flowery article, written in 1955 for the *Canadian Nurse*, he obviously intended to attract general nurses to careers in institutions for the mentally ill and defective. After flattering the general nurse by calling *her* a specialist, he outlines in glowing terms not only the social and financial benefits of working in the Manitoba government-run psychiatric institutions, he also appeals to her sense of duty:

If these concrete facts are not enough by themselves, there does remain one that has no precise measure but is the privilege of all. That is the opportunity for service to our afflicted fellowman. This has unlimited possibilities, dictated by the most potent forces man has ever had---his ideals.³⁴

He may have had some success in securing RNs. A longtime employee of the Portage institution, graduate of their programme, and subsequently a board member of the CCPN and the Psychiatric Nurses Association of Manitoba (PNAM), Elinor Samels, recalls that general nurses did come to work at the institution. But her recollections include a tone of betrayal:

If Dr. Atkinson could get hold of an RN she would come in and much to our chagrin they always got the senior position despite the fact there were three of us, Mrs. W. Mrs. F. and myself. We were the three senior staff and we had to work all the weekends and night shifts and we even had keys to the dispensary and did the weekend medications because the RNs had the weekends and nights off. We always resented having to work the night shifts. They (RNs)

were always a sore spot. Some of the RNs would not have had any experience with how to manage the kinds of people you managed.

Samels also recalled a situation regarding medications:

She (The RN) opened the medicine cupboard and she asked me what each medication was. [*Interviewer*, So she was not familiar with them?] Well either that or she was checking to see if I knew!

Throughout the interview she often spoke of resentment and gave an example of one of the RNs being afraid of the patients and she (Samels) had to intervene, “But they still got the weekends off!”³⁵

Samels reflects one of the dilemmas that has always dogged the question of care of the insane and retarded, “Is it nursing or is it a special kind of care that requires a special kind of educational preparation?” Samels, when asked if nursing was the most suitable occupational category to care for patients with mental illness or disability, responded, “There was no other model at that time.”

The examination of the Portage School raises some of the confusion surrounding psychiatric nursing. Certainly at the Portage School Atkinson believed his charges were not sick and that nursing was an incidental part of the care provided to his little girls and boys. Yet, he did not even give the nurses trained at the institution, who were at least familiar with the needs and behaviour of the children, much respect. This resonates with the review of earlier works that suggest that prestige, rather than usefulness, was raised by the employment of RNs.

The Portage story also illustrates that psychiatric nursing in Manitoba in the 1950s had no particular epistemological or ontological underpinning. It was entirely contingent on the needs and wishes of the superintendent of the establishment in which they were employed. The fact that Portage was graduating psychiatric nurses,

who performed very little psychiatric nursing, demonstrates the contingent and political nature of psychiatric nursing.

Selkirk and Brandon

The institutions at Brandon and Selkirk were certainly mental hospitals even if Portage was not. Life inside these mental hospitals still bore some resemblance to older asylums. For the most part, the patients and staff were separated by gender. There were some female RNs working in the male infirmary, perhaps a further testament to the fact that *nursing* male patients with physical illness was viewed as different from *nursing* male patients with mental illness. Daily life continued to revolve around a routine of work and recreation as it had in the asylums of old. The majority of patients were engaged in some sort of work-related activity, much of which had to do with the running and maintenance of the institution. On the admission wards, where the patients were considered acutely ill, the work was called *occupational therapy*. Other treatment afforded the acutely ill, or newly admitted patients, was based as much on speculation as it had ever been. Physiological treatments such as electro-convulsive therapy, insulin coma, and leucotomies were common practices.

In the 1950s, the superintendents and the provincial psychiatrist continued to manage all aspects of life in the institutions, from the farms to the personal lives of the nurses. Provincial Psychiatrist Dr. Thomas Pincock, like many other psychiatrists of his generation, had developed his interest in psychiatry during WWI as a stretcher bearer.³⁶ He had risen through the ranks in Manitoba from superintendent at Brandon, 1930-1942, to provincial psychiatrist, a position he held for seventeen years. Dr.

Stuart Schultz had been the superintendent at BMH since 1942, following seventeen years at the hospital as a staff physician.³⁷ Similarly at Selkirk, Dr. Edward Johnson, who had been superintendent there since 1943, had worked at SMH for fifteen years prior to his superintendency.³⁸ These three men, Pincock, Schultz, and Johnson along with Atkinson at Portage had been in the Manitoba mental hospital system since their graduation from medical school. Apart from some graduate training, they had little psychiatric experience outside the mental hospitals of the province.³⁹ Therefore, their orientation to psychiatric care was steeped in the traditional asylum/mental hospital philosophy. This meant the management and control of all aspects of the institution, including the lives of patients and staff.

Unlike other physicians, who saw their patients in hospitals intended for cure, these superintendents resided on the grounds of their hospitals along with their patients and staff and were responsible for every aspect of the facility. For example, in March 1951, the meeting of the medical superintendents was largely devoted to a dispute between Atkinson and the manager of the power house at the Portage School. Pincock insisted, “The superintendents must at all times be in charge of institutions and all staff.”⁴⁰ Minister of Health Mr. Ivan Schultz, who was present at the meeting, agreed with Pincock, “That the medical superintendent of each institution should have supervisory authority over all staff.”⁴¹ The remainder of that particular meeting also dealt with such issues as whether or not sliced bread should be purchased and whether or not the medical superintendents “should have some control over the farm produce that was sold.”⁴² How little things had changed from 1894 when Dr. Weir Mitchell rebuked:

Those who still bear the absurd label ‘medical superintendents’. Where are your annual reports of scientific study, of the psychology and pathology of your patients? We get odd little statements . . . a few useless pages of isolated post mortem records . . . sandwiched between incomprehensible statistics and farm reports.⁴³

His criticism could well apply to the superintendents’ reports sixty years later in Manitoba. Throughout the 1950s, statistics on amount of potatoes harvested, numbers of cows milked, and pounds of laundry washed formed a significant part of these annual reports.

But the annual reports also provide evidence that the superintendents were concerned with providing the best care to the patients and keeping abreast of new medical developments. At the June 1951 superintendents’ meeting, Johnson, of SMH, reported on his attendance at the American Psychiatric Association (APA) meeting in Cincinnati, as well as his visits to Anoka State Hospital in Minnesota and St. Elizabeth’s Mental Hospital in Washington. He attended a session of the APA entitled, *What Psychiatric Nurses Should be Trained to Do*:

I am pleased to be able to report that we are providing in our Training School essentially what the majority of Superintendents feel is required for the best care of psychiatric patients.⁴⁴

In 1955, Pincock attended the APA meeting in Atlantic City. The opening paragraph of his report describes his enthusiasm for the latest innovations in psychiatric treatment:

It is 12 years since I had such an experience, and I was feeling somewhat out of touch with newer developments and procedures. Attendance at such meetings gives one an advantage of . . . listening to scientific papers . . . meeting outstanding leaders . . . exchanging ideas and being challenged to make greater effort on behalf of our own specific problems in Manitoba.⁴⁵

He comments on the address of Dr. Noyes who expressed:

Fear that in our search for and study of the dynamics and mechanisms of the psychotic or psychoneurotic state we were in grave danger of sacrificing that warm interpersonal relationship . . . which is so essential in therapy and . . . being helped as a human being and not as a neurophysiological mechanism.⁴⁶

This statement reflects a major dilemma in the practice of psychiatry, as well as psychiatric nursing in the 1950s. Did the medicalization of mental illness reduce the human relationship with the mentally ill person? Pincock's point of view is unknown as he goes on to say, "In regards to therapy the emphasis was on physical methods, the newer drugs Largactil, Serpasil, and electro-convulsive therapy."⁴⁷

He also spoke of the open door policies originating in Great Britain and believed, "We should be doing more in the way of group therapies in our hospitals."⁴⁸ He reported on a paper given by a British psychiatrist, Maxwell Jones, who is credited with developing the concept of the therapeutic community. Jones observed that educational discussion groups for patients evolved into problem solving groups. The patients were able to identify and discuss problems of living as a group on mental hospital wards, and the nursing staff became an important part of these problem solving discussions. Jones summarized his observations and conclusions under three headings:

1. Treatment was a continuous process throughout the entire waking day of the patient:
2. A reorganization of hospital society was needed with a greater degree of social penetration between the three main groups, patients, nurses, and doctors:
3. The importance of the patient's role in the hospital society.⁴⁹

The nurse's role in daily life was further reinforced by the study of Morris Schwartz and Emmy Shockley, who called attention to the influence of interpersonal relationships in the mental hospital:

Other studies confirmed the importance of hospital atmosphere, attitude of employees, and relationships . . . in influencing ward behavior and outcomes of illness.⁵⁰

The therapeutic community concept was also identified in the nursing literature. Grayce Sills, in a comprehensive review, summarized the evolution of the therapeutic milieu as it related to nursing.⁵¹ This literature illustrates that there was a growing recognition of the therapeutic role of daily life and the staff who managed it. In many ways this was not unlike the moral treatment advocated in earlier Quaker asylums. But how this was translated into curriculum content for nurses in Brandon is unclear.

The therapeutic milieu as a treatment method was soon enhanced by the increasing interest in psychobiology. In 1956, Dr. William Forster, Clinical Director at Brandon, provided a detailed account of his attendance at the APA meeting in Chicago where there was a preponderance of papers related to genetic and psychobiological theories of mental illness. The same meeting was attended by Superintendent of Selkirk Dr. Roy Tavener, who “was impressed by a significant increase in the investigation and treatment of mental illness by organic methods.”⁵² Forster and Tavener encouraged the implementation of the best practices of the day in their respective institutions, which at that time meant physiological treatments. They also provided this psychobiological information to nurses in the form of curriculum content. In the 1950s, the nurses’ procedure manuals gave far more instruction in medical procedures, based on beliefs in the biological underpinning of mental illness, than in creating a therapeutic environment.

* * *

The annual reports of BMH provide a glimpse into the daily life and therapeutic activities of that mental hospital. They also give an indication of the place of nurses and nursing in the hospital community. Some information is provided about patient care, especially easily quantifiable data such as the number of teeth extracted, the number of bones broken, and the number of x-rays taken.⁵³ References to psychiatric treatment include the number of electro-convulsive treatments administered, insulin comas induced, and leucotomies performed. This highlights the great difficulty in identifying the meaning of psychiatric care. The number of physiological treatments carried out tells little about the emotional or existential experiences of patients with mental illness, or, how any improvement came about. Counting specific activities was highly prized in the *scientific* era of the 1950s. No doubt, the political masters viewed these numbers as some kind of measure of progress.

Occupational and recreational therapies such as crafts, woodworking, and entertainment received considerable coverage in the annual reports, perhaps because the activities of this department were visible and quantifiable, or, perhaps because there was still a belief in the value of work as treatment. The 1956 annual report provided a detailed account of how many items were made in each particular occupational therapy class and includes the monetary value of the sales of the items.

The introductory statement reads:

This department continues to make excellent progress. Cash sales for the year for \$14,201.65 Sales (sic) to the institution \$17,400.30.⁵⁴

Almost as an after thought, Activity Director, Jack Seymour, added:

The sale of work serves as an indicator to register the amount of work performed, but the important aim of the department is the rehabilitation of the mentally ill.⁵⁵

Many of the items made in the occupational classes also received prizes at local fairs. This was a source of pride for one medical director who wrote to the minister of health providing him with a list of prize winners and noting, “I think we can be justly proud of the work being done by our Occupation Classes.”⁵⁶ Whether the pride was in the success of the items at the fairs or the therapeutic value of the activities is unknown, but it reinforces the observation of Forster following the 1956 APA meeting, “Occupational and recreational therapists are of more importance than psychotherapists.”⁵⁷

Seymour also notes that besides the occupation classes, a large number of patients were employed in hospital-based services. For example, at the beauty parlour the number of perms, shampoos, and other beauty treatments provided by staff and patients reached 16, 054. Patients also worked in the kitchen, the laundry, and, of course, on the farm. Narfason recalls, “Patients also worked on the farm. Those who milked cows had to be awakened by 4 A.M. to be out to the barns on time.”⁵⁸

Although the superintendents would have reported such occupational activities as *therapies* it is not easy to distinguish therapeutic activities from those that contributed to the overall maintenance of the institution; certainly no patient in a general hospital would be expected to arise at 4 A.M. to milk cows! Such practices were still being criticized as late as 1962. Following a re-organization of the BMH, intended to provide a more therapeutic environment, Dr. Cziller remarked:

There is still a great amount of staff and patient time involved in work around the hospital which is not related to the therapeutic environment.⁵⁹

The recreational activities are outlined in as much detail as the occupational therapy and the value of recreation to recovery from mental illness is stressed. The nurses and attendants were expected to participate in these activities, but apparently not all regarded this as therapeutic as the following memo issued by Dr. Forster and Dr. Schultz suggests:

December 7th 1956

To all Attendant and Nursing Staff

1. Recently several attendants have refused to take part in patient activities although they were on duty at the time and in charge of the patients concerned, and ordered to do so by the Director of Activities.
2. It must be clearly understood that, in the treatment of mental patients, it is essential for the attendant or nurse to take part in patient activities and occupation, and to work with the patient.
3. Consequently, when a nurse or attendant escorts a patient to any form of activity, for the time he or she is in charge of that patient, he or she is under the orders of the Director of Activities or other senior officer in charge of the activity.
4. Failure to participate in patient activities or occupation will be regarded as failure to perform a duty.

Signed by
William Forster, M.B., B.S., DPM.,
Clinical Director.

Stuart Schultz, M.D.,
Medical Superintendent.⁶⁰

The significance of this memo lies in the fact that the relationship between the patients and attendant and nursing staff was recognized as an important therapeutic activity, but having to put it into the form of a veiled threat was indicative that the attendants and nurses were either unclear about their therapeutic roles, did not know how to carry them out, or simply did not care.

Nursing Procedures

This incident regarding participation in recreational activities also reflects the difficulty in describing, both quantitatively and qualitatively, *nursing* in the mental hospital environment. This may account for the very brief comments on nursing in the annual reports. The information was primarily in the form of statistics on who was hired or resigned, meticulously kept records of the numbers of students in each class, the numbers on affiliation, and the numbers of male attendants in each year of their three year training programme. But the therapeutic roles and activities of the psychiatric nurses and attendants are much more difficult to determine and received little attention in these reports.

The inability to clearly identify psychiatric nursing roles does not mean that psychiatric nursing activities were random. In fact, the extensive procedure and regulation manuals of the 1950s, which governed the work of the psychiatric nurses and attendants, suggest that their daily tasks were highly regularized and ritualized. The *General Regulations Manual*, assembled in 1957 under the authorship of Superintendent Schultz, governed all aspects of life in BMH, including the behaviors of the nurses and attendants. The general regulations cover the usual admonitions to attend to one's duties on time, properly dressed, and clean smelling. The regulations also governed who should eat in which dining room, at which table, and at what time. The manuals also identify the speed limit of cars driving on the hospital grounds and the importance of turning off lights not in use. Someone has also gone to considerable trouble to work out the fact that if every staff member quit five minutes early there would be a loss of 1250 hours of work annually.⁶¹

The *Ward Regulation Manuals* are even more prescriptive. For each ward in the hospital the daily routine, on an hourly basis, is spelled out in great detail. A weekly schedule identified additional tasks such as counting the linen and bathing the patients; these activities receiving the same degree of emphasis in the manuals.⁶² It seems cleanliness and good order were paramount. This vision of the well run, orderly mental hospital of the 1950s, in Brandon, echoes the nineteenth century orderly asylums described in the studies of Digby, Tomes, and D'Antonio.⁶³ Dr. Cziller, who had noted the amount of hospital service that was masked as therapy, observed:

Antiquated adherence to rigid routines is still a major handicap both in respect to the general administration of the hospital and the operation of the wards by the nursing staff.⁶⁴

Daily life was not the only activity that was highly regulated. The nursing procedure manual of 1954, entitled *Brandon Hospital for Mental Diseases Manual of Nursing Procedures* is, in fact, the manual designed for the Licensed Practical Nursing Course. The manual provides step by step instructions for such unlikely procedures as *care of flowers* and *managing a blood transfusion*. Few of the procedures listed would ever be carried out in a mental hospital. In fact, only two refer to specific activities for BMH, namely the admission and discharge procedures.⁶⁵

Likewise, *Notes on Medical and Surgical Nursing* was obviously adapted from a general nursing procedure manual without any reference to psychiatric patients.⁶⁶ This emphasis on the *nursing* component of psychiatric nursing may result from the fact that it was easier to articulate general nursing procedures, although few

patients in mental hospitals were receiving this type of nursing care. On the other hand, it may be due to the elusiveness of the *psychiatric* component of psychiatric nursing. The attention to the *physiological* aspects of nursing was, however, relevant to certain psychiatric therapeutic procedures of the day.

Although the physiological underpinnings of mental illness were only vaguely understood at the time, the predominant modes of treatment reflected the ongoing hope that mental illness was organic in nature. This justified the use of unproven, and often strange, physiological methods of treatment. The major treatments on the admission wards were insulin coma, electro-convulsive therapy, and leucotomies.⁶⁷ These treatments required much the same nursing care as that provided to any patient receiving a surgical or medical intervention. The *Instructions for Leucotomies Manual* outlines pre-operative and post-operative orders just as they would for any surgical patient.⁶⁸ The *Insulin Shock Therapy Manual* provides detailed instructions on how to prepare the bed, the equipment, and manage emergencies.⁶⁹ One of the nursing text books in common use at the time, *Psychiatric Nursing* by Steele and Manfreda, provides more information on how to set up the emergency tray than how to relate to the patient receiving insulin shock treatment.⁷⁰

The only indication in the BMH Manual that this procedure was used as a treatment for patients with mental illness is a brief reference to the fact, “Saturday being free of treatment so that group therapy may be held with the insulin patients.”⁷¹ How the group therapy was conducted and by whom is not stated. A psychiatric nurse who practiced at that time, Marlene Brichon, reported she was told, “The personal care and small group interaction might well be as important in the patient progress as

the insulin.” She also goes on to say that she learned “first hand about blood sugars and bizarre behavior but also the power of caring and group support.”⁷²

The *psychiatric* part of psychiatric nurse training appears to have been a mix of physician’s lectures and vague admonitions to the attendants and nurses to observe the patients closely, follow the doctor’s orders, attend the recreational activities, and reassure the patients. Brichon recalls, “We were expected to do things like listening and empathizing about the patient’s *problems*, but we were cautioned not to engage in problem-solving and to respond with ‘what does your psychiatrist say?’”⁷³

The *Notes on Psychiatry*, prepared by Schultz in 1956, is clearly addressed to nurses, “The main objective of a nurse is to aid in the care of a mentally ill patient and failing this, to aid him to become a useful member of the hospital community.”⁷⁴ Clearly, there was no distinct role for the psychiatric nurse to play. In these lecture notes, each disease classification is fully described without any particular reference to nursing care. Schultz also described the latest and most important treatment of the 1950s to be introduced at BMH, the psychotropic medication Largactil.

The discovery of drugs to modify the behavior and emotions of people with mental illness has been hailed as the most significant event of the century in the treatment of mental illness.⁷⁵ In France, in early 1951, a Rhone-Poulenc drug called 4560RP was found to calm patients in anxious states. A year later it was tried, cautiously, on psychiatric patients and was found to reduce psychotic symptoms. The year after that it was tried in London, Ontario, and later in Montreal, Quebec. In April 1954, the drug was introduced at BMH. The first published Canadian trials were carried out in Montreal by Dr. Heinz Lehman. He received more credit than the

female psychiatrist, Dr. Ruth Koeppe-Kajander, who had actually first tested Chlorpromazine in London, Ontario.⁷⁶

The mechanisms by which the drug brought about the changed behaviour was poorly understood, but its effects on the wards of mental hospitals have been described as dramatic. Not only did patients become calmer, they were also able to engage in a greater variety of activities, and the discharge rate increased. The effects of the drugs also dramatically reduced the use of mechanical restraints. In Brandon, the last patient was removed from restraints in 1955:

The complete abolition of mechanical restraint has been beneficial . . . It has placed greater responsibility on the ward staff . . . This emphasizes the need for training of personnel so they can handle disturbed patients and stimulate apathetic ones.⁷⁷

Brandon Mental Hospital became a centre for research in the use of Largactil and other drugs. For a number of years, research reports formed part of the annual reports.⁷⁸

The effect on the nurses and attendants was both positive and negative. For those who enjoyed the hands-on nursing, the introduction of medication meant there was less physical care to provide. Some nurses reported feeling more like *real nurses* when participating in the complex tasks associated with insulin coma and electroconvulsive therapy. For nurses whose identities had been formed around their ability to manage difficult behavior, many experienced a sense of loss of purpose. The mental hospital wards changed as a result of the introduction of these medications, yet there is little evidence that the nurses were taught about their complex effects. Brichon recalls, “I poured enough medication to sink a ship with not a whole lot of knowledge about those drugs and their potent actions.”⁷⁹ These medical events

influenced the practice of psychiatry in the 1950s. The way in which they influenced the knowledge and practice of psychiatric nursing can only be determined by examining the available information on the training programmes and curricula from that time.

The Knowledge and Values Underpinning the Training

Set in this mental hospital context, a mixture of the ritualization of daily life, unproven medical treatments, and adherence to regulations, it is not unexpected that the training of the psychiatric nurses and attendants in the 1950s was designed to ensure a level of decorum, compliance, and the performance of ritualized techniques. This training was directed less by curriculum frameworks than by tradition and the expectations of certain kinds of behaviour from the staff.

Training is always based on a set of values and beliefs about its purpose, what is worth knowing, and how best to inculcate the learners with the valued attitudes and knowledge. These are usually embodied in a curriculum document that sets out these expectations. There is no single document identified specifically as *The Curriculum* from the 1950s. There are lists of the subjects to be taught, the number of hours to be devoted to each, and how many weeks were to be spent in clinical areas.⁸⁰ In the absence of a clearly written curriculum, the content, values, and beliefs underlying the training must be discerned from skimpy documents, lecture notes, policy and procedure manuals, and failing memories.

There are numerous ways of defining and studying curricula but one model that is useful is based on Schwab's concept of four "desiderata" or social forces.⁸¹ These four, milieu, content or subject matter, teacher, and learner provide a useful

framework for examining educational practices. Within Schwab's framework, the subject matter is not the centre of the educational experience. The skills of the teacher, the abilities and motivation of the learners, and the context of the educational experience are considered equally influential. Schwab argues that even when not overtly considered, these factors affect the educational experience.⁸² Connelly and Clandinin state, "The commonplaces are useful in examining historical curricular trends and in coming to understand the forces giving rise to changes in curricular foci."⁸³ Although Schwab's framework was designed to address pedagogical concerns, it can also be applied to an examination of psychiatric nurse training in the 1950s.

Milieu

Milieu, as described by Schwab, includes a number of environments, the school, family, and religious and cultural communities. For psychiatric nurses, milieu meant the ward environment with daily life controlled by superintendents assisted ward supervisors. It also meant the maintenance of an orderly hospital and well-managed patients. The intellectual environment could best be described as medically oriented. The psychiatric nursing knowledge was based on the medical model of mental illness and many of the psychiatric nursing tasks were based on the performance of nursing procedures. For example, it was required on admission wards that patients had to have their temperature recorded weekly, whether or not they showed any signs of being physically ill. Maintaining order and performing procedures were valued in an environment in which the skills of relating to troubled

individuals were difficult to describe. The content of the curriculum reflected the value placed on tasks and procedures.

Content and the Licensed Practical Nurses Curriculum

The content of the curriculum, at the end of the 1950s, can only be gleaned from brief documents located at the BMH. Little documentation was recovered from SMH or the Portage School. One of the most helpful documents was the carefully compiled list of the six programmes which had been run over a fifty year period at the BMH. This document provides a glimpse of the relative importance of each subject. The influence of general nursing and medical psychiatry is clear.

For example, in the combined RN/psychiatric nurse training programme of 1952-1957, nursing arts received 200 hours of instruction, psychiatry-presumably the psychiatry taught by the physicians-75 hours of instruction, but psychiatric nursing only 50 hours of instruction. The disproportionate number of hours assigned to nursing arts and medical psychiatry vis-à-vis psychiatric nursing, no doubt, reflects the difficulty in identifying and articulating the nature and content of psychiatric nursing. In the 1950s, there was a firm belief in the physiological underpinnings of mental illness which resulted in the treatments already described. This necessitated a nursing work-force skilled in many medical/surgical nursing procedures. Yet it signified a lack of attention to the emotional experience of patients, or at least attention that could be articulated in a written curriculum document.

* * *

The influence of general nursing knowledge continued to be felt throughout the 1950s when a new era in psychiatric nursing education was ushered in with the

implementation of LPN training. By 1953 the nursing schools at Selkirk and Portage were each offering a combined LPN/psychiatric nurse training programme. Brandon joined this programme in 1955. Certain requirements had to be met, as set out by the LPN Advisory Council in a *Manual for Administrators of Schools of Practical Nursing*.⁸⁴ An orderly and detailed curriculum of the ten general nursing courses is set out under the headings: topic, content, objectives, expected outcomes, learning activities and student application.⁸⁵ There must have been a recognized need to have a similar curriculum outline for the psychiatric nursing component of the course. It is reported in the September 1953 LPN Advisory Council minutes:

A meeting regarding policies for the Combined course was held on Monday, June 22nd. Not all the items were thoroughly discussed and the group met again to prepare materials for presentation to the medical superintendents of the combined course.⁸⁶

The group who met included members of the Advisory Council along with the instructors from the three provincial institutions. The resulting manual was similar to the *Manual for Administrators of Schools of Practical Nursing*. There were some minor modifications relevant to the provincial institutions and a minimum curriculum for the four psychiatric nursing subjects. The four subjects were: psychiatry, 20 hours; psychiatric nursing, 20 hours; psychology, 10 hours; and occupational therapy, 5 hours. The document retrieved from BMH lists considerably more hours in these subjects and includes first aid and microbiology.⁸⁷ Even with the increased number of hours, nursing arts instruction still exceeded the number of hours of psychiatry, which exceeded the number of hours devoted to psychiatric nursing. The same degree of detail was not set down for the *psychiatric nursing* subjects as for the *general nursing*

subjects. Either there was much less psychiatric nursing knowledge available, or else it did not lend itself to that particular curriculum format.

The interest taken by the LPN Advisory Council in the psychiatric nursing programme did not end at that time. Attention to a curriculum framework and standards and good relationships between the Advisory Council and the educational directors of the three provincial mental institutions may well be at the centre of further improvements to the psychiatric nursing training. In September 1957 the minutes of the Advisory Council record:

The Registrar informed the council that special committee(s) to study . . . the combined course policies had met and that their findings will be presented at the next Educational committee meeting.⁸⁸

A report was provided in December 1957. Some of the recommendations were directed to the Civil Service Commission which was responsible for staff in provincial institutions, and clearly resulted from the fact that the pupil nurses were considered as staff, not students, in these institutions. There were a fixed number of positions into which staff could be hired; the intake of students was therefore dependent on the number of positions available.⁸⁹ Potential students were frequently employed before classes started and they received salaries rather than stipends. The Advisory Council believed that many students in the provincial institutions were there for the money rather than the training. The students were also expected to gain clinical experience on wards where service was required, rather than being assigned to wards for suitable learning experiences and appropriate supervision by trained nurses. Each of these points was noted in a set of recommendations. The

thoughtfulness put into them suggests that the LPN Advisory Council was making a sincere effort to improve the training of psychiatric nurses.

The second set of recommendations was related to the curriculum. The committee made a number of observations:

First: That the same psychiatric nursing curriculum should be followed at the three institutions and should be consistent not varied according to the interest of the instructor. Second: Grade X is the educational requirement for applicants to the combined course. Therefore, the curriculum should be geared to Grade X level. It is not fair . . . to have the course geared to the level of a medical interne. If the course is beyond the comprehension of the student, she will be muddled and not able to apply the necessary knowledge to her nursing.⁹⁰

Clearly this was levelled at the practice of medical superintendents providing psychiatric knowledge to the pupil nurses. The committee further recommended:

That for the combined course there be a special Committee of the Education Committee for Licensed Practical Nurses. The members of the committee to include nurse and medical instructors of the psychiatric subjects. . . [A]nd that provincial exams be held in the psychiatric nursing subjects.⁹¹

Obviously the LPN Advisory Council was aware of the content and process of psychiatric nursing training in the provincial institutions. These recommendations were designed to improve the quality of the training and perhaps to wrest it away from the domination of the medical superintendents. Their suggestions were helpful in providing a curriculum framework which would impose some order on the psychiatric nursing instruction. This may well be why John Kellie noted “This was the first time standards were applied to the training of psychiatric nurses in Manitoba.”⁹²

There was further collaboration between the Advisory Council and the provincial institutional instructors. In May 1958 it is reported, “As February 17th

(presumably February 1959) is convenient for Dr. Pincock and the Medical Superintendents . . . an organizational meeting for the combined course has been called for this date.”⁹³ This note shows a willingness to work with the provincial psychiatrist and mental hospital administration for the improvement of psychiatric nursing education. The length of time between the request to meet and the first available date is curious and cannot be explained with the present information. Unfortunately, no minutes of such a meeting taking place have been located and there are no further references to this meeting. Later in 1959 Pincock retired, as did Schultz from Brandon and by 1960 the psychiatric nurses had gained their own legislation and there was a new structure in place to direct their education. This relationship with the LPN Advisory Council had been helpful to the nursing instructors in the provincial mental institutions. It had given some direction to the organization of psychiatric nursing content and also a forum for the psychiatric nursing instructors.

Teachers and Learners

Teachers and learners are the other two commonplaces in Schwab’s framework. The teachers in the 1950s were general nurses who may have had training or experience in psychiatric nursing. The requirement of the LPN Advisory Council that the instructors be RNs had to be met. At Brandon many of the instructors had additional education. Both the postgraduate course and the combined course were sources of instructors. There was also the opportunity for additional education such as the Teaching and Learning Certificate from McGill University or the University of Manitoba. Some of this additional education had been made possible through the National Health Grants.⁹⁴ In 1955 at Brandon there were four RNs identified as

instructors of nursing. Director of Education Patricia Beecher, and three other instructors taught *Nursing Arts, Science, and Psychiatric Nursing*. These four women carried a heavy teaching load. As well as the nursing courses they taught to the male and female students, they were also responsible for aspects of the education of the laboratory technicians, the training of nurse aides and orderlies, the general students affiliating from other hospitals, and the post-graduate students.⁹⁵ The practice of having only four instructors continued well into the 1960s.

There was no clinical supervision for students on the wards except that provided by interested head nurses. Brichon recalls that learning on the wards depended on the enthusiasm of the head nurses:

And most went out of their way to see students were involved in conferences and learning experiences. . . . But I also washed floors, windows & (sic) beds and sorted laundry and did cleaning that I know nursing instructors had discouraged staff from assigning to students.⁹⁶

The male students also spoke of their dependence on ward supervisors to provide direction during this time.⁹⁷

With their heavy teaching load, the nursing instructors had little choice but to depend on ward supervisors and graduate nurses. With the practice of having students on *the establishment*, and counted as staff, there was little the learners could do but take the initiative and avail themselves of learning opportunities as they arose.

Psychiatric nursing training in the 1950s was certainly an apprenticeship model but it was also assuming a shape that reflected other nursing education. The general nursing component was well outlined in accordance with the standards of the day and the curriculum outlines show a preponderance of general nursing content. There were emerging concepts in psychiatric nursing such as the therapeutic

community and interpersonal relations⁹⁸ although there is not a lot of evidence they were being applied in psychiatric nursing training in Manitoba at that time.

There was, however, increasing attention to educational policies and practices initiated by the female RN nursing instructors. Attention to policies and propriety based on general nursing educational policy manuals are evident. There is no doubt that this resulted in a greater sense of professionalism by the men and women who held the *Psychiatric Nursing Diploma*. Most of the female graduates of this course also possessed an LPN diploma which was recognized beyond the institutional walls. The most disadvantaged educationally were the men. Their diploma had no professional status outside the institution and this may well be one of the factors that motivated them to seek greater recognition.

The Male Attendants in Manitoba Institutions

Since the inception of modern nursing, men have always had a greater presence in mental nursing than in general nursing, although, historically, men were providing nursing care before it became a feminized profession.⁹⁹ The employment of men in psychiatric settings has never evinced the same degree of curiosity as men in general nursing. The general speculation is that men were needed in psychiatric nursing for strength to deal with disruptive or violent patients of both sexes. Yet men also worked in male wards performing many of the same duties with male patients as female nurses with female patients. It was the custom to separate male and female patients and staff so there was little option but for the male staff to provide care to male patients.

The literature on male nurses in general nursing is small and even smaller on men in psychiatric nursing. The focus in the general nursing studies is usually on role strain and sex role stereotyping;¹⁰⁰ challenges of being a male student;¹⁰¹ discrimination towards men in nursing in the military and in certain female wards;¹⁰² the strategies used by men when providing intimate care to female patients;¹⁰³ and that men are disproportionately represented in nursing management.¹⁰⁴ A recent Canadian study compared male nurses and elementary school teachers and examined issues related to sexuality, professional relationships, and the use of touch.¹⁰⁵ Most of this literature is based on stereotyping and the assumption that nursing is women's work, that only women can care, and that men cannot be tender or nurturing.¹⁰⁶ But the concept of androgyny, articulated by Sandra Bem, suggests that many characteristics such as warmth and caring are not confined to women just as assertiveness and competitiveness are not necessarily a solely masculine trait. Androgyny views a constellation of characteristics as desirable in individuals of either gender and defines such individuals as androgynous.¹⁰⁷ This may be a more useful concept than gender, with its dichotomized perspective, for examining the role of both men and women in nursing, general or psychiatric.

Many early works concerning male psychiatric nurses fall into the category of attendant and asylum literature, but a new body of literature on men in psychiatric nursing is beginning to emerge.¹⁰⁸ This literature offers a different perspective from the commonly held belief that men were required for strength, there is evidence to suggest that many of the male attendants were attentive to the needs of their patients.¹⁰⁹

Works such as that of Connor identify the discrimination against educating the male attendants at the Kingston Asylum because of the hegemony of the female nursing establishment. While this was regretted by the superintendent at Kingston other superintendents wanted only female nurses. Boschma included in her dissertation on Mental Nursing in Dutch Asylums a section on the plight of male attendants who were excluded from the training programmes and made to feel less worthy than women caregivers.¹¹⁰ More recently, Boschma examined the role of men in the development of psychiatric nursing in Alberta. She concluded that the male attendants felt excluded from professional status as eligible female students were encouraged to participate in a registered nurse/psychiatric nurse combined programme similar to the one in Brandon. As a response to this feeling of exclusion, along with a sense of commitment to their patients, and bolstered by the success of males in the neighbouring province of Saskatchewan, the Alberta attendants formed an association that was attentive to registration and educational issues, and improved the standards of care of mental patients. Dooley has also recorded the goal of attendants in Manitoba and Saskatchewan to be recognized for their nursing skills.¹¹¹

In Manitoba, a similar picture emerges. The male attendants at the three institutions had been receiving varying degrees of training for over thirty years, but with no legal recognition and no standards beyond what each superintendent felt was necessary for the operation of their own institution. It is recorded that at Brandon the first course for male attendants was organized in 1921. It was to be three years in length. The first class graduated in 1924 with seven members. The first few courses may in fact have been two years in length as the lists of students note only the junior

and senior classes, but by 1927 junior, intermediate and senior classes are reported. Between 1924 and 1946, 103 male attendants graduated. In 1947, the course was made compulsory.¹¹² Many of the names are recognized as attendants who remained for up to thirty five years at the BMH.¹¹³ It is also on record that many of the male attendants had family members such as fathers and brothers working in the mental hospitals. Not all stayed in the nursing department, a number took positions in the woodworking and occupational therapy departments. In an environment where work was often considered therapy, the dual function of a male psychiatric nurse who was also skilled in masculine crafts was an advantage. In Brandon, even the farm manager was a graduate psychiatric nurse.

A record of the instruction provided to male attendants at Brandon reveals that during the 1950s the number of hours of instruction in the three year programme ranged from 197 to 358. With just the titles of courses to be taught, it is only possible to guess at the content, and the number of hours devoted to each subject seems minimal at best. In 1956 anatomy and physiology received 50 hours and nursing arts 72 hours whereas psychiatric nursing received 42 hours. Psychiatry, first aid, drugs, and medical-surgical nursing, occupational therapy and ethics made up the remainder of the time spent in the classroom. The rest of the three year programme was spent on the various wards of the hospital, but service always preceded learning. Any clinical teaching was provided by the ward supervisors.

The association with the LPN programme also had benefits for the male students. In August 1959 it is noted:

The Male Psychiatric Nursing course was increased to include the same number of hours of instruction as the Female (sic) students except for MICC (Maternal Infant Child Care) and Nutrition.¹¹⁴

The omission of the MICC turned out to be optional, as some of the male psychiatric nursing students took the opportunity to gain the LPN.

The LPN Advisory Council was concerned with the question of male students.¹¹⁵ In the minutes of December 6, 1956, meeting it is reported that despite some challenges regarding male students, policies would be established. Maternity experience was optional and could be replaced with urological ward experience, but nursery ward experience would be required. If accommodation was an issue the male students were to be given an allowance and, finally, the style of uniform was determined.¹¹⁶ The first male student was enrolled in the LPN programme in 1957.¹¹⁷ This must have bolstered the superintendents and male attendants in the provincial mental hospitals. Atkinson from Portage sent a letter “re-preparing certain male attendants to become Licensed Practical Nurses.”¹¹⁸ Subsequently, in Brandon, at least five of the male students during the 1960s undertook the LPN training along with their psychiatric nursing.¹¹⁹ Even though not all the male students chose to take the LPN programme the structure and content of the remainder of the curriculum benefited them by generally improving their education.

Education was not the only area in which men were making gains. They were also organizing themselves into associations. In neighbouring Saskatchewan and the provinces to the west, psychiatric nurses’ associations had already formed. Male leaders had also banded to form a national association of psychiatric nurses. Manitoba

found an ally and support in this new group the Canadian Council of Psychiatric Nurses (CCPN) in their pursuit of professionalization.

The Canadian Council of Psychiatric Nurses

In 1949, Wilf Pritchard, the chairman of the *British Columbia Association of Psychiatric Nurses*, wrote to Bill Vowles, the president of the *Saskatchewan Psychiatric Nurses Association* saying, “Dear Bill, let’s start an association.”¹²⁰

These two men had both taken a leadership role in establishing psychiatric nursing associations and legislation in their own provinces. In British Columbia meetings about the formation of an association had taken place in May 1946.¹²¹ The first recorded general meeting was held on June 2, 1947, for the purpose of forming a society or association. The neatly handwritten notes show that discussion revolved around wanting standards similar to the mental nurses in Great Britain, and despair that the Registered Nurses of British Columbia “did not look favorably upon any affiliation with the mental hospital staff so why should we not set our own standards.”¹²² Wilf Pritchard was the organizer and first president of this group which was registered under the Societies Act in September 1947.¹²³ This differed from Saskatchewan where a bill was passed to enact legislation in 1948. The passage of the bill in Saskatchewan was the *stunning victory* described by Tipliski in her study.¹²⁴

Pritchard, in his letter to Vowles, suggested:

Ward staff in mental hospitals pool their resources to send a delegate to a convention to be held in 1950. ‘The scope of such an organization would be far reaching and would be of mutual benefit to all.’¹²⁵

In 1950, Alberta joined British Columbia and Saskatchewan in forming an association of psychiatric nurses. It is recorded that in March 1950 the graduate staff

of the two provincial mental hospitals, one at Ponoka near Calgary and the other at Oliver near Edmonton, met to form a body:

For the purpose of uniting one and all together for a common purpose; that being one group of experienced psychiatric nurses who would work together for the betterment of the mentally ill patients and the conditions they were living under.¹²⁶

They drew up articles and bylaws and called themselves the *Alberta Psychiatric Nurses Association* (APNA) and Mr. E. (Ted) James was elected president. On May 1, 1950, the Association was officially registered under the Societies Act.¹²⁷

With three provinces having associations of psychiatric nurses, it is not surprising that there was a move to join the three together. In June 1950, representatives of the three associations met in North Battleford, Saskatchewan; unfortunately, there seems to be no written record of this meeting. The following year a more formal gathering was held on June 15 & 16, 1951, at the Crease Clinic in Essondale, British Columbia. This drew nineteen psychiatric nurses “representing the Psychiatric Nurses Associations of Alberta, Saskatchewan and B.C. Observers attended from Manitoba and the State of Washington.”¹²⁸ This is the first written record of the participation of Manitoba in any national association of psychiatric nurses. The participants from Manitoba were identified as Dave Gibson Jr. from BMH and Alf Barnett of SMH. It is noteworthy that this burgeoning association was spearheaded by men and that men dominated this association for the next several years. In fact, at the 1954 Annual Conference in British Columbia it is reported in the minutes that Dr. Gee, Provincial Psychiatrist “stated he was sorry to see the lack of female delegates and hoped the Association would keep this in mind when next years

delegates were chosen.”¹²⁹ This was the same Dr. Gee who had been discomfited when three men attended the meeting with the CNA in April 1954 in Ottawa.¹³⁰ No doubt he was also dismayed a year later in when, again, three male psychiatric nurses from the west attended a meeting in Ottawa concerning psychiatric nursing.¹³¹ The preponderance of men continued until 1978 when the first female president of the CCPN was elected.¹³²

The CCPN met annually throughout the 1950s. The *Manitoba status*, as it was called, appeared on most agendas during this time. The June 17 & 18, 1954, meeting at the Crease Clinic in British Columbia records:

It was felt by the delegates present that the information from the materials on hand from Manitoba that we cannot accept them into the council at the present time but it was hoped that a representation could be sent to Manitoba to try to organize them.¹³³

Manitoba could not be accepted into the CCPN at that time due to the fact that there was no provincial recognition or association of psychiatric nurses. Information on the people and processes employed to interest Manitoba in forming an association is limited, but at the 1955 meeting of the CCPN the president, Mr. Strong of British Columbia reported:

Efforts have been made mostly by mail, to interest mental hospitals in Manitoba to form an Association there, but as far as I know have not been very successful. I am afraid we have not been able this year to make the personal contacts we had hoped. This I regret very much.¹³⁴

The CCPN persisted. In 1956 the following resolutions were passed:

That the Canadian Council of Psychiatric Nursing make an effort towards interesting the graduates in psychiatric nursing of Manitoba in forming a Provincial Psychiatric Nurse' Association.

That the Saskatchewan P.N.A. be authorized to send one of their members to Manitoba to help organize an Association in that Province, and that the cost of this trip be payed (sic) for by the C.C.P.N.¹³⁵

The president, Max Schreder, reported that he and Duke Leflar, both from Weyburn Hospital Saskatchewan, had visited Manitoba in 1957:

To encourage and help psychiatric nurses to form a Provincial Association. . . . That the incoming executive be empowered to take any steps deemed necessary to form Psychiatric Nurses association in Manitoba and other provinces.¹³⁶

The emerging profession of psychiatric nursing and the visit to Manitoba was not unnoticed by the Manitoba Government Employees Association (MGEA). In July 1957, *The Bison*, the publication of the MGEA, reported that Saskatchewan was increasing its enrollment of student nurses into their psychiatric training programme.¹³⁷ The description of the skills of these psychiatric nurses and the need for them in the province of Manitoba may well have been levelled at the Manitoba Government. In the same issue it is reported *Officers of the Canadian Psychiatric Nurses Association Visit Manitoba*.

Mr. Leflar, President and Mr. Schraider, (sic) Treasurer visited Brandon, Selkirk, and Winnipeg. Such an organization could mean a great deal, not only to the individual psychiatric nurses, but to the hospitals, and the standard of care they provide. It certainly deserves careful consideration.¹³⁸

It may not be a coincidence that the recently appointed director of nurses at Brandon, Gladys Fitzpatrick, had recently moved from North Battleford where she would have known psychiatric nurses. She had also been at Weyburn and knew Leflar and Schreder.¹³⁹ Subsequent events and documents illustrate she encouraged a similar organization in Brandon.

Art Russell, one of the senior male attendants at Brandon, contacted Schreder for more information. In his response Schreder included information on the formation of the association in Saskatchewan and also enclosed the acts from the three western provinces. He encouraged Russell to get Manitoba organized:

Your status, prestige, fields of opportunities, and yes even your pay would increase . . . it would be another step towards the formation of a Dominion P.N.A.¹⁴⁰

But the interest must have extended beyond the male attendants. The next communication, three months later from Schreder, informed Russell that Provincial Psychiatrist Dr Pincock “had made inquiries re establishing psychiatric nurses association.”¹⁴¹ With obvious support from the superintendents, and encouragement of their western counterparts and the MGEA, work proceeded on the development of an association.

Manitoba Legislation

The name Alf Barnett of Selkirk is generally associated with the establishment of the psychiatric nurses association in Manitoba. But Brandon was the first institution to form a local group. Russell, no doubt encouraged by Fitzpatrick and the correspondence from Schreder, called a meeting in Brandon in February 1958. The purpose of the meeting was to educate local people on the value of an organization of psychiatric nurses and to form a central group. Russell noted “Sask standards much higher than Manitoba (Miss Fitzpatrick)”¹⁴² Obviously he was quoting Fitzpatrick who must have brought the culture and ethic of organized psychiatric nursing with her from Saskatchewan. An executive was formed and Russell was elected the local president.¹⁴³ He notified Selkirk and Portage and encouraged them to form local

groups. Miss Dryden from Portage answered promptly, saying that the staff at Portage were in favour. She added that “Selkirk Superintendent Johnson was sending documents and constitutions from other provinces to Portage Superintendent Atkinson.”¹⁴⁴ Clearly the superintendents were in favor of this move. Miss Hornibrook, Director of Nursing at Selkirk, apparently did not respond. In October 1958, Russell appealed to his MGEA colleague at Selkirk to determine what action had been taken.¹⁴⁵

Russell also notified Superintendent Schultz of Brandon, and Provincial Psychiatrist Pincock.¹⁴⁶ Pincock’s response must have been encouraging:

Thank you . . . I would very much like to see this . . . will do what ever I can. [K]eep us informed in order that we may be able to cooperate more intelligently and effectively¹⁴⁷

Pincock sincerely supported this move. In November 1958, he sent a memo to the three superintendents with a proposed bill for the training of psychiatric nurses.

I have examined the Acts now in force in Saskatchewan, Alberta and British Columbia, and it seems to me that the Alberta legislation would suit our purpose better than the others. . . . [W]ould allow rules for training, standards, certification curriculum. . . . [R]esponsibility for the organization of the Association where it belongs with the nurses themselves. This could be done by act of Legislature or under the Companies Act which is how Alberta is organized. . . . [A]n effort to have it introduced at the next session of the legislature. We must act swiftly.¹⁴⁸

This was a generous gesture. But as Brandon and Portage were barely organized and Selkirk still did not have any organized group, it seems the superintendents were proceeding with haste and with little regard for the psychiatric nurses. The superintendents had also engaged the legislative counsel, Mr. Rutherford, to prepare a draft bill. This swift action by Pincock could indicate that the

superintendents wanted to keep control over the bill, rather than give the psychiatric nurses time to hire their own attorney.¹⁴⁹

It is possible that the interest taken by the superintendents was self-serving. In order to carry out their therapeutic procedures they required a better educated and more professional psychiatric nursing staff. It was obvious that general nursing was not in the position to provide the necessary nursing staff and they did not seem particularly interested in doing so. Perhaps the superintendents felt obliged to develop their own trained nurses. Other factors may have influenced the superintendents. Just as the attendants had a close affiliation with the staff in Saskatchewan, no doubt the superintendents also had collegial relationships with the superintendents to the west rather than in distant eastern Canada. This combination of circumstances made the western model of psychiatric nursing both available and attractive.

The bill did not reach the legislature in 1959, but by mid 1959 all three institutions had local organizations approved by the superintendents. A meeting was to be held with Mr. Rutherford, legislative counsel, on May 14, 1959, to discuss the proposed bill, and the psychiatric nursing group became aware they needed to hire a lawyer. It is not clear how they selected their lawyer, but it may have been at the suggestion of Rutherford. In planning for the meeting with Rutherford, Barnett notified Sprowl in Portage that making formal application for a charter required a solicitor, "Mr. Rutherford has graciously offered to meet . . . and provide us with information and services."¹⁵⁰ Two weeks after the meeting with the group, Rutherford notified Dr. Elliott, Deputy Minister of Health, that that he had prepared a bill and

was sending a copy to Mr. James Wilson the solicitor for the association.¹⁵¹ Mr. James Wilson was with the firm Guy, Chappell, Guy, Wilson & Coghlin.

The nature of the type of bill became an issue almost immediately. The association lawyer Mr. Wilson, sent a draft of the proposed act to Barnett with a note:

Dr Pincock was not happy with the suggestion that the act combine training standards and the affairs of the organization.¹⁵²

The lawyer appreciated Pincock's concern to maintain a separation between the Government department responsible for operating the mental hospital training schools, and the day-to-day conduct of affairs of the association. The lawyer suggested this could be done by preparing the bill in two parts: Part 1 relating to training and qualifications and Part 11 the affairs of the association.¹⁵³ This could have satisfied the determination of the superintendents to have control over the training, but one of those contingencies occurred that may have altered this particular course. Due to the large volume of legislation it was decided to hold the bill until the spring session.¹⁵⁴

The delay may have caused the government to rethink the nature of the bill. In November, MacInnes, executive assistant to the minister, notified Rutherford that the bill as drafted in two parts would be placed before the Legislature in spring 1960.¹⁵⁵ He also informed Rutherford that the Minister of Health and Public Welfare would sponsor the bill.¹⁵⁶ In January 1960, Elliott sent a note to the minister summarizing discussions with Pincock regarding the bill. He added that Part 11 could perhaps be implemented by other means such as being introduced as a separate private bill or by incorporation under the companies act.¹⁵⁷ Why he raised this issue and what happened behind closed doors during the next six days is unknown, but on January

12, 1960, MacInnes in a note to the file and copied to Elliott stated that it had been decided to introduce the Psychiatric Nurses Act as a Private Bill and Dr. Martin would introduce it. He had informed the association lawyer, Wilson, who expressed disappointment in the change but he was informed the government as a whole had decided.¹⁵⁸ What impact this last minute decision had on psychiatric nursing can only be guessed at and a month later two separate bills came to the floor of the house.

* * *

On February 17, 1960, *The Standing and Select Committees on Private Bills* presented their reports to the house. The Clerk introduced the reports of the committees which had examined the petitions of no less than thirty-four private bills, including petitions from a number of Hutterite colonies, church organizations, religious hospitals, the Winnipeg Canoe Club and the Greater Winnipeg Transit Commission. Towards the end of the list, between The Abram Arthur Kroeker Foundation and The Dental Technicians, was:

Alfred Herbert Barnett and others praying for the passing of the Act to incorporate the Psychiatric Nurses Association of Manitoba.¹⁵⁹

Mr. W. G. Martin, the progressive conservative member for St. Matthews, had introduced Bill 86. The bill passed second and third reading with no discussion and so the Psychiatric Nurses Association of Manitoba was born by royal assent on March 26, 1960.

The second bill was introduced during the same legislative session and aroused slightly more interest. Bill 66, a public bill, was introduced by the Honourable George Johnson, Minister of Health and Welfare. Its first reading was unremarkable, but at the second reading Johnson rose to speak to the bill:

The principle of this bill simply regularizes and makes uniform the curriculum of training at our three institutions. . . . This new proposal will raise the standards and improve the quality of patient care and will put our nurses on a par with those from other provinces. . . . Also in this bill a curriculum committee is established.¹⁶⁰

Questions were raised about the length of the course, whether the students would be paid, and what the entrance requirement would be. Seeming to be satisfied with the answers, the speaker presented the motion, and, following a voice vote, declared the motion passed.¹⁶¹

Following an unremarkable third reading, the bill received royal assent on March 26, 1960.¹⁶² The curriculum committee (officially called the Education Advisory Committee) established by this legislation became a dominant force in the education of psychiatric nurses over the next twenty years.

Conclusion

Throughout the 1950s psychiatric nursing in Manitoba began to develop a self-consciousness of its place in the mental health system. Changing beliefs about the nature and treatment of mental illness were slowly reflected in the education of psychiatric nurses. The MARN seemed indifferent to nursing in the mental hospitals, while the new LPN Advisory Council assisted the nursing instructors in the mental hospitals in acquiring basic standards for a curriculum. Developments in western Canada, and the newly formed CCPN encouraged the emerging male leadership in Manitoba to formalize their interest through legislation. The superintendents, although perhaps still paternalistic, encouraged the move towards legislation.

At the end of the 1950s psychiatric nursing in Manitoba was being carried out by a mix of men and women with varying degrees of training and experience. Some

were skilled at working with the mentally handicapped at Portage, but had never worked in a mental hospital. There were also male attendants who had graduated from either BMH or SMH with a diploma in psychiatric nursing issued by their respective superintendent. Some of the female nurses were mental hospital graduates with training similar to the male attendants but some of the females also had an LPN diploma. There were a few graduates of the combined general/psychiatric nurse and post graduate programmes, although most of these were employed in the schools of nursing. Over the next few years this diverse group became united under the title Registered Psychiatric Nurse.

There was no single event that brought about the establishment of the profession in Manitoba; rather there were a number of factors that coalesced at critical moments to bring about the pivotal legislation in 1960. In the next chapter the struggle to establish the new association as a professional body is described and the emerging view of psychiatric nursing education and curriculum models are discussed.

Endnotes Chapter 3

1. One of the strategies of the Canadian Nurses Association to involve itself in the western Canadian psychiatric nursing situation, following the “Battle at Banff” was the development of a curriculum framework that would allow certain psychiatric nurses to become registered nurses (RN). The CCPN had been invited to a second meeting in Ottawa in 1955 and three male psychiatric nurses attended. They gave a favorable report to the CCPN inter-provincial conference at North Battleford in June, 1955 and agreed that the plan gave the psychiatric nurses a good deal. British Columbia was chosen as the test site for the proposed curriculum. At the June 1956 annual meeting, the Chairman of the CCPN, Richard Strong, gave a comprehensive and favorable report of the work of this committee although he also cautioned “We still must be constantly on guard and wary of proposals which might be detrimental to Psychiatric Nurses.” At the 1957 CCPN Annual Meeting, held in British Columbia, the project was briefly alluded to but it never appears again in the minutes of the meetings of this body. The proposed combined curriculum was similar in structure to the one already in place in Brandon. Tipliski simply noted the project failed, “Parting at the Crossroads” 463. In fact a committee was struck in B.C. to develop the recommended programme. The members included instructors from Essondale Mental Hospital, a number of General Hospitals, and the University of British Columbia. The committee was divided into two, to develop a psychiatric nursing section and a general nursing section. One of the sub-committees declared it was not able to define a psychiatric nurse and instead decided to define psychiatric nursing. They then established a central objective that the programme would develop a person who would function in general nursing and psychiatric nursing. This group worked throughout 1956 and it is noted that Dr. Gee was present at one meeting. They were obviously carrying out the mandate from Ottawa to develop a combined programme. One of the difficulties that this project seemed to have from the outset was that the two subcommittees met independently. They referred to the psychiatric portion and the general nursing portion of the proposed curriculum. This may well highlight the fundamental problem between the two kinds of nursing. Despite obvious goodwill in trying to arrive at a combined programme, the nursing educators continued to keep psychiatric nursing and general nursing separate. Was this at the request of the psychiatric nurses at the table or does it reveal a deeply inherent difference between the two? The muddled thinking revealed in the minutes suggests that separation rather than integration marked the deliberations. The minutes of five meetings were found in the papers of Miss Catherine Murray at the College of Registered Psychiatric Nurses of British Columbia. There were no minutes after December, 1956 and there is no explanation as to why the project did not proceed.

2. PAM, GR 157, H-14-21-1B, Schultz to Elliott, October 10, 1952.

3. PAM, P 4562, Minutes of Licensed Practical Nurses (LPN) Advisory Council, February 11, 1946 and Minutes of LPN Advisory Council, September 25, 1950.

4. PAM, P 4562, Minutes of LPN Advisory Council, December 18, 1945.
5. PAM, P 4562, Minutes of LPN Advisory Council, November 12, 1945.
6. PAM, P 4562, Minutes of LPN Advisory Council, December 18, 1945.
7. Ibid.
8. Ibid.
9. PAM, P 4562, Minutes of LPN Advisory Council, February 11, 1946.
10. PAM, GR 157, H-16-19-1, Special Conference February 26, 1946.
11. PAM, P 4562, Minutes of LPN Advisory Council, September 9, 1946.
12. PAM, P 4562, Minutes of LPN Advisory Council, September 25, 1950.

13. Personal communication Terry Gibson, December 11, 2007. Gibson was a graduate of the three and half year programme in 1957. She remained at BMH and became Senior Nursing Administrative Officer (SNAO) in 1970. She said the well-educated nurses who had both an RN and mental nurse diploma got excellent job offers and many of them left for better opportunities. It seemed there was no commitment to stay at BMH following the training. They had received a small stipend while they were on affiliation. The Register. Six classes graduated from this programme with a total of 60 graduates. Appendix E, curriculum three and half year combined programme at Brandon.

14. The minutes of the LPN Advisory Council gave the names of the places from where the students graduated. In the early 1950s there was a school at St. Boniface Infirmary and another at a Central School in Winnipeg as well as the schools at Portage School for Retardates and Selkirk Mental Hospital. The names of the students are listed from each training site.

15. At the February 23, 1953 *Meeting of Directors and Instructresses*, Miss Ditchfield from Portage, Miss Solar from Selkirk, and Miss Ryfa and Mrs. Hotson from Brandon participated. The instructresses from the three mental institutions appear as active participants at subsequent curriculum meetings.

16. Wendy M. Nehring, *A History of Nursing in the Field of Mental Retardation and Developmental Disabilities* ed. Gary Siperstein (Washington, D.C.: American Association on Mental Retardation, 1999), xiii.

17. For example, all three superintendents reported to the provincial psychiatrist. The Minutes of Meetings of Medical Superintendents show that they shared similar concerns.

18. Edginton, "Moral Treatment to Monolith": 176

19. Vera Stokes undated short article entitled "Articles of Interest: The Evolution of the Manitoba School for Mental Defectives Portage la Prairie 1890-1943". Manitoba Developmental Centre Museum. (Formerly the School for Retardates) Portage la Prairie, Manitoba.

20. Edginton, 176.

21. Note 19, Chapter 3 this study. This information is a synopsis of the article by Vera Stokes. There are no references, therefore, its authenticity cannot be verified. The annual reports suggest the information is reasonably accurate.

22. Legislative Library, Department of Health and Public Welfare Annual Report, Provincial Mental Hospitals, 1930, 102.

23. Ibid., 99.

24. Ibid., 100.

25. Ibid., 100.

26. Kellie, "A History of the School of Nursing: The Manitoba Developmental Centre," 1.

27. CRNM Archives, Minutes of MARN Board Meeting, October 1, 1937 and Special Meeting November 1, 1937. The suggestions were: 1. Portage School should be affiliated with Brandon and Selkirk. 2. That the students from both schools might benefit from the added experience in caring for this type of patient. 3. That a small group of women just sufficient to meet the needs be admitted once a year and that they be given three to four months intensive preparation. This could be made as wide and varied and cultural as desired and would satisfy the statement that a Teaching Institution is the most efficient and would provide at the same time better prepared personnel. It is difficult to understand the intent of these statements when the MARN was basically opposed to the plan and stated they would not register these workers anyway. But perhaps they viewed the training of an auxiliary group of personnel as acceptable. They seemed to be concerned that the proposed programme had been designated as *nurse training*. What concern it was of theirs is indicated by the Minister's response.

28. Ibid.

29. Ibid.

30. Ibid.

31. Legislative Library. Department of Health and Public Welfare Annual Report, Manitoba School for Mentally Defective Persons, 1951, 173.

32. *Ibid.*, 175.

33. *Ibid.*, 177. Also PAM, GR 157, S-14-21-1B. Correspondence Ivan Schultz, the Minister of Public Health and Welfare and Dr. Pincock, Provincial Psychiatrist, October 1950. It is interesting to note that Dr. Atkinson had considerable difficulty in finding a suitable instructress. He advertised and solicited the Registered Nurses Association without result. He finally secured the services of Miss Ditchfield, a local RN, on a part time basis. This did not sit well with Schultz who wrote to Pincock, with the observation "The lady in question is 46 years of age and there is a provision that individuals over the age of 40 are not to be hired." Pincock responded that there was little choice and Atkinson had done the best he could. Miss Ditchfield gave 20 years of faithful service to psychiatric nursing education in Manitoba.

34. H. S. Atkinson, "The Registered Nurse—A Specialist: Psychiatric Institutions Need Them," *The Canadian Nurse* 51 (7) (July 1955): 544-546, 546.

35. This interview was conducted in stages. The interviewee was elderly and frail but she was quite clear in her feelings towards the RNs. August 2, 2005, and February 14, 2006.

36. Refvik *History of the Brandon Mental Health Centre*. Pincock "A Half Century of Psychiatry."

37. Refvik, 55.

38. Dr. Edward Johnson, Graduate of the Manitoba Medical College, joined the staff of the Selkirk Mental Hospital as a psychiatrist in 1928 or 1931. (There is a discrepancy in the dates of his appointment to Selkirk between the *Bison* and his obituary). He was appointed Superintendent in 1943 and Provincial Psychiatrist in 1959. He retired in 1967. Sources: *Bison* Vol XII #3, p 14 and Obituary, *Winnipeg Free Press*, Oct 18, 1994.

39. Dr. Pincock, M.D., L.R.C.P. Dr. Pincock graduated from Manitoba Medical College in 1921. He was a medical missionary in China until 1928 and was appointed Superintendent of Brandon Mental Hospital in 1930, a position he held until 1942 when he became Provincial Psychiatrist. Sources: *Bison* Vol XII, #3, page 14 and Obituary *Winnipeg Free Press*, May 25, 1978. Dr. Johnson had undertaken post graduate training at Harvard Medical School and the Henry Phipps Psychiatric Clinic, John Hopkins Hospital. Source Obituary. Dr. Stuart Duncan Schultz, B.A., L.R.C.P., M.R.C.S. (England). He received his Bachelor of Arts from University of Manitoba in 1916. He then joined the Canadian European Forces, serving until 1919. Following this he studied medicine at Middlesex Hospital and University of London graduating in 1925. That same year he

returned to Canada and joined the staff of Brandon Hospital for Mental Diseases. He served as Medical Superintendent from 1942 to 1959. Source: Obituary, Winnipeg Free Press, August 13, 1974.

Dr. Atkinson graduated from the Manitoba Medical College in 1928. He was at Selkirk Hospital for Mental Diseases for 2 years before beginning his superintendency at the Manitoba School for Mentally Defective Persons at Portage la Prairie in 1930, a position he held until his untimely death in 1965. Source: "Atkinson Dies of Injuries," Winnipeg Free Press, October 19, 1965.

40. PAM, GR 157, H-16-19-1, Minutes of Meeting of Medical Superintendents of Hospitals for Mental Diseases, the Manitoba School for Mentally Defective Persons and the Provincial Psychiatrist, March, 1951.

41. Ibid.

42. Ibid.

43. Quoted in Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), 68.

44. PAM, GR 157, H-16-19-1, Report Johnson to Elliott. Appended to Minutes of Medical Superintendent's Meeting June 6, 1951.

45. PAM, GR 157, H-16-19-1, Report Pincock to Elliott May 24, 1955.

46. Ibid., 2.

48. Ibid., 2.

48. Ibid.

49. Jones, 14.

50. Morris S. Schwartz and Emmy Lanning Shockley, *The Nurse and the Mental Patient: A Study in Interpersonal Relations* (New York: Russell Sage Foundation, 1956).

51. Grayce Sills, "Use of Milieu Therapy," in *Psychiatric Nursing 1946 to 1974: A Report on the State of the Art*. Compiled by Florence L. Huey. (New York: The American Journal of Nursing Company, 1975), 23-34.

52. PAM, GR 157, H-16-19-1, Reports Dr. Tavener and Dr. Forster to Dr. Elliott on their attendance at the Annual Meeting of the American Psychiatric Association in Chicago, April 30–May 4, 1956.

53. PAM, GR 6224, Q 12366. The annual reports compiled at the BMH provide far more detail than the condensed Annual Reports found in the Legislative Library. The 1954 BMH report, for example, gives details of various examinations performed as well as the number of injections given and dressing pads used.

54. Legislative Library, Department of Health and Public Welfare Annual Report, Mental Hospitals, 1956,166.

55. Ibid., 166. Jack Seymour had been a mental hospital trained attendant and identified himself as M. Dip. meaning Mental Nurse Diploma. His description of the way that male nurses participated in woodworking and crafts is consistent with Boschma's concept of the nurse artisan.

56. PAM, GR 157, H-16-19-1A, Schultz to Schultz July 18, 1952.

57. Note 52, chap. 3, this study.

58. Narfason, "Historical Persective," 5.

59. PAM, GR 6224, Q12366, Annual Report Brandon Hospital for Mental Diseases 1962 (Hospital Copy). Dr. Cziller's comment was made in the Annual Report of Team 3.

60. McKee Archives, Brandon University, SB 8, File 2

61. PAM, GR 6224, Q12352, General Regulations of the Brandon Hospital for Mental Diseases, April 1, 1957, 1-4.

62. PAM, GR 6224, Q12352, Ward Regulations of the Brandon Hospital for Mental Diseases, April 1, 1957, 93. Weekly Routine Ward 1, Monday patients bathed, Saturday laundry counted.

63. Digby, "Madness, Morality and Medicine" Tomes, "A Generous Confidence" D'Antonio, "Negotiated Care":

64. Note 59, chap. 3, this study.

65. McKee Archives, Brandon University, SB 47, File 4. Brandon Hospital for Mental Diseases Manual of Nursing Procedures, September 1, 1954.

66. BMHC Museum. Notes on Medical and Surgical Nursing, Brandon Hospital for Mental Diseases, September 1, 1957.

67. PAM, GR 6224, Q12366, 1954 Annual Report (Hospital Copy). In 1954 it is reported that on The Continued Service (a euphemism for chronic ward) it was necessary to keep many disturbed patients on treatment at regular intervals. Four hundred and sixty-eight patients received treatment resulting in many thousands of

treatments. Treatment for newly admitted patients numbered 367 receiving electric shock, 84 insulin shock, 15 combined electric and insulin shock, and 35 leucotomies were performed. For the first time the use of Largactil is reported as a therapeutic agent. One hundred and fifty-four patients were the first to receive this.

68. PAM, GR 6224, Q12344, Instructions Re: Leucotomies by Stuart Schultz, M.D., Medical Superintendent, January 22, 1953. It is reported in the annual report of 1954 that Dr. Schultz also published papers on leucotomies performed at BMH. "An Evaluation of Treatment: The Brandon Hospital for Mental Diseases," Schultz Stuart, Henderson A. L., Clarke, E. F., Fisher, J. W. *Medical Services Journal Canada XIV* (4) (April 1958).

69. BMHC Museum, Insulin Shock Therapy Manual by E. Bunch, West Insulin Supervisor, November 14, 1958.

70. Katherine McL. Steele and Marguerite L. Manfreda, *Psychiatric Nursing*, 4th ed. (Philadelphia: F.A. Davis Company, 1953), 421.

71. BMHC Museum, Insulin Shock Therapy, 2.

72. Email Marlene Brichon, August 30, 2006.

73. Interview Marlene Brichon, October 22, 2006.

74. PAM, GR 6224, Q12344, Notes on Psychiatry, Manual by Stuart Schultz, M.D., December 1, 1956.

75. Shorter, "A History of Psychiatry," 1997.

76. John D. M. Griffin, "An Historic Oversight," *Canadian Psychiatric Association Bulletin* 26 (2) (April 1994): 5. Kajander never published her work and ended up practicing in Thunder Bay, Ontario.

77. PAM, GR 6224, Annual Report, 1955 (Hospital Copy), 23.

78. PAM, GR 6224, For example the 1957 Annual Report cites the following 3 studies conducted by BMHC staff: 1. A Clinical Study of "Frenquel" in Schizophrenia; Foster, W., Henderson, A.L. C.M.S.J. Jan. 15, 1957; Perphenazine (Trilafon) Therapy - A Pilot Study: Schultz, Stuart, Henderson, A.L. C.M.A.J. Dec. 15, 1957; Final Report Psychiatric Research Project 606-5-67-Study of Application of New Drugs in Psychiatry; Schultz, Stuart, Henderson, A.L. Brandon Hospital for Mental Diseases, April 30, 1957, 22.

79. Email Marlene Brichon, August 30, 2006.

80. There is a meticulously compiled document, by an unknown author, which identifies the number of hours of instruction and the number of weeks of clinical

experience for each of the 6 educational programmes conducted between 1920 and 1970. The 6 programmes were: Psychiatric Nursing Diploma for female students, Psychiatric Nursing Diploma for male students, both of which had been in place since 1920 though the males received fewer hours of instruction. The two Combined Psychiatric Nursing with Registered Nursing programmes, the 4 year which was important to Tipliski's and Dooley's studies and the 3 1/2 year Combined Programme which replaced it. The fifth programme was the post graduate course for general nurses by which an RN, after a period of study at BMH, received a Psychiatric Nurses Diploma. The sixth programme was the Combined Psychiatric Nursing with Licensed Practical Nursing which is important to this study. The unknown author went to considerable effort to assemble this information.

81. Joseph J. Schwab, "The Teaching of Science as Enquiry," in *The Teaching of Science* (Cambridge, MA: Harvard University Press, 1966), 1-99, 32.

82. The model of commonplaces is articulated by Joseph J. Schwab, "The Practical: Translation into Curriculum," Chapter 12 in *Science, Curriculum, and Liberal Education: Selected Essays* (eds.) Ian Westbury and Neil Wilkof (Chicago: The University of Chicago Press, 1978).

Other curriculum models are identified in William H. Schubert, *Curriculum: Perspective, Paradigm, and Possibility* (New York: Macmillan, 1986).

Joan S. Stark and Lisa R. Lattuca, *Shaping the College Curriculum: Academic Plans in Action* (Boston: Allyn and Bacon, 1997). Stark and Lattuca identify *curriculum frameworks* for higher education. For example Geneva Gay, 31-32; Chickering, 33; Dressel and Marcus, 33.

The term training is preferred to education. Education implies a more critical, academic style of learning whereas nurse's training at that time entailed attention to ritualization and procedures rather than thought.

83. M. Connelly and D. J. Clandinin, *Teachers as Curriculum Planners: Narratives of Experience* (New York; Teachers College Press, 1988), 85.

84. PAM, GR 157, H-14-21-1B, Manual for Administrators of Schools of Practical Nursing. Advisory Council Licensed Practical Nurses Department of Health and Public Welfare, November, 1952.

85. BMHC Museum. The Curriculum for Manitoba Licensed Practical Nurse Training Schools, Department of Health and Public Welfare. The 10 subjects taught were Nursing Arts, Human Body and How it Functions, Personal and Community Health, Surgical Nursing, Medical Nursing, Drugs and Solutions, Care of Mother, Infant and Child, Nutrition and Homemaking, Behavior and Working Relationships, Civil Defence. Each subject was set out identifying discrete topics and the objective and student application for each. The document was developed between 1949 and 1951.

86. PAM, P 4562, Minutes of LPN Advisory Council. On June 22, 1953 a special meeting was held regarding policies for the combined course to prepare

materials for presentation to the superintendents. Appended to Minutes of the LPN Advisory Council, September 23 1953. The material is in the form of a manual which gives information on the requirements of the combined course. The manual is similar in format to the one prepared for the LPN course. A copy of the manual was located in McKee Archives SB 47.

87. The document identified in note 80 this chapter, this study reports the following hours in the Combined LPN programme: Psychiatry, 73; Psychiatric Nursing, 55; Psychology, 10; Occupational Therapy, 8 First Aid, 12; Microbiology, 15; Personal Hygiene, 37. These were over and above the requirements of the LPN training.

88. PAM, P 4562, Minutes of LPN Advisory Council, September 12, 1957.

89 The Civil Service Commission determined the number of positions for each government department called *the establishment*. In order to change the establishment the superintendents had to provide detailed explanations for their requests. This seems to have been part of the difficulty of running the training programmes in which students were away on affiliation. Their positions could not be filled while they were away.

90. PAM, P 4562, Minutes of LPN Advisory Council, December 12, 1957.

91. Ibid.

92. Kellie, 4.

93. PAM, P 4562, Minutes of LPN Advisory Council, May 1, 1958.

94. PAM, GR 6224, Q12344, School of Nursing Annual Reports. Refvik, 119. Throughout the 1950s the majority of the nursing instructors had received psychiatric nursing training either as a *post graduate student* or they had graduated from the *combined course*. For example, the Director of Education was Mrs. Hotson who had graduated from the *post graduate* course in 1944. In 1951 there were 4 instructors. Anne Stanley and Hope Toews were both graduates from the *combined course* in 1948. Patricia Beecher was a *post graduate* of 1951 and Lillian Arnott, *post-graduate* 1949. Both Mrs. Stanley and Mrs. McDonald (nee Hope Toews) attended McGill 2 years later and obtained a certificate in teaching and supervision. By 1958 all the instructors listed in the annual report had 1 year post-graduate university education. Some had been funded under the National Health Grants. A similar profile of the instructors is evident throughout the remainder of the 1950s and into the early 60s.

95. In 1955, 32 students graduated from the 5 different programmes offered by BMH. There were also a total of 29 students affiliating from the Brandon General Hospital and Dauphin General Hospital. The instructors also provided 18 hours of instruction to the Student Laboratory Technologists and 31 hours to Nurse Aides.

Source: 1955 School of Nursing Annual Report. By 1958 the number of students affiliating had increased to 48 as Children's Hospital in Winnipeg was now sending their students to BMH. In the 1959 Annual Report it is noted a new course outline had been approved by the Psychiatric committee, (Selkirk, Portage, and Brandon). The classroom hours for the male psychiatric nurses increased from 398 to 530 in the 3 year programme. The entrance requirement for the males was changed to be the same as for the Licensed Practical Nurses. Grade X. This may have been in response to the pending legislation. Source: School of Nursing Annual Report. 1959.

96. Interview Marlene Brichon, October 22, 2006.

97. Interview Remi Beaudette, November 27, 2006, and Interview Walter Tetzlaff, February 1, 2007. These two male psychiatric nurses spoke highly of the instruction they received from senior male staff on the wards.

98. Suzanne Lego, "The One-To-One Nurse Patient Relationship," in *Psychiatric Nursing 1946 to 1974: A Report on the State of the Art*. Compiled by Florence L. Huey (New York: The American Journal of Nursing Company, 1975), 1-14.

99. Bruce P. Mericle, "The Male as Psychiatric Nurse," *Journal of Psychosocial Nursing* 21 (11) (1983): 28-34. John S. Hughes, "Country Boys Make the Best Nurses: Nursing the Insane in Alabama, 1861-1910," *Journal of the History of Medicine and Allied Sciences, Inc* 49 (1994): 79-106. Caroline Mackintosh, "A Historical Study of Men in Nursing," *Journal of Advanced Nursing* 26 (1997): 232-236.

100. James W. Egeland and Julia S. Brown, "Sex Role Stereotyping and Role Strain of Male Registered Nurses," *Research in Nursing & Health* 11 (1988): 257-267. Moshe Krausz, Peri Kedem, Ziona Tal and Yehuda Amir, "Sex Role Orientation and Work Adaptation of Male Nurses," *Research in Nursing & Health* 15 (1992): 391.

101. Norma R. Kelly, Mary Shoemaker and Tim Steele, "The Experience of Being a Male Student Nurse," *Journal of Nursing Education* 35 (4) (April 1996): 170-174. Gary D. Okrainec, "Perceptions of Nursing Education Held by Male Nursing Students," *Western Journal of Nursing Research* 16 (1) (1994): 94-107.

102. Dean Care, David Gregory, John English and Peri Venkatesh, "A Struggle for Equality: Resistance to Commissioning of Male Nurses in the Canadian Military, 1952-1967," *Canadian Journal of Nursing Research* 28(1) (1996): 103-117. Katrina Burt, "Male Nurses Still Face Bias," *American Journal of Nursing* 98 (9) (September 1988): 64-65.

103. Rodney B. Kebicz, "The Art of Caring: Male Nurses Providing Personal and Intimate Care with Female Patients" (masters thesis, University of Manitoba, 2000).

104. Sandra Ryan and Sam Porter, "Men in Nursing: A Cautionary Comparative Critique," *Nursing Outlook* 41 (6) (November/December 1993): 262-267. Christine L. Williams, "Hidden Advantages for Men in Nursing," *Nursing Administration Quarterly* 19 (2) (Winter 1995): 63-70. Joan Evans, "Men in Nursing: Issues of Gender Segregation and Hidden Advantage," *Journal of Advanced Nursing* 26 (1997): 226-231. Tim Porter-O'Grady, "Reverse Discrimination in Nursing Leadership: Hitting the Concrete Ceiling," *Nursing Administration Quarterly* 19 (2) (Winter 1995): 56-62.

105. Joan Evans and Paula Cameron, *Final Report: Contradictions and Tensions in the Lives of Men: Exploring masculinities in numerically female-dominated professions of nursing and elementary school teaching*, Dalhousie University, Social Sciences and Humanities Research Council of Canada, June 10, 2007.

106. Barbara L. Paterson, Sharon Tschikota, Marta Crawford, Marian Saydak, Peri Venkatesh and Teri Aronowitz, "Learning to Care: Gender Issues for Male Nursing Students," *Canadian Journal of Nursing Research* 28 (1) (1996: 25-39).

107. Sandra L. Bem, "Probing the Promise of Androgyny," in Alexandra G. Kaplan and Joan P. Bean, *Beyond Sex-Role Stereotypes: Readings Toward a Psychology of Androgyny* (Boston: Little Brown and Company, 1976).

108. Connor, "Neither Courage Nor Perseverance Enough," Moran, "Keepers of the Insane,"

109. McKee Archives, SB 3A, File 3. One small document discovered in the McKee Archives appears to be a list of observations, made by a group of attendants, deploring some of the conditions under which the male patients lived. It included references to, porridge being served on flat plates, lack of spiritual guidance, and many patients with untreated hernias. The document is undated but from references made to the *airing court* it would seem to be from the 1940s. It is signed by a group of concerned attendants but no names appear. It does however show that there was a certain concern for fellow human beings. See also Boschma, "The Gender Specific Role of Male Nurses in Dutch Asylums: 1890-1910," *Nursing History* 4 (3) Summer 1999, 13-19.

110. Boschma, "Creating Nursing Care for the Mentally Ill: Mental Health Nursing in Dutch Nursing Asylums".

111. Geertje Boschma, Olive Yonge, and Lorraine Mychajlunow, "Gender and Professional Identity in Psychiatric Nursing in Alberta Canada, 1930-1975," *Nursing Inquiry* 12 (4) (2005): 243-255. Christopher Dooley, *Needle Nurses and People Persons: Examining the Representational Strategies of Male Psychiatric*

Nurses in Post-war Western Canada. Paper presented at the Canadian Association for the History of Nursing Conference, Saskatoon, Saskatchewan, June 1, 2007.

112. The Register. In the records kept of all of the students who had passed through Brandon Mental Hospital School of Nursing, certain notations are made. It is noted on the entry of 1947 that the course is now compulsory for men. 197.

113. In the Annual Report of the Brandon Mental Hospital 1958 in the section entitled, *male staff resignations*, Mr. Peter Bertuzzi served on the staff from August 23, 1916 to March 31, 1958. Mr. Alexander Douglas served from April 1927 to April 1958. Mr. Alfred Morley served from 1930 to 1958. We wish to acknowledge the faithful service of these employees.

114. The Register, 194. Appendix E, Curriculum for Male Attendants.

115. PAM, P 4562, Minutes of LPN Advisory Council, December 6, 1956.

116. Ibid.

117. PAM, P 4562, Minutes of LPN Advisory Council, April 24, 1957. Our first male Practical Nurse student is now attending the Central School.

118. PAM, P 4562, Minutes of LPN Advisory Council, December 12, 1957

119. The Register. It is noted that in 1967 David Ezzard gained his LPN and in 1968 Patrick Golding achieved his LPN. In 1965 it is noted that 3 male students took the LPN but it is unclear if they were successful.

120. Author Unknown, *Dear Bill, Let's Start an Association . . .* The original letter seems to have been lost but the tradition is strong that this is the way in which the Canadian Council of Psychiatric Nursing began.

121. Office of the Registered Psychiatric Nurse's Association of British Columbia. "A Short History of Psychiatric Nursing in BC." Circa 1951 by Richard Strong. Papers donated by the family of Miss Catherine Murray.

122. Handwritten notes found in Miss Murray's papers of the first meeting of Psychiatric Nurses of British Columbia in 1947.

123. Strong, A short history.

124. Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing," 300.

125. Author Unknown, Dear Bill, 6.

126. File called *History* located at the Alberta Registered Psychiatric Nurses Association, Edmonton, Alberta. The filing in this provincial association (as indeed in other provinces as well) is not done according to any particular system, although there are obvious efforts to file chronologically. This file came from a filing cabinet with items in more or less chronological order from oldest to most recent. Ted James became the first president.

127. Ibid.

128. Author Unknown, "Psychiatric Nurses Association of Canada," *Prism* (July 1980): 7-16, 8.

129. Canadian Council of Psychiatric Nursing Archives (hereafter CCPN) Minutes of CCPN Meeting June 17 and 18, 1954, Essondale, B.C. The archives of the CCPN are now stored in the Offices of the Registered Psychiatric Nurse's Association of Saskatchewan (RPNAS) Regina, Saskatchewan. References to records of this body are located there unless otherwise stipulated.

130. Tipliski, 444.

131. Mr. Strong and Mr. Butcher, British Columbia, and Mr. James, Alberta, attended the CNA meeting in Ottawa, 1955. This was the meeting which involved a lengthy discussion regarding a programme which could enable psychiatric nurses to become registered nurses. The programme was to be implemented in British Columbia. Note 1, chap. 3, this study.

132. Author Anonymous, "The History and Future of Psychiatric Nursing," *Canadian Journal of Psychiatric Nursing* XXIV (4) (Oct/Nov/Dec.1983): 6-10, 9.

133. CCPN Archives, Minutes of CCPN Meeting, June 17 & 18, 1954. Essondale, British Columbia.

134. CCPN Archives, Minutes of the CCPN Meeting June 16 & 17, 1955. North Battleford, Saskatchewan.

135. CCPN Archives, Minutes of CCPN Meeting June 14 & 15, 1956, Oliver, Alberta.

136. CCPN Archives, Minutes of CCPN Meeting June 13 & 14, 1957. Essondale, British Columbia.

137. *The Bison*, X (2) (July, 1957), 6

138. Ibid., 14. Mr. Schreder's name was frequently spelled incorrectly. It seems Schreder is the correct spelling.

139. PAM, GR 6224, Annual Report, (Hospital Copy), 1957 notes that Miss Gladys Fitzpatrick was hired as Matron of BMH May 1, 1957. *The Bison* notes she had worked at Weyburn as well as North Battleford. Personal communication Wayne Leflar, December 17, 2007. Wayne Leflar, a BMH graduate, was the son of Duke Leflar. He confirmed his father knew Fitzpatrick.

140. CRPNM Archives, File Old Correspondence. Schreder to Russell September 23, 1957.

141. CRPNM Archives, File Old Correspondence. Schreder to Russell, December 16, 1957.

142. CRPNM Archives, File Old correspondence. Handwritten notes of the first meeting of the psychiatric nurses held in Brandon, Manitoba, February 20, 1958.

143. Ibid. Miss Fitzpatrick declined the presidential nomination.

144. CRPNM Archives, File Old Correspondence. Russell to Hornibrook, Superintendent of Nurses in Selkirk and Miss Dryden in Portage la Prairie, March 17, 1958. Miss Dryden replied on April 2, 1958.

145. CRPNM Archives, File Old Correspondence. Russell to President, M.G.E.A. Selkirk, Oct 22, 1958. The name of the president is not known.

146. CRPNM Archives, File Old Correspondence. Russell to Pincock, April 23, 1958. Russell to Schultz, March 17, 1958.

147. CRPNM Archives, Pincock to Russell, May 2, 1958.

148. CRPNM Archives Pincock to Superintendents, November 24, 1958, attached to letter from Schultz to BMHC senior staff.

149. PAM, GR 459, File Psychiatric Nurses Act 1959-1968. Rutherford to MacInnes, November 25, 1959. In this letter Rutherford, Legislative Counsel, informed MacInnes, Assistant to the Minister of Health, that he had drawn up the bill and that Mr. Wilson lawyer for the psychiatric nurses had the opportunity to add to it.

150. CRPNM Archives, File Old Correspondence, Russell to Gunter at Selkirk March 13, 1959 congratulating them on forming their association. Barnett to Sprowl at Portage la Prairie, May 14, 1959, informing him of a meeting with Rutherford.

151. PAM, GR 459, File Psychiatric Nurses Act 1959-1968. Rutherford to Elliott, May 29, 1959.

152. CRPNM Archives, File Old Correspondence, Wilson to Barnett, June 10, 1959.

153. PAM, GR 459, File Psychiatric Nurses Act 1959-1968. Wilson to Minister of Health, June 23, 1959.

154. Ibid., Johnson to Wilson, June 26, 1959.

155. Ibid., MacInnes to Rutherford November 24, 1959.

156. Ibid., MacInnes to Rutherford November 27, 1959.

157. Ibid., Elliott to Johnson, January 6, 1960.

158. Ibid., MacInnes to file, copy to Elliott, January 12, 1960.

159. Legislative Assembly of Manitoba, Debates and Proceedings, Vol. 1V No. 22, (February 17, 1960). This was the customary way of presenting Private Bills in the 1960s. E-mail Rick MacLowick, Legislative Librarian, July 17, 2003.

160. Legislative Assembly of Manitoba, Debates and Proceedings, Vol. 1V No. 27, (February 24, 1960), 889.

161. Ibid., 890.

162. Legislative Assembly of Manitoba, Debates and Proceedings, Vol. 1V No. 56, (March 26, 1960), 2009.

CHAPTER 4

... TO BOOKS ...

Introduction

In this chapter, the evolution of the newly formed Psychiatric Nurses Association of Manitoba (PNAM) during its first decade is reviewed. This time was critical to the development of the administrative and legal structure of the governing body, and an emergent professionalism. It was characterized by professionalizing strategies of the male leaders, and the acquisition of a professional ideology. The role of the official Education Advisory Committee was blurred. This committee frequently overstepped its educational mandate and interfered with the legislated right of the association to control membership, including the right to evaluate the credentials of out-of-country graduates seeking registration.

The PNAM tried to gain some influence over its education, but this was hampered, again, by the Advisory Committee who kept control of the curriculum. By the end of the first decade a working compromise was reached with the Advisory Committee, a new curriculum sub-committee had been established, and new curriculum models were beginning to emerge. The leaders of the PNAM also found themselves caught up in political issues that may well have brought about the demise of the association.

The chapter is divided into sections which represent the tenures of the first three presidents of the PNAM, all men. The tenures of the presidents provide natural divisions and also correspond with internal and external events which shaped not only

the presidencies but also the evolution of the profession. The first period is from 1960 to 1966 and covers the first two presidencies. The second period covers 1966-1971.

The First Two Presidents (1960-1966)

The Barnett Years (1960-1965)

Alfred Herbert Barnett is recorded as the first president of the newly formed PNAM, but his involvement in psychiatric nursing in the province went back to 1935. He left few personal files so, even though he is credited with heading the move to form the association, facts about his work are found in brief documents and oral reports. Barnett was an Englishman who came to Canada about 1930 at age 20.¹ Following a short time working at Kingston Mental Hospital in Ontario he came to Manitoba in 1935 where he commenced work at Selkirk Mental Hospital (SMH). In 1942, he joined the war effort as a medic on a troop ship and the story, as recollected by his widow, Myrtle Barnett, is that he met a male attendant from a British Columbia Mental Hospital who was also serving. Barnett learned from this wartime colleague that British Columbia was trying to start an association of psychiatric nurses in that province. Barnett, recalled, “Alf said if they can do it so can we!”²

Barnett’s concern for the welfare and status of psychiatric attendants is a matter of record. He probably participated in the contentious union activities at SMH during 1937 and 1938. It is recorded that in 1947 he was expelled from a convention of the Government-sanctioned Manitoba Civil Service Association (MCSA) because of his affiliation with the Canadian Hospital Employees Union (CHEU).³ He must have switched allegiance to the reorganized MCSA, renamed the Manitoba Government Employees Association (MGEA) in 1950. He is identified as one of the

leaders of the MGEA in the 1950s along with Arthur Russell, a senior attendant from Brandon.⁴ By 1955, Barnett was the second vice-president of the MGEA.⁵

These union activities of Barnett indicated not only a concern for the financial welfare of mental hospital employees, but also their status. While the MGEA was not a *professional* association in the usual meaning of the term, it supported the move towards professionalism by the attendants. An article in *The Bison* which noted the visit of the two CCPN officers from Saskatchewan concluded, “The Manitoba Branch (a psychiatric nurses association) would be independent of the M.G.E.A but would need its support, and there is no doubt the two organizations would cooperate.”⁶

The relationship between the emerging profession of psychiatric nursing and the unions was also remarked upon by Geertje Boschma in her study on the development of psychiatric nursing in Alberta. Boschma observes that psychiatric nursing in Saskatchewan emerged with union support when the male attendants from North Battleford “managed to get a bill passed” and she adds, “In Alberta, attendants resisted and accommodated their exclusion in similar ways. They began to act like their colleagues in Saskatchewan.”⁷ Acting like their colleagues in Saskatchewan meant engaging in union-type activities. When the CCPN was formed in 1951, remnants of this union ethic persisted. In 1954 and 1955, the president, Mr. Strong, and secretary-treasurer, Mr. Butcher, both signed their reports to the annual meeting as *Fraternally Yours*, a term more commonly associated with unions than with professional bodies.⁸

Despite the conceptual confusion, acquiring professional status was the goal of these leaders. Celia Davies describes strategies to acquire professional status as:

The collective actions of leaders of an occupational group designed . . . to institutionalize activities and relations. . . The devices they propose may be political . . . aiming at participation, influence, regulation.⁹

The regulation of the title, work, and behaviour of members of an occupation is commonly achieved through legislation. The accomplishment of the legislation in Manitoba was a political act and a clearly visible step in the process towards professional status for psychiatric nurses. With the passage of the legislation in February 1960, there was a framework in place to govern and control the affairs of the PNAM.

The Psychiatric Nurses Association Act

An Act respecting the Psychiatric Nurses Association of Manitoba states:

The objects of the association are to promote, approve and maintain an enlightened and progressive standard of psychiatric nursing, and to assist in the promotion of mental health and prevention of mental illness, and for such purposes to foster and encourage the maintenance of schools for the training of psychiatric nurses and others concerned with the care and treatment of the mentally, and to cooperate with other persons or organizations interested in the promotion of mental health and prevention of mental illness.¹⁰

The act set out the structure and responsibilities of the *council* which was to be the governing body of the association. It set down criteria for membership and restricted the use of the title *Psychiatric Nurse* (Psych. N.) to those who met the criteria. The legislation also gave the council power to suspend, revoke, or cancel a licence for dishonesty, incompetence, habit or illness, conduct not conforming to standards or unbecoming, but it left to the council any action for such offences as it may deem advisable. It also stated to whom the act did not apply including family members, registered nurses, and licensed practical nurses. This last statement was

important. When the MARN learned of the passage of the act, it immediately set up a committee to study it, no doubt concerned that its own powers might be threatened.

On November 5, 1960, almost nine months after the legislation had been enacted, it is recorded in the MARN board meeting minutes:

There was extensive discussion of the acts pertaining to the education of psychiatric nurses and the establishment of the Manitoba Psychiatric Nurses Association, and the anticipated increase in the number of psychiatric nurses which (sic) will be seeking employment outside psychiatric institutions.¹¹

How the last conclusion was arrived at is not clear, but it was obvious that the MARN believed that these two acts might affect the practice of general nurses working in psychiatric settings outside the provincial institutions.

The MARN established a committee, "To define the method by which this legislation and its implications for RNs should be studied."¹² On February 4, 1961, Miss M. Wilson reported that the committee had met and reviewed the act and concluded:

The committee was of the opinion that neither of these acts conflict with the RN act. Section 24 of the PN act specifically states that that the act does not affect or apply to the nursing care of the mentally ill by an RN.¹³

Apparently the drafters of the legislation thought it wise to state that this body had no jurisdiction over other nurses. Subsequent events, however, proved this was a loophole as the practice of psychiatric nursing was difficult to define. The MARN may have thought that was the end of the matter, but the following month they received a letter from a member of the new association discussing conditions under which psychiatric nurses were being employed in general hospitals.¹⁴

* * *

The LPNs did not acknowledge the passage of the two acts in their Advisory Council minutes, probably because they already had a close working relationship with the instructors from the provincial mental institutions and a number of psychiatric nurses were also LPNs.¹⁵ The LPN Advisory Council had proven itself helpful in developing some standards for psychiatric nursing education, and the matter of legislation seemed not to be an issue for them. Over the next twenty years, relationships among the three nursing bodies in Manitoba experienced a number of high and low points.

The Psychiatric Nurses Training Act

The enlightened and progressive standard of psychiatric nursing, which was stated as the first object of the *Psychiatric Nurses Association* was not to be the responsibility of that body. One path to enlightenment is through education, but the responsibility for education was entrusted to a separate body in *An Act to Provide for the Education of Psychiatric Nurses*. This act prescribed the structure and functions of the body legislated to control psychiatric nursing education:

There is hereby established an Advisory Committee, which shall be known as:

The Psychiatric Nurses Education Advisory Committee, which shall consist of

- (a) the provincial psychiatrist appointed under the Mental Deficiency Act, who is the chairman of the committee;
- (b) the medical superintendent and also the superintendent of nurses of each approved school;
- (c) three persons appointed by the Lieutenant-Governor-in-Council from among persons nominated by the association.¹⁶

The structure of this committee is rather remarkable. First, it was called an Advisory Committee which it was not. It made all the decisions concerning psychiatric nursing education and it ordered rather than advised. Second, the

superintendents of nurses were given the same status as the medical superintendents. The equivalent chief male attendants from the male sides of the hospitals were not included, despite their service to the male patients and their leadership role in the formation of the association. The message was obvious; this was to be a *nursing* programme. As the chief attendants were not RNs, they were excluded. Third, there were no nursing educators on the committee. Fourth, the Lieutenant-Governor-in-Council had the power of choice over the nominations from the association. This was the only opportunity for the association to have any input into the education of its members. There was no particular number of nominations stated, so the association could nominate as many of its best people as it wished knowing that three had to be selected by the Lieutenant-Governor.

The committee was given the powers and duties in respect of the training and qualifying of persons to become psychiatric nurses and to:

- (a) recommend to the minister the schools for the training of psychiatric nurses . .
- (b) approve the courses of training to be provided and maintained by approved schools . . .
- (c) prescribe the examinations to be taken by students . . . ¹⁷

The approved schools were identified as the three schools already in operation in the provincial institutions, Brandon, Selkirk and Portage:

Each Approved School shall provide and maintain a course of training for students of psychiatric nursing that is of such length, embraces such subjects, and requires such studies and practical experience, as the committee approves.¹⁸

This remarkable committee was therefore given a lot of power over the education of psychiatric nurses and it is within this political and administrative

framework that decisions were made which influenced the education and evolving professionalism of psychiatric nursing for twenty years.

* * *

The structure of the council which was to manage the affairs of the association was also determined by legislation:

The affairs of the association shall be managed by a council which shall consist of:

- (a) the immediate past president of the association and;
- (b) five representatives from each district association to be elected by that district association.

The council shall elect from their own number a president, two vice presidents, a secretary, a treasurer, and a registrar.¹⁹

The inaugural meeting of the association took place in Portage La Prairie on May 24, 1960.²⁰ It was moved by Mr. Art Russell from BMH that nominations for the provincial executive be the first step of this meeting.²¹ It is no surprise that the first executive was almost unanimously acclaimed from amongst the people who had worked to bring about the legislation. Mr. Alf Barnett of SMH became president. The secretary and treasurer were Mrs. Henrietta Fedorchuk and Miss Rose Skirupski, respectively, both from Portage. Mrs. Anne Stanley from Brandon became first vice-president. This last selection was particularly interesting. Stanley was a 1948 graduate of the combined programme, therefore, she was both an RN and also held the Brandon Mental Hospital psychiatric nurse diploma (Psych. Dip.)²² She was the director of nursing education at BMH, a position she had held since 1959. She was particularly supportive of psychiatric nurses and was also on the education committee of the LPN Advisory Council. Her name also appears in minutes of board meetings of the MARN as a member of the Nursing Education Committee, but she tendered her

resignation to that body November 5, 1960.²³ Stanley may have given her resignation to the MARN in November because of a perceived conflict over being on both the MARN and the new psychiatric nurse's council, but she continued on the Advisory Council of the LPN. She therefore brought a broad perspective to the new council.²⁴ Stanley only held the position of first vice-president for a short time, but she contributed in many other ways to the growth of the profession in her capacity as director of education at Brandon, a position she held until the late 1970s.

The second vice president was Mr. Garth Cooke of Portage. The position of registrar was the only one declined by the nominee, Miss Evelyn McKenzie. McKenzie held a psychiatric nursing diploma from Brandon, and was the assistant director of nursing at that hospital, where she had served for 33 years.²⁵ Instead, Mr. Spud Armstrong, also from Brandon, was acclaimed as registrar. Therefore, the first executive was in place.

This council was a mix of nursing administrators from the male and female sides of the institutions. There was a director of nursing education, and there were rank-and-file attendants, some of whom who brought a union perspective to the council. This rich and diverse group was symbolic of psychiatric nursing, comprised of male and female members, varying degrees of training and perspectives on the purpose of the organization, but with the common goal of improving the status of psychiatric nurses and the care provided to psychiatric patients.

The selection of the three members to send to the advisory committee was another item of business conducted at the initial meeting. Russell moved that, "We elect a member for Advisory Committee from meeting at home unit as soon as

possible.”²⁶ This was the only connection the association had with the Advisory Committee, and it is surprising that more emphasis was not put on this item. Perhaps at the time they did not recognize the importance of these appointees, or that they could nominate more than one person from each hospital. The remainder of the first meeting was concerned with how the fees should be structured, who should attend the CCPN meeting to be held in British Columbia in June 1960, and how the by-laws should be drafted.

* * *

The Advisory Committee took longer than the association had done to organize its first meeting. Nor do they appear to have been as diligent in maintaining records of their meetings or adhering to the terms of their legislation. The first meeting for which a written record exists is August 19, 1960, although it is identified as a *Medical Superintendents' Meeting*. The minutes of August 19, 1960, refer to a meeting of superintendents on May 6, 1960, although the business discussed at that meeting rightfully belonged to the Advisory Committee.²⁷ Was it ignorance or arrogance that the superintendents conducted business related to the education of psychiatric nurses at one of their meetings when the legislation mandated that the Advisory Committee was to be responsible for psychiatric nursing education? Which ever it was this became a pattern over the next few years. The superintendents would discuss educational issues amongst themselves, and then refer them to the Advisory Committee. As the superintendents comprised a significant and powerful group within the Advisory Committee, they were in fact referring issues to themselves.²⁸

At the meeting of August 19, 1960, the superintendents decided to recommend to the executive committee of the PNAM, “Approval for membership of all male psychiatric nurses who have had at least fifteen years satisfactory experience on the nursing staff of his institution.”²⁹ On the other hand, “No female Psychiatric Nurse should be considered for admission to the Psychiatric Nurse Association unless she holds a certificate from an approved school.”³⁰ It seems as though there was a gender distinction between the way in which the female psychiatric nurses and male attendants were to be entered onto the register with the males perhaps being treated more generously as they did not necessarily have to have written an examination. The male attendants at Brandon had been required to take the training programme since 1947, yet the recommendation did not state that the male attendants needed to have taken this training; *satisfactory service* was not defined. On the other hand, the females had to have taken the training and to have successfully passed an examination. A long time employee of BMH, who subsequently became the Senior Nursing Administrative Officer (SNAO), Terry Gibson, offered an alternative explanation. She believed that many of the male attendants were considered to be solid men who gave good care to the patients, yet may not have been particularly literate which would have made writing exams difficult for some of them. She recalled that during the 1950s, Superintendent Schultz gave oral exams to many of the male attendants.³¹ This is a generous explanation. It made allowances for good men who had not written the exams. Nevertheless, the superintendents were overstepping the mandate given to the Education Advisory Committee. The classes of membership

and the criteria for membership were contained in *The Association Act*, not *The Training Act*.³²

The superintendents had to enquire as to who had been appointed as the chairman of the PNAM. Apparently they were not notified that Barnett had assumed this role, although it seems unlikely that they had not heard, at least at Selkirk, which was the hospital at which Barnett was employed. Neither did it appear that they knew the representatives to the Advisory Committee:

The Superintendent of the institution from which the chairman had been selected was to supply the Provincial Psychiatrist with the names of members who had been nominated . . . representing the association on the educational committee.³³

The superintendents were also concerned with how the Portage students would gain psychiatric nursing experience and in turn how the students from the two mental hospitals would gain experience in caring for the mentally retarded at Portage:

As soon as possible the three superintendents will communicate with each other to set up a program (sic) that will enable the initiation of this affiliate training.³⁴

The superintendents were making these nursing education decisions without any apparent consultation with the education directors or the directors of nursing and chief attendants of the institutions. It is also noted that a curriculum committee had met on May 25, 1960. Who comprised the curriculum committee, what powers they had, and what decisions they made is not known.³⁵

* * *

At first there seemed to be little contact between the two groups, one responsible for psychiatric nursing licensing and the other for education. With the

superintendents proceeding without due regard for the legislation, the PNAM council became concerned. On February 14, 1961 it was decided:

To promote a closer working situation between council and the advisory committee it was moved that the association representatives to the advisory committee, in future attend all council meetings in an advisory capacity.³⁶

In this way, the council could be made aware of the discussions and decisions of the Advisory Committee. The association also recognized its limitations in regards to the education of psychiatric nurses, and moved:

An Education Committee be appointed to keep the Provincial Council informed on all activities concerned with education.³⁷

These two motions were the first recorded efforts of the council to take some control of the education of its members, although it was obviously hampered by lack of information. The council may not have been aware that a meeting of educators had already been held on February 10, 1961.³⁸

The council continued to be concerned with the power of the Advisory Committee. At the March 1961 meeting it was moved that:

Mr. Wilson (our lawyer) be asked to clarify our position as to the powers of our advisory board and association regarding policy of training programme.³⁹

In April 1961, it was reported:

Regarding motion #10 [the motion to request information from the lawyer] it was reported to us by Mr. Barnett that our association does not have power to make policies, but may make recommendations affecting such matters.⁴⁰

The only recommendation they made that day was that the post-graduate course taken by RNs should be one year in length. This was longer than the nine months recommended by the group of psychiatric nursing educators who had met in February 1961.⁴¹

These must have been frustrating times for the council which had little power regarding education, but they were not prepared to let the matter rest. In May 1961, the council requested a meeting with the Minister of Health.⁴² The agenda for the meeting included:

- a) Present and future plans regarding the employment in our hospitals of nursing staff for psych nursing.

Presumably, this item referred to the fact that the new profession believed it should have equal status to RNs when psychiatric nursing positions were available. The new council was just beginning to realize that their legislation had not granted them the professional status they wished.

- b) Procedure to be followed between our association and those in authority for the implementation of the Psych. nursing acts.

Accustomed as the attendants and institutional psychiatric nurses were with the paternalism of the superintendents, it is possible that the council was having difficulty in interpreting its authority for the implementation of its own act. Likewise, the superintendents had difficulty in recognizing the limitations imposed on them by the Training Act.

- c) Regulations pertaining to the act and information about certain aspects of the training and control of training.

Clearly the council recognized the role of education in enhancing the status of psychiatric nurses. Their appeal to the minister represented an effort to gain some control although they may not have been satisfied with the Minister's responses.

The meeting was held with the Deputy Minister of Health and the Provincial Psychiatrist in September 1961. When Barnett gave a report, the following was noted:

Psych Nurses Assn should contact General Hospitals with regard to the standing of Psych Nurses in Gen Hospitals with regard to pay, requirements, etc. (Psych wards in general Hospitals do not come under the Mental Diseases Act).⁴³

This does not specifically address any of the agenda items identified at the May meeting of the council, but the status of the psychiatric nurses in general hospitals was increasingly becoming an issue. Registered nurses in general hospitals were also caring for patients with mental illness. The psychiatric nurses working in the general hospitals saw themselves as being more competent in this field than RNs, yet not receiving much recognition.

The council resolved to develop a campaign to inform general hospitals concerning psychiatric nurses:

A letter to be drafted for sending to all general hospitals explaining the need for psychiatric nurses; policy of government regarding same; qualification of Psych. Nurses; mention of wages etc.⁴⁴

The prepared letter was presented for approval at the October meeting and included the following points:

Impress the fact that we are an organized association of Registered Psych Nurses:

- a) That it appears to be Government Policy to have Mentally Ill Patients cared for by Graduate Psych. Nurses.
- b) That it is our hope to extend this Policy to all hospitals caring for mentally ill persons.⁴⁵

The motion was approved and was “to be done as soon as possible with a curriculum included.”⁴⁶ This may have been problematic as it was noted, “This could not be done until curriculum is officially established.” The curriculum and the curriculum makers remained elusive. It is difficult to understand that the association

did not have a copy of a curriculum or that they were unable to obtain one from one of the schools of nursing, but it delayed their correspondence to the general hospitals.

They also appealed to Herman Crewson, of the Manitoba Association of Hospitals, to determine the status of psychiatric nurses in general hospitals. It was decided in November:

The Letter planned to be sent to the General Hospitals be tabled until we have further information from Mr. Crewson.⁴⁷

The association was clearly trying to establish itself as a legitimate professional body within the broader health care system and was seeking recognition through improvements to salaries and status. Crewson's response in January 1962 must have been disappointing. He stated, "Our organization does not act in any way as a bargaining agent."⁴⁸

The first annual meeting of the association, held in February 1962, differed little from regular council meetings and in some ways could have been considered a dismal failure. The usual council attendees were present and the business conducted was ongoing business of the council. There was nothing that distinguished this meeting from regular meetings, and very few of the general members attended. Further correspondence with Crewson was discussed. He must have responded with a draft of information about psychiatric nurses, but the council was not satisfied. It was moved that a letter be sent, "To inform him that his draft of information is inadequate and in some places misleading."⁴⁹

The letter which was to be sent to Crewson had to be delayed, again, "We are unable to supply a curriculum for basic training."⁵⁰ For the second time they were unable to secure a curriculum and resolved:

A letter be written to Dr. Johnson (Director of Psychiatric Services) requesting information regarding the present standard basic curriculum for Manitoba Schools of Psychiatric Nursing.⁵¹

In May 1962, there was some encouraging news for the council. It is reported

at the May council meeting that, "A letter from Miss Vera Ostapovich, Associate

Director of Nursing Service had been received stating:

We have established positions for Licensed Psychiatric Nurses at the Wpg. Gen. Hosp. To help us utilize these graduates to their fullest capacity and stay within the framework of safe practice, would you kindly send the following information;

- a) Copy of the Psych. Nurses Act
- b) The requirements for licensure of Psych Nurses in Man.
- c) A copy of the Psych. Nurses Assoc. Regulations and By Laws.
- d) A copy of the required curriculum for schools of Psych. Nurses and an outline of nursing procedures as permitted under the Psych. Nurses Act.⁵²

How frustrating this must have been. The opportunity the association had been waiting for, to become recognized as a legitimate part of the mental health system, yet they would not be able to respond to these requests. It was moved for the third time:

The President is directed to personally contact Dr. Johnson (Prov. Psychiatrist) to request a copy of the basic curriculum for training Psych. Nurses in Man.⁵³

Having two separate bodies responsible for psychiatric nursing was obviously creating problems.

The June 1962 meeting brought no further discussion of the response to Ostapovich of the Winnipeg General Hospital, but it reported on a letter received from Mrs. McPherson, a psychiatric nurse from Winnipeg:

Psych. Nurses in Winnipeg have organized a group of twenty members requesting information on establishing a Metro District of Psych. Nurses in Manitoba.⁵⁴

The development of this group highlighted the difficulty of the establishment of boundaries. As a group of psychiatric nurses interested in their own welfare, this

would have been worthwhile, but the Winnipeg group had no authority to proceed on its own behalf without the approval of the PNAM. It must have been an embarrassment when the council received a letter from the executive secretary of the MARN, Miss Pettigrew. She requested information regarding a group of psychiatric nurses in Winnipeg who were circulating letters to the general hospitals in Winnipeg about their status on psychiatric wards. These letters had come to the attention of the MARN. At their August 25, 1962, board meeting they resolved to write to the PNAM asking for information on the relationship between the MPNA and the Winnipeg group.⁵⁵ Part of the concern of the Winnipeg group related to the fact they felt their “status subordinate to student RNs and equal to LPNs on psych. wards.”⁵⁶ Barnett’s response, read at the MARN board meeting of September 1962, assured the MARN that even though the Metro Winnipeg group of psychiatric nurses had applied to become a unit, this had not yet occurred. The letters, circulated to the general hospitals, did not represent the views of the association.⁵⁷ It was resolved at the September meeting of the council that in future all correspondence was to be sanctioned by the provincial council.⁵⁸ The executive of the PNAM met with the group from Winnipeg in October 1962, and advised them to send members to the council meetings.⁵⁹

The concern over status was clearly coming to a head, especially in general hospitals, where the psychiatric nurses (PN) were competing with other nurses, RNs, who sometimes believed themselves superior to the PNs, who in turn believed themselves superior to the LPNs. A stratified system was emerging which revolved around the use of the term *nurse* and *nursing*. Even though achieving distinct

professional status was one of the goals of the association they were also sensitive to the use of the term *nurse*. The experience of their colleagues in Saskatchewan and Alberta had perhaps made them uneasy about the use of the term. In those provinces the general nursing bodies had protested when they heard there was to be a new body using the title *nurse*.⁶⁰

In Manitoba, similar concerns were voiced when the association's proposed pay and reclassification brief was discussed at a meeting with the Deputy Minister of Health, the Provincial Psychiatrist, superintendents, and the Civil Service Commission on December 4, 1963. John Kellie reported on this meeting in March 1964:

Mr. Barnett expressed our concern regarding the title of *Nurse*, marking both the effect on our membership and possible legal connotations, and also asked the pertinent question why no *Psychiatric nurse* title.⁶¹

The delegates rather astutely noted that in the new classification the title *nurse* was used rather than *psychiatric nurse*. The use of the modifier *psychiatric* before the term *nurse* was a safeguard against any legal repercussions, but the classification *nurse* also made it possible for RNs to fill certain positions. This, of course, was distressing. One of the premises of the new profession was that they were distinguished from general nurses, and their training and skills made them uniquely suited to work with patients with mental illness. They did not wish to be placed in the same classification as *general nurses*. They wanted a classification of their own. Perhaps they felt they would be disadvantaged given the hegemony of the general nursing establishment and they wanted to retain their identity. The commissioner of the Civil Service, Mr. Newton, informed them it was for pay catalogue only, not job

title. Miss McKay, a Civil Service employee, responded to Barnett that the act could be enforced under this title and no one would be employed without producing a licence. When asked why there could not be separate or parallel classifications, Tavener, from Selkirk, replied that it would be too unwieldy.

But Provincial Psychiatrist Dr. Johnson offered an alternative perspective, and even though the tone is patronizing, it may have touched the anxieties of the delegation. He suggested that “perhaps the delegates were motivated by fear.”⁶² Although they assured him it was motivated by concern they were probably also insecure and suspicious for they also questioned the policy of only appointing registered nurses to Institutional Nurse Grade IV (Nurse III) positions. Selkirk superintendent Dr. Tavener, and Brandon superintendent Dr. Bristow, both asserted this was not necessarily the case, but Tavener added:

The classification be left open . . . so that Registered Nurses could be brought into the framework anywhere where there was an apparent need for this . . . specialized area such as treatment rooms and physical nursing.⁶³

This exchange highlights not only the apprehension of the psychiatric nurses in Manitoba. It also reflects the experience of the psychiatric nurses associations in Alberta and Saskatchewan. The Manitoba psychiatric nurses knew their position in the health care system was precarious, and they asked if guidance could be given regarding promoting psychiatric nursing. Atkinson from Portage, who had always been ambivalent about psychiatric nurses, observed “that perhaps we should not be too exclusive and not go too far too fast.”⁶⁴ It can only be surmised what he meant by this, but his loyalty to psychiatric nurses was always in question. He had a record of encouraging general nurses to work in the mental retardation facility on one hand, yet

on the other claiming he did not run a hospital but a school. The results of this meeting may not have been entirely satisfactory for Barnett and the council, nevertheless, they continued to view themselves as distinct professionals.

Professionalism in Nursing

There is abundant literature on professionalism in nursing. Despite the fact that some sociological literature claims that nursing is a semi-profession, this has not deterred nursing leaders from proceeding with their own view of nursing as a profession.⁶⁵ Definitions of a profession vary somewhat, but it is generally accepted that the following characteristics distinguish a profession from other forms of work: A specialized body of knowledge and skill, developed through a period of study, which is used to provide altruistic service to the community. Patricia Schwirian adds that recently the notions of self regulation, self control, and self identification have been added to the definition.⁶⁶ The degree to which nursing bodies have attained these characteristics and the degree of struggle to attain them has resulted in much of the celebratory history of nursing.

The meaning of professionalism is bound by time, place, culture, and context. In this study, gender could be added as a factor of influence. Almost all studies of the achievement of professionalism in nursing use a feminist lens to explore and explain both the triumphs and trials of the development of nursing.⁶⁷ But in the present study, the leaders were not female, so the traditional gendered explanations for the successes and failures do not fit.

Professionalism in nursing has had different meanings over time and has generally adopted the view of the wider society towards work and gender. Late

nineteenth century views of professionalism in nursing focused on appropriate behavior, appearance, and demeanour for middle class young women. The early twentieth century saw the achievement of registration and control of membership as a defining characteristic of professional nursing. Nursing leaders also sought to enhance the status of nursing by laying claim to certain skills and knowledge they identified as uniquely theirs. Tasks such as monitoring vital signs, carrying out procedures such as dressings, applying poultices, attending to the cleanliness of the environment, and keeping nurse's notes were considered proprietary skills by mid-twentieth century. The correct method for the performance of such tasks was usually set out in policy and procedure manuals which, in effect, became the textbooks of the day. The next stage in the professionalization of nursing involved one of the most commonly accepted hallmarks of professionalism, having a unique body of knowledge.⁶⁸ This has resulted in a vast volume of scholarly work devoted to the development of *nursing knowledge*.

Other patterns of the acquisition of professional hallmarks have been suggested. Howard Vollmer and Donald Mills cited a sequence identified by Caplow. The first step is the formation of an association, the second step is adopting a name which asserts a technological monopoly over skills, the third step is the adoption of a code of ethics, and the fourth is political agitation to obtain support for the maintenance of occupational barriers.⁶⁹ The formation of the profession of psychiatric nursing in Manitoba resembles this pattern.

The achievement of professional landmarks is not an orderly process and has been challenged by Celia Davies. She argues that the process of becoming

professional is not fixed and may take different forms.⁷⁰ She used the term *professionalizing strategies* to describe the activities of leaders who wished to imbue their occupation with professional status.

The strategies of the first generation of male leaders in psychiatric nursing in Manitoba were administrative and organizational. They focused on legislation, registration, pay, and classification rather than proprietary nursing skills and knowledge to distinguish themselves from unskilled workers. For these men, achieving professional status became a matter of public recognition in the workplace. They submitted pay briefs to the government claiming that they needed to be paid as *professionals*. They also sent letters and documents to the Manitoba Hospital Commission claiming equality with RNs in general hospitals.⁷¹

They recognized the value of education and the need to gain control of their education. Nursing historian Anne Marie Rafferty argues:

Education lies at the centre of professional work and expertise and therefore occupies a pivotal position in the shaping of occupational culture and the politics of nursing.⁷²

Kathryn McPherson describes patterns of professionalism that evolved from general nurses in general hospitals by claiming procedures and techniques as their proprietary skills.⁷³ In psychiatric settings there were fewer procedures and techniques to perform, although the head nurses or attendants ensured that the treatments such as insulin coma therapy and electro shock treatments were carried out in a professional manner.⁷⁴ The management of the ward environment and the development and reinforcement of socially acceptable behavior in patients became a particular skill of many of psychiatric nurses in the 1960s and 1970s. But the

articulation of unique psychiatric nursing knowledge was not part of the professional ideology at that time.

The End of the First Five Years

The first five years of the association were characterized by increasing bureaucratization and efficiency in the management of the business of the association. But the council also recognized the value of education as a professionalizing strategy, and they had colleagues in the west who shared that view. The PNAM had actively participated in the affairs of the CCPN. One of the highlights of the relationship with this national body was the hosting of the annual conference in Brandon in June 1962.

A motion from the meeting reads:

That a brief be prepared to indicate the desirability of having psychiatric nurses groups in control of their education . . . and point out the need for advanced education for psychiatric nurses.⁷⁵

The following year it was moved:

The CCPN should be incorporated . . . [F]or the purpose of promotion of professional interests of psychiatric nurses, the promotion and maintenance of professional standards, the promotion of research and public interest in the field of mental health and the promotion of uniformity in training programs throughout Canada.⁷⁶

The improvement of psychiatric nursing education and the development of standards of practice became a shared goal for the four western provinces during the next ten years and also signaled a maturing of the new profession.

* * *

Barnett gave his last report as president at the annual meeting in January 1965. One issue he reported on was an amendment that had been made to the Training Act in 1963. This amendment, which just now seemed to be coming to the attention of the

association, stated that the *certificate of qualification*, which had formerly been issued by an approved school, would now be issued by the Advisory Committee. In the original act, the approved school would advise the association, by means of the certificate of qualification, that the student had met the standards. The amendment took that responsibility away from the school and placed it in the hands of the Advisory Committee who could, if they wished, issue certificates of qualification to whomever they wished. Barnett read excerpts from a letter sent by the association lawyer:

Section 15 of the Act was, however radically amended . . . whereas before the Certificate of qualification was to be one issued by the Approved School . . . the 1963 amendment provides that a Certificate of Qualification is to be one issued by the committee.

Barnett went on:

He [the lawyer] did not mean that it will happen but it . . . opens the door to the possibility that a person . . . who has not successfully passed the required examination . . . that perhaps ways may be considered satisfactory to pass on that application. The lawyer asked whether [they] were fully conversant with that condition.⁷⁷

The explanation for the change is outlined in a briefing memo from the Deputy Minister of Health Dr. Elliott, to the Minister of Health Honourable Dr. Johnson, explaining why the amendments were being requested:

Experience has indicated since the passing of the two acts in 1960, some of the provisions are too restrictive and do not . . . meet the intent of the Department . . . in some cases give the Association powers which were not originally envisaged.⁷⁸

Johnson pointed out to the Cabinet:

We have run into problems for my staff . . . in the Psychiatric Nurses Training Act we made provision for the licensing of psychiatric nurses by the Psychiatric Nurses Association. . . . [T]here is conflict between these two acts. . . . [D]espite the Advisory Committee which is under the control of our

Department the Association can refuse a licence under certain conditions. . . . I recommend we adopt what our psychiatrists feel they must have in order to *control the Psychiatric Nurses Association* (italics added).⁷⁹

Control over membership is one of the criteria of a profession, but this was taken away from the association by the amendments of 1963.⁸⁰ With this change, the association had no choice but to issue a licence to whomever the Advisory Committee gave a letter of qualification. This may well have been a way for the Advisory Committee to maintain control, not only over membership, but also over the workforce. With this amendment, the Advisory Committee determined who should receive psychiatric nurse status, and who could therefore be hired as psychiatric nurses by the superintendents. The lawyer's reassurance that this may not happen⁸¹ proved false as events of 1969 demonstrate. How this potentially contentious amendment slipped by the association is unclear and may illustrate the political naiveté of the PNAM council.

* * *

Despite the tensions and the faltering during the first five years, there were also bright moments. When Barnett's term ended there were four units of the association: Brandon, Portage, Selkirk, and Metro District in Winnipeg. There was a functional council which met regularly and dealt with issues under its jurisdiction, such as recalcitrant members who were delinquent in paying their fees. They also notified hospitals of members not holding a valid licence. They had submitted pay and classification briefs to government and the Manitoba Hospital Association. They maintained meticulous handwritten records. There was a registrar who was paid an honorarium; equipment had been purchased to help in the task of maintaining

accurate records; and there was over \$8000:00 in the bank.⁸² All this had been accomplished at kitchen tables and in borrowed hospital space. But there were other issues, especially educational, which needed to be addressed and these became goals of the next two presidents.

* * *

Barnett had been thirty years working for the cause of psychiatric nursing. The establishment of the legal body called the Psychiatric Nurses Association of Manitoba was, no doubt, one of his proudest accomplishments. His widow recalls that every Sunday, his only day off during the late 1950s, he would ride his motorcycle to Portage La Prairie where the organizational meetings were being held. He was president for two terms but “he refused the third time because he told them he didn’t want it to stagnate. He said we need new blood, we need to keep changing.”⁸³ The new blood turned out to be Arthur Russell from BMH who had been instrumental in establishing the group there in 1958.

The Russell Year (April 1965-June 1966)

Arthur Russell was a Manitoban. He was born in 1919, the tenth of twelve children of a United Church minister. As a young man he was in the Royal Canadian Air Force from 1941-1945. He commenced employment at BMH in 1945 and graduated from the attendant training course in 1948. He quickly achieved a ward supervisor position, and by 1958 was the assistant chief attendant and became the chief attendant in 1962.⁸⁴ He was known for his great concern and respect for the patients and this moved him to find ways to improve the status and education of the

male attendants. During the 1950s he was active in the MGEA as he worked for improvement of the attendants' working conditions.

Russell's address to the 1965 annual meeting, in his position as first vice-president, included references to the good relationship the association had with the MGEA and to changes in classification with subsequent raises in pay. He added:

We are aware of the changes taking place in this modern age of nursing, and believe that it is essential that we, as a professional organization, be ready and able to keep pace with these changes . . . fostering in our membership a willingness to uphold the ideals of the Psychiatric Nursing profession. . . . With this in mind I suggest a committee should be formed from the membership to look at the educational aspects of our profession. Does our curriculum meet the standard necessary to graduate nurses of a caliber that will compare favourably with other nursing professions?⁸⁵

His use of the term *nursing* interposed with *psychiatric nursing* reflects the ongoing dilemma of how the group should represent itself. In some ways, it saw itself as a particular group of nurses, but in other ways as a distinct profession. The use of the term and the paradigm of nursing to identify and distinguish psychiatric nursing became a difficulty during the coming years.

During Russell's one year tenure as president, a number of important issues came to the foreground. Some challenged the association's ethical sensibilities and professionalism. The association had no written code of ethics or standards of practice and they were coming to realize the limitations of the association act. One of the first issues of 1965 was disciplinary in nature but, as Russell reported:

We can't even take action unless we have satisfactory witnesses . . . this Association should be in a position to automatically suspend a license until we have thoroughly looked into the situation . . . we as the governing body . . . should take steps to change our act to give us this authority. . . . We can suspend a license of a man who has not renewed his license. But apparently in the case of necessity of suspending . . . for certain actions we are in no position to do it.⁸⁶

The incident occurred at the Selkirk Mental Hospital:

A number of hospital staff became involved in a very unpleasant episode which amounted (sic) to a serious offense upon the person of two of the student nurses . . . it causes (sic) a great deal of personal embarrassment to the nurses, along with considerable emotional upset.⁸⁷

Shortly after, Barnett gathered a committee together “to conduct an inquiry into the incident.”⁸⁸ The employer (Selkirk Mental Hospital) had already disciplined the staff involved according to the dictates of the Department of Health.⁸⁹ In a letter to Tavener, Barnett informed him of the action taken by the committee and after apologizing for the behavior of the licensed psychiatric nurses involved he concluded:

We . . . can only hope that our aims for higher standards for our profession will not be greatly impeded but that we learn from our mistake.⁹⁰

Two general affiliating students were involved in this unfortunate event and it is also noted in the minutes of MARN meeting of April 24, 1965.⁹¹

This must have been an embarrassment to the PNAM, especially as a few months later they made efforts to establish a professional relationship with the MARN. The inquiry initiated by Barnett and his committee represented one of the earliest efforts of the association to enforce professional standards. There was no mechanism to deal with such an incident as Russell ruefully observed, and no legal requirement to do so. Past incidents of a similar nature had always been dealt with by the employing institution, yet the association recognized that if they were to become professionals, they needed to have a code of conduct and a way to enforce it.

Forming professional relationships was another goal during 1965. In May 1965, John Martyniw, the new council member from Selkirk, moved that a person be appointed to work as a liaison between the psychiatric nurses and the MARN:

To promote better communication and understanding concerning mutual problems and in the interest of both associations.⁹²

This request, which was sent by Russell, is recorded in the minutes of the MARN board meeting of August 1965. They indicated they would be pleased to have a liaison.⁹³ It was a politically astute move, and the MARN could hardly refuse.

The psychiatric nurses' association was also challenged on the education front, a fact which Russell had recognized in his speech as vice-president. Again, it was Martyniw who brought the issue forward. In September 1965 he proposed, "The Council appoint an Educational Committee within the Association to serve in an advisory capacity to the Council."⁹⁴ The committee, he suggested, should be comprised of nine members, three instructors from each school of psychiatric nursing. He stated, "The educational committee is an essential aspect of any professional association concerned with education."⁹⁵ The educational committee:

Shall develop a plan which will provide for evaluation of all educational aspects of psychiatric nursing and its entire educational programme . . . the plan should review the present programme . . . the performance of graduates on exams . . . advise the council . . . on matter of graduates from out of province and . . . setting courses for those . . . who do not meet requirements for registration.⁹⁶

It was an ambitious plan, and, if accepted would, in effect, take over the functions of the legally mandated Advisory Committee. It is not known if this was Martyniw's intent, but he certainly recognized that the association needed some control over education. His proposal was modified but passed at the October 1965 council meeting.⁹⁷

* * *

In December 1965, one of those contingencies occurred that may well have altered the path of psychiatric nursing in Manitoba. The first vice-president had been

delinquent in attending meetings and it was decided that he could no longer maintain his position. This necessitated a replacement, and when Martyniw was nominated, it was quickly moved that nominations cease and “Mr. Martyniw was acclaimed to fill the term for one year.”⁹⁸ In this position, the door was open for him to become president when Russell resigned suddenly after one year into his own term. Martyniw’s approach to psychiatric nursing and to problems could only be described as passionate. The challenges that confronted psychiatric nursing during 1966 and 1967 could have spelled the demise of the profession and Martyniw’s tenacity may well have been a factor in its continuation.

At the annual meeting of 1966, the only one over which Russell ever presided, the resolution section was dominated by the Selkirk group and although the resolutions were presented by different members, many had the stamp of Martyniw on them. Three of the resolutions specifically related to education. The first was that the entrance requirement into psychiatric nursing be increased from grade X to grade XI with preference given to those candidates with grade XII.

The second potentially more contentious resolution:

That the general hospital affiliation be completed as psychiatric nurses and not as LPNs” was carried unquestioned.⁹⁹

The motion was probably orchestrated by Martyniw, and as events unfolded during the following year, his antagonism towards the LPNs became evident. The close association between the LPNs and the psychiatric nurses, which had been beneficial in the 1950s, was seen by Martyniw as a liability in the 1960s. There was a perceived pattern of stratification in which the psychiatric nurses were on the same plane as the LPNs and the RNs were in a superior position. Rightly or wrongly, this

was how Martyniw viewed the situation. The resolution to disengage from the relationship with the LPNs was a strategy employed to emphasize the distinctiveness of psychiatric nursing and to see it as equal to general nursing, not below it.¹⁰⁰

The third and most audacious resolution of the 1966 annual meeting read:

That the Training Act be dissolved and that the Psychiatric Nurses Association of Manitoba have legal jurisdiction of the training of psychiatric nurses in Manitoba.¹⁰¹

This resolution passed, but of course it carried no weight. Nevertheless, the boldness of the resolution suggests that the association was developing a self-consciousness of its need to control its own education, but also its impotence in doing so. At the same annual meeting the membership also resolved that the Advisory Committee should meet more regularly. This may have been well founded, as after the initial meetings of 1960, the Advisory Committee met infrequently.

The Elusive Curriculum and Curriculum Makers

Throughout the first six years there is little tangible evidence of any progress being made by the Advisory Committee on a current curriculum for psychiatric nursing. Instead, at their few meetings, the committee spent time designing certificates and developing regulations. In March 1961, a short meeting took place which dealt with a report generated by the three directors of nursing education and other instructors at a meeting on February 10, 1961.¹⁰² The report was mainly of an administrative nature: passing grades for students, allowable absences, amount of credit to be granted to LPNs wishing to take psychiatric nursing, the length of the post graduate course for RNs, and ward reports of students from clinical areas. This last issue was identified as problematic. It was agreed that because of staff shortage the

clinical evaluation of students could not be factored into their overall mark percentage. The clinical component of the psychiatric nursing education programme was not well articulated at that time. The students continued to go to wards where they provided considerable service and were poorly supervised.

This pattern of extended hours of ward work, disguised as clinical experience, was not uncommon in other nursing fields. The conflict between student learning needs and hospital service needs was highlighted in the *Royal Commission on Health Services* in the section *Nursing Education in Canada*:¹⁰³

There is a growing tendency to call all nursing care experiences ‘laboratory experiences’ but in too many instances these are not actually selected learning experiences. Staffing problems rather than students’ educational needs often dictate the selection of patients for study, and, too often the student has inadequate supervision.¹⁰⁴

So while this may have been a common pattern in nursing, the situation at the mental hospitals may have been even worse as the nursing instructors fell under the control of the nursing office who assigned students to work areas. There may have also been the added problem that many of the graduate attendants and nurses working on the wards had even less education than the students.

A curriculum was referred to at the February 10, 1961 meeting:

The curriculum was discussed and certain points clarified. It was felt that until 3 years had elapsed since commencing the use of the present plan, it could not be properly evaluated.¹⁰⁵

The only document available from that time, which was identified as a *curriculum*, was a list of courses and the minimum number of hours devoted to each. It totalled approximately 534 hours with an additional 80 hours for the female students taking the LPN course.¹⁰⁶ The combined number of hours devoted to basic

nursing and medical surgical nursing exceeded number of hours devoted to psychiatric nursing and psychiatry.¹⁰⁷ The number of hours stated for a course tells very little about the content, but the number of hours assigned to each course suggests either their relative importance or the difficulty of articulating them. Clearly, there was either difficulty in identifying suitable psychiatric nursing content, or there was a belief that physical care was of greater importance.

Basic nursing, or nursing arts as it was sometimes called, could be described as the skills and knowledge required to meet basic human needs for maintenance of life, safety, cleanliness, and comfort of patients experiencing physical illness. It included such nursing activities as observation, recording, and reporting of life signs (blood pressure, temperature, pulse, and respirations); attending to the care and comfort needs of patients; and performing tasks such as bed making, bathing, feeding, and attending to bodily functions. These activities were sometimes dubbed by nursing students as the provision of beds, baths, and bowels! These are essential nursing skills in the care of acutely ill patients, but in a psychiatric hospital, apart from the infirmary units, there were far fewer occasions for the employment of such skills. The disproportionate amount of time given to teaching these skills as opposed to using them may indicate either the difficulty of identifying and naming psychiatric nursing skills or the influence of the instructors, most of whom were RNs. While there were certainly patients in the mental hospitals who required physical nursing care, the greater number were there for psychiatric reasons. But the number of hours devoted to learning the art of psychiatric nursing was much less. Even the hours devoted to the subject of psychiatry, presumably the study of mental illness, was less than the

number of hours of devoted to medical-surgical nursing. The difficulty surrounding the articulation of psychiatric nursing skills and knowledge is a central concern. The relative number of hours devoted to these topics may not represent importance, but rather may represent the difficulty of articulation, a struggle which continues.

* * *

Early in November 1961, Tavener sent a note to his colleagues at the other two institutions and to Provincial Psychiatrist Dr. Johnson, calling a meeting for November 14. It is planned that:

1. The three Medical Superintendents will meet to finalize the form of standard diploma awarded to graduates from an approved school
2. Mrs. Samels, Miss Fitzpatrick and myself will meet . . . to complete regulations under Bill 66.¹⁰⁸

This meeting was followed by another in December 1961 where the regulations were approved, a minimum curriculum was agreed upon, and the format of the certificate of qualification was designed.¹⁰⁹ The regulations were required by law, although they were not completed and filed until June 1963.¹¹⁰ The development of these regulations had dominated the few meetings held by the Advisory Committee in 1960 and 1961. The minimum curriculum agreed upon was probably the one page document referred to at the February meeting. The certificate of qualification was the document provided by each school of nursing to the students, who then submitted it to the PNAM to obtain their licence to practice. There is no evidence that the committee met in 1962 and this is congruent with the statement made at the Psychiatric Nurses Association annual meeting in February 1963:

It was reported by Mrs. Samels, and Mr. Dalzell, the representatives of the association on the Education Advisory Committee, that to their knowledge no meetings of the Provincial Advisory Board have been held.¹¹¹

It seems the Education Advisory Committee was accountable to no-one.

* * *

Despite the lack of attention to the curriculum by the Advisory Committee, improvements were being made to the training programme in Brandon. Stanley, the Director of Education, in her 1962 report, provided the numbers of students in the various programmes receiving instruction in the classroom, but she added ruefully “clinical instruction was given on the wards when time permits.”¹¹² She recommended the addition of “at least two clinical instructors, one for the male service and one for the female.”¹¹³ She repeated her plea one year later stating:

It can be readily seen that that our present establishment cannot . . . attempt to give adequate supervision . . . The supervisors on the wards have insufficient staff . . . the students cannot be counted on for service . . . the supervisors are seeing the patients are cared for . . . Accuracy in (clinical) performance can only be ensured if qualified staff is available to provide the required guidance and supervision. During 1963 we had 170-175 students who required supervision.¹¹⁴

Stanley also reported that a new film had been purchased, “Nurse/Patient Relationship [was] added to our library. This film is used extensively in our teaching program.”¹¹⁵ This film was based on the concept of the nurse/patient relationship which was articulated by Hildegard Peplau in 1952.¹¹⁶ A burgeoning body of psychiatric nursing knowledge, based on this concept, was being generated by a growing number of scholars in universities in the United States. However, its application in the context of Manitoba mental hospitals is questionable. The purchase

of this film, nevertheless, represented part of the continuing efforts to improve the educational programmes.

Psychiatric Nursing Knowledge in the 1960s

Having an esoteric body of knowledge is one of the characteristics of a profession. Nursing leaders recognized this and the 1960s saw an upsurge of the development of nursing knowledge through research.¹¹⁷ The specialty of psychiatric nursing generated its own literature. Florence Huey reviewed the state of knowledge in four areas of psychiatric nursing: one-to-one relationships, milieu therapy, group therapy, and family therapy.¹¹⁸ Likewise, Grayce Sills reviewed the research into psychiatric nursing with a focus on the assumptions underlying the research.¹¹⁹ But much of the research discussed had been carried out in restricted environments, in controlled conditions, unlike the large mental hospitals in which the psychiatric nurses in Manitoba worked. Nevertheless, some of the language crept into the curriculum of 1968. *Interpersonal relations* became a new phrase, and skills in communication were included for the first time.¹²⁰

Other events which indicated that psychiatric nursing knowledge was taking shape included the publication of two new specialty journals. In 1963 *Journal of Psychiatric Nursing* and *Perspectives in Psychiatric Nursing* were launched. These became forums for the “furtherance of knowledge and practice of psychiatric nursing”¹²¹ and a medium of communication between nurses interested in psychiatric nursing. Whatever awareness the Advisory Committee had of this growing body of psychiatric nursing knowledge, there is no evidence it was discussed at their meetings.

* * *

The Advisory Committee met only once in each of the years 1963, 1964, and 1965, and these meetings were concerned with procedural issues for the writing of the psychiatric nursing qualifying examinations, although these tasks had been relegated to a sub-committee established for that purpose. This sub-committee included directors of nursing education and educators, and although their mandate was to carry out administrative tasks related to the setting and writing of examinations, it seems they did not waste this opportunity to discuss other educational issues. The directors of education had no formal power at the Advisory Committee and were only permitted to attend as *observers*. Nevertheless, this did not stop them from forwarding recommendations to the Advisory Committee.

In 1966, a bold move was made by Stanley from Brandon and Della Narfason, an educator from Selkirk. It was moved and seconded:

That the Education Advisory Committee establish a two year course in psychiatric nursing, and that the curriculum committee be asked to draw up a curriculum which would be applicable if the LPN Course were discontinued.¹²²

If the Advisory Committee members were surprised, they did not show it and merely noted that “one of the resolutions will require a revision of the regulations set up under the Psychiatric Nurses Training Act.”¹²³ Bringing this resolution forward was the educators’ way of having some influence over the education of psychiatric nurses.

The lack of surprise may have been the result of the fact this had already been considered by the superintendents, so whether the educators unwittingly played into their hands or whether there it was shrewd maneuvering, the result was an

examination of the education of psychiatric nurses. The lack of involvement of educators in curriculum development was challenged under the next president, John Martyniw.

The Martyniw Years (1966-1971)

Martyniw was a different kind of person from the previous two presidents. He was differently educated and had a different perspective on what psychiatric nurses should do and be. Barnett and Russell had both come through the Manitoba mental hospital system and both had strong union affiliation. Martyniw had moved from Ukraine to England following WWII and had come through an English training system. He viewed education, not unionization, as the path to professionalism. He had received a year of training in England as a fever nurse, another as a tuberculosis nurse, and three years as a psychiatric nurse. He said he never felt the need to become a general nurse as the fever and tuberculosis nursing gave him adequate general nursing skills.¹²⁴

He came to Manitoba in 1958 and went to work at SMH where he remained for one year. He was greatly offended when he arrived in Manitoba and found that he was to be classified as an attendant rather than a nurse. He secured a position at Misericordia Hospital where he taught the general nursing students psychological aspects of illness and psychiatry.¹²⁵ Martyniw was the writer of the letter to the MARN in March 1961, expressing dissatisfaction with the status of the psychiatric nurses in general hospitals:

That you the MARN consider the merits of affiliation with the newly formed Psychiatric Nurses Association putting psychiatric nurses on a supplementary register¹²⁶

This, of course, reflected his experience with the English system of registration. He had no position with the PNAM at the time of this letter, but its tone suggested that he would be a strong advocate for psychiatric nursing as a distinct, but equal, profession.

In 1962, Martyniw attended the University of Saskatchewan for one year where he obtained a certificate in teaching and supervision of nursing. The University of Manitoba, Faculty of Nursing did not allow students into its teaching and supervision programme unless they were RNs, but Martyniw said, "Saskatchewan was more advanced."¹²⁷ On his return to Manitoba he was given a position as an instructor at SMH School of Nursing. Thus began a twenty-two year involvement with psychiatric nursing education in Manitoba.¹²⁸

In 1964, he became the counselor to the PNAM from Selkirk and quickly made a mark on the proceedings with his assertive approach to problems. His participation as an active council member and first vice-president and the surprise resignation of Russell in 1966 moved him quickly into the presidency. The personality of Martyniw, combined with the political challenges to nursing in Manitoba in the second half of the 1960s brought the PNAM onto the public arena, into conflict with its own Advisory Committee and with the MARN. It also opened the way for an in-depth examination of the curriculum.

* * *

Martyniw took the chair in June 1966. It was customary to hold the first meeting of the new council in the fall, but rather than wait, he called a meeting three weeks after he assumed the chair and immediately began attacking problems. The

special meeting of July 20, 1966 concerned changes to the Psychiatric Nurses Act. Some were routine changes but one of the most important would be that the word *registered* should be added to the title psychiatric nurse.¹²⁹ It is reported at the September council meeting that “the changes to the act were to be considered favorably by Dr. Johnson, Provincial Psychiatrist.”¹³⁰ While changes to the act reflected the ongoing professionalization of psychiatric nursing it is also evident that Martyniw viewed education, as much as legislation, as the path to professional status. But the professional status of psychiatric nursing was soon to be challenged by a political decision.

The Minister’s Report on the Supply of Nurses 1967

In November 1965, Minister of Health Honourable Charles Witney commissioned a study to be entitled *The Minister of Health’s Committee on the Supply of Nurses* (hereafter called the Minister’s Report). He was no doubt following the lead of the federal government who had released the *Royal Commission on Health Services* (hereafter called the Hall Report) in 1964.

The Hall Report had examined all aspects of health care in Canada and made hundreds of recommendations regarding how the health system was to be managed and health personnel recruited and educated.¹³¹ The Hall Report recommendation concerning nursing stated:

Our studies indicate that two categories of registered nurses are required; one a graduate of a university school of nursing, and the other a graduate of a hospital school of nursing or of another post high school type of school of nursing—a diploma nurse.¹³²

The report also addressed the question of other types of nursing personnel including psychiatric nurses:

The psychiatric nurse programmes in the four western provinces were instituted to meet the demand for qualified attendants to care for the mentally ill. . . . The emerging patterns of care for the various types of psychiatric patients will require the large mental hospitals in which the psychiatric nurse is located to assume much less importance in the future than it has in the past.¹³³

The report concluded that because of proposed changes to psychiatric care, the need for the psychiatric nurses would disappear in the western provinces.¹³⁴

An accompanying report, *Nursing Education in Canada*, also considered the situation of *psychiatric nurses* at some length:

In the four Western provinces . . . formal programmes are offered to qualified applicants to prepare them as “psychiatric nurses.”¹³⁵

The schools for psychiatric nurses were developed in response to a need for prepared attendants to care for the mentally ill. . . . As the mental health movement progressed there was a need to prepare individuals who could support the therapeutic regimes of the psychiatrist. Since there very few registered nurses working in this field, and fewer who had any specific additional preparation for psychiatric nursing . . . the psychiatric hospitals promoted short formal courses for attendants.¹³⁶

The report continued by describing the programmes in the four western provinces including the entrance requirement. The report concluded:

A review of the aims of the curriculum of the programmes for psychiatric nurses indicate that they seek to prepare nursing personnel who will have an understanding of human behaviour, a knowledge of psychiatric principles and concepts . . . skill in the preventative . . . and rehabilitative aspects of mental illness.

Although these objectives are commendable, the question is raised as to whether students of these programmes should be responsible for the care of the mentally ill . . . it prepares a technical nurse. . . . the need for these workers at present is recognized . . . eventually those nursing practitioners who care for the mentally ill should have a similar preparation . . . with additional post basic preparation.¹³⁷

The assumptions underlying the comments of the Hall Report and the Nursing Education in Canada Report were, of course, challenged by psychiatric nurses in

western Canada. The relevant issues were discussed at the CCPN annual meeting in Saskatoon in September 1964.¹³⁸ One of the assumptions challenged was that psychiatric nurses only worked in large institutions, and as the institutions were closing, psychiatric nurses would no longer be required. But the report of the second vice-president predicted that “psychiatric nurses expand their role right out of the institutions”.¹³⁹ Psychiatric nurses across western Canada were actively seeking a new role as community mental health workers.

* * *

With the Hall Report as a model, Witney obviously had a similar plan in mind for Manitoba. In November 1966 he wrote to the president of the MARN stating his intentions of studying nursing in the province and identifying the structure of the committee, which was to be a small group with one representative from each of the following:

- Manitoba Association of Registered Nurses
- University of Manitoba
- Hospital Schools of Nursing
- Associated Hospitals of Manitoba
- Manitoba Medical Association
- Department of Health
- Manitoba Hospital Commission

The proposed terms of reference included a study of present and future roles and relationships of all categories of nurses and methods of recruitment for the education and employment of both professional nurses and licensed practical nurses.

¹⁴⁰ Dr. Tanner, a representative of Witney spoke to the superintendents at their meeting in January 1966 advising them of the task of the committee and requesting:

A submission which would indicate the requirements at the institutions and the thoughts of the Medical Superintendents on the methods of training psychiatric nurses.¹⁴¹

The minister's failure to acknowledge the psychiatric nurses or to solicit any representation from the PNAM, and his request that the superintendents speak for the psychiatric nurses was a political blunder which offended the psychiatric nurses. It also became a rallying point which spurred them to look more critically at their place in mental health care in Manitoba.

The omission also concerned the superintendents who, following Dr. Tanner's presentation, noted:

The desire of the MARN to discourage the training of psychiatric nurses . . . and establish two types of RNs, one having taken a two year diploma and the other a four year university degree.¹⁴²

It is clear that the MARN was adopting a similar viewpoint as the Hall Report and this concerned the superintendents.

In response to the direction suggested by the Minister's Report, the superintendents raised three issues. First, the failure of the RNs to come and work in the mental hospitals, "that was the reason we developed a psychiatric nurse . . . because there were no RNs available."¹⁴³ Second, they noted, "Psychiatric nurses look after approximately 2000 patients yet they have no representative on the *Minister's Report*."¹⁴⁴ Third, they expressed:

Grave concern that the *Committee* might lessen the prestige of the psychiatric nurse . . . and not be aware of the extent of the need for psychiatric nurses in our mental hospitals.¹⁴⁵

While it may appear the superintendents were being solicitous in their expressed concern for the status of the psychiatric nurses, it may have been self-

serving. They admitted they could not envisage a situation under the present training of registered nurses that would “enable the psychiatric hospitals to adequately staff their facilities.”¹⁴⁶ They concluded their lengthy discussion by agreeing these matters should be brought to the attention of the minister of health.

* * *

It is not known how aware the psychiatric nurses were of the Minister of Health’s committee, but regardless, Martyniw was proceeding with his plans to uplift psychiatric nursing through education. He wrote to authorities at the University of Manitoba, asking whether a course for RPNs in hospital administration was available.¹⁴⁷ It is also reported that he wrote to the registrar of the University of Manitoba regarding courses for psychiatric nurses.¹⁴⁸ He asked the superintendents for their support in obtaining further education for psychiatric nurses, and this was discussed at the superintendents meeting on November 17, 1966. They advised him that they would support any nurses eligible to attend the University of Saskatchewan, but they “felt the University of Manitoba would certainly not consider this in light of what they are going to do for Registered Nurses.”¹⁴⁹ This last comment would have referred to the pending Minister’s Report. It was reiterated in a letter from Tavener, read at a special meeting of the PNAM in December, which advised “that the matter be dropped at this time.”¹⁵⁰ So the efforts of the psychiatric nurses on their own behalf were hampered by the superintendents who were no doubt being cautious about the impact of the Minister’s Report.

The Minister’s Report was published in November 1966. Not unexpectedly, nursing education was one of the central themes. It was recommended that the

education of nurses be in a separate system from the management and staffing of hospitals. Further:

The function of nursing be carried out by nursing practitioners at two levels of preparation . . . first with a degree from a university . . . second with a diploma.¹⁵¹

The committee acknowledged psychiatric nurses in a chapter carefully entitled *Other Nursing Personnel* and deliberately distinguished *others* from the *nursing profession*, “It should be realized that registered nurses occupy the pivotal position in nursing care; developments regarding other categories of nursing personnel will hinge on what happens with registered nurses.”¹⁵² *Licensed Practical Nurses, Psychiatric Nursing Services*, and *Orderlies* were the *others* addressed in this chapter. Even though there was an obvious effort to recognize the contribution of the psychiatric nurses in the report, it was equally clear that if the recommendations were implemented, both psychiatric nurses and licensed practical nurses would be phased out. The committee was not entirely unsympathetic to the situation of these two groups and recommendations #57 and #58 established a mechanism to enable eligible practical nurses and psychiatric nurses to become registered nurses.¹⁵³

* * *

The first reaction of the medical superintendents to the Minister’s Report was confusion. At the meeting of medical superintendents on January 24, 1967, Tavener advised that “we still do not know what we are going to do with our Psychiatric Nurses course.”¹⁵⁴ Superintendent Dr. Lowther of Portage, was concerned that the Minister’s Report did not address the special role of the psychiatric nurses in the care

of the mentally retarded. If psychiatric nurses were to be phased out who would provide this special care? It was therefore agreed:

Dr. Lowther would chair a meeting for the purpose of trying to come up with some concrete suggestions as to how a two year course could be implemented taking into consideration the needs of the School for Retardates.¹⁵⁵

The superintendents apparently paid no heed to the recommendation that psychiatric nurses would be phased out. Neither did they see the need to involve the psychiatric nurses themselves in these discussions. The paternalism continued.

* * *

The 1967 annual meeting of the PNAM in February marked the beginning of further challenges and counter-challenges for the PNAM. Martyniw noted in his address, “The past year has been a trying one . . . we have been faced with the threat of the ‘phasing out’ of Psychiatric Nurses.” He had prepared excerpts from the Minister’s Report to be handed out at the meeting. He included a portion of the report which recommended the formation of a Manitoba Nursing Council that would “exercise an overall licensing function in respect to all categories of nursing personnel.”¹⁵⁶ Martyniw suggested that a committee be formed to study the report and “send suggestions, comments, objections etc. to the Minister of Health.”¹⁵⁷

He listed the accomplishments of the past six months, particularly efforts to obtain courses for psychiatric nurses at the University of Manitoba. He noted the pay and classification briefs which continued to be presented to government. Finally, he mentioned the need for a full-time executive secretary and central office.¹⁵⁸ This last suggestion was supported by noting the increased workload of the volunteer executive and the need to expedite the business of the association. The association

was growing, and the trappings of increasing bureaucratization and legitimacy would be demonstrated by a visible public presence:

All this growth is justified if it is remembered the basic reason for our existence is care of the mentally ill.¹⁵⁹

Martyniw's annual report and his desire to have a physical presence in the form of an office illustrated either enormous confidence or arrogance. The Minister's Report, in effect, had recommended doing away with psychiatric nurses, but Martyniw was proceeding with plans to expand, not only the bureaucracy, he was also actively seeking further educational opportunities.

* * *

Twelve days after the annual meeting, and before the psychiatric nurses had an opportunity to react to the Minister's Report, Martyniw received a letter from the Minister of Health asking for comments and recommendations from the PNAM. A meeting was hastily called for March 8, 1967.¹⁶⁰ By April 22, 1967 a three and one-half page brief was prepared and submitted to the Minister of Health. A number of the statements in the report were questioned, such as the dropout rates for student psychiatric nurses, and the identified need for a large number of general nurses in the mental hospitals. The composition of the committee was also challenged. Martyniw pointed out that the PNAM had no representation on the committee; therefore, "inaccuracies and misinformation with regard to nursing the mentally ill were inevitable."¹⁶¹ Naturally the psychiatric nurses emphasized their superior ability to care for the mentally ill, based on the length and content of their education:

We . . . have a sincerity of purpose . . . therefore criticized . . . where necessary whilst attempting to point out that there are two fields of nursing, Psychiatric Nursing and General Nursing. . . Psychiatric Nursing is such a

broad field and requires such skills that for a general nurse to attempt to practice within this field after only three months of training is as ridiculous as for a psychiatric nurse to claim superiority on a general ward with only the same amount of training.¹⁶²

Other concerns were expressed, one in response to the recommendation regarding the establishment of a *Manitoba Nursing Council* which would control the registration of all nurses.¹⁶³ The PNAM recommended that the Council be comprised of *Psychiatric Nurses and General Nurses*, and would have jurisdiction over the two fields of nursing. The PNAM also reacted strongly to the statement that:

The regulatory powers under [The Psychiatric Nurses Act] should not exceed those granted to registered nurses.¹⁶⁴

We are deeply concerned . . . and object most strongly.¹⁶⁵

This, of course, is the crux of the matter. The Act stated:

No person who is not a psychiatric nurse shall practice (sic) in the province as a psychiatric nurse.¹⁶⁶

Interpreted narrowly, this could have meant that it was illegal for anyone, other than a psychiatric nurse as identified under the Psychiatric Nurses Association Act, to practice psychiatric nursing. But with the term *psychiatric nurse* and the practice of psychiatric nursing poorly defined, it would have been difficult to enforce any sanctions against those who were practicing psychiatric nursing without a licence. The act gave little protection to the title *psychiatric nurse* and the practice of psychiatric nursing. There were indeed general nurses giving care to patients diagnosed with psychiatric illness. Were these nurses practicing psychiatric nursing without a licence? There is no doubt that the Minister's Committee considered the possibility that the PNAM could invoke the act to sanction such nurses, but the act also contained the clause, "The act does not apply to general nurses."¹⁶⁷ This

loophole was recognized and a letter was sent to the association lawyer in June regarding the issue:

It would appear that clause '24' of our act is in direct contradiction of clause 8-C in particular, it is not our intention within the limit of our act to allow non Psychiatric nurses to practice Psychiatric nursing as such, this includes, aids R.N. orderlies etc., and since these states that our act does not apply to these persons, there is a loophole here (sic).¹⁶⁸

It would seem that no further action was taken at that time, but in one way or another, this became a central question: What is psychiatric nursing and how is it distinguished from other forms of nursing?

* * *

In June, another brief, written in conjunction with the MGEA, was sent to the Minister of Health. This one concerned classification, and the language was even stronger than the previous brief on the Minister's Report. This brief started out, "The present classification of nurses in mental hospitals is not only misleading but a disgrace to the profession."¹⁶⁹ Martyniw explained, because the classifications call for either a psychiatric nurse or registered nurse, it can only be assumed:

One does not have to be qualified to care for the mentally ill. One may be a nurse trained in care of the physically ill . . . and during the three months affiliation (sic) . . . one should by some miraculous process be acquainted with all phases of necessary care required by the mentally ill."¹⁷⁰

He went on at length, and quoted names of leaders who supported the specialist view of psychiatric nursing. He suggested that registered nurses should be considered *unqualified* for purpose of salary. He stated, "Registered Nurses . . . should work only under the supervision of qualified psychiatric nurses."¹⁷¹ He was using the same argument to invoke superiority of skills and knowledge that the

general nurses used. He concluded that the present classification system was “meaningless, derogatory and useless.”¹⁷²

In June, the PNAM sent a list of eighteen suggestions to the Minister of Health who passed it to the superintendents.¹⁷³ It was another strategy initiated by Martyniw to push the agenda for better recognition and self-regulation for psychiatric nurses. On June 22, 1967, the superintendents dealt with the eighteen suggestions, one by one. They concluded:

Four items which were thought to be pertinent for consideration by the Education Advisory Committee; these are items 1, 6, 7 and 14. The remaining 14 suggestions received consideration by the Superintendents.¹⁷⁴

The majority of the suggestions were related to educational policies such as: raising the entrance requirement to grade XI, shortening the course to two years, revising the curriculum, providing bursaries so that dependence on the students for service could be eliminated, and separating the school of nursing from the nursing service department. Some suggestions related to the concerns already voiced, “Why did psychiatric nurses have to be subordinate to general nurses?” One of the two most contentious items addressed the issue of why it should take a general nurse only six months to become a psychiatric nurse, whereas it took the psychiatric nurses two years to become a general nurse. This perceived inequity was one of the items which nagged at Martyniw. The superintendents dodged the issue by noting that this was a policy of the Registered Nurses Association and they had no jurisdiction. Apparently they had no opinion either.

The final item about which they had a very firm opinion was item 12:

The Psychiatric Nurses Association of Manitoba should have jurisdiction over the training of Psychiatric Nurses with senior psychiatrists in an advisory capacity.

To this they responded, “The Superintendents were not prepared to accept this statement.”¹⁷⁵ But even as they continued to exert control over the education of the psychiatric nurses, they were also aware that they needed to support them. It was recommended:

A working committee be set up to study aspects of psychiatric nursing problems. . . so the position of the psychiatric nurses could be given full consideration and appreciation and form the basis for an increased status for psychiatric nursing in Manitoba . . . and with a published report similar to the ‘blue book’ which dealt primarily with registered nurses.¹⁷⁶

While this may seem as though the superintendents were indicating support to the psychiatric nurses, they were also apprehensive about staffing issues.

* * *

A meeting of the Advisory Committee was planned for July 1967. Martyniw had an opinion about the items the committee should discuss, and a week before the meeting he had sent a letter stating that PNAM had given instructions to the association representative with regard to the future education of psychiatric nurses:

We are not advocating double qualifications . . . we have doubt with regard to the practicability of training a comprehensive nurse . . . the necessity to equip oneself with an additional year of General Nursing is not a desirable situation . . . our decision for general nursing opportunities . . . is to give the opportunity to those who may feel they wish to practice general nursing in a general hospital.¹⁷⁷

Martyniw went on:

The training of female Psychiatric Nurses as Practical Nurses . . . Must cease!. . . The qualifications RPN with the necessary related post-graduate training, should be sufficient for the most responsible posts in the field of Psychiatric Nursing.¹⁷⁸

Martyniw's language was not always clear, but there is no doubt about his intent. He was trying to achieve recognition for psychiatric nurses as a distinct profession and he believed there should be access to university courses for further education. Martyniw viewed any additional training in general nursing, whether as an LPN or an RN, as unnecessary for psychiatric nurses. In fact, he viewed it as detrimental.

Martyniw's plea went unheeded. Tavener apparently had his own agenda, and initiated a discussion on how the education of psychiatric nurses and nurses in general might be integrated:¹⁷⁹

We should go along with the trend developing . . . which involves a two year basic training period and specialization thereafter as a post-graduate nurse.¹⁸⁰

The motion was defeated: three for the resolution and five against. This obviously did not suit Tavener:

He expressed an opinion that other members of the committee who were not present would have swayed the vote in the opposite direction, and that indeed, non-voting visitors to the meeting would have ensured its passage.¹⁸¹

This is an interesting comment. Most of the members were present, although the directors of nursing from both Selkirk and Brandon had sent substitutes. Would the absent members have swayed the vote? Three physicians were present, as well as Dr. Johnson the non-voting chair, and five voting nurses. It would appear that the resolution would not have passed anyway if it had been based on disciplinary lines. The two members present who could not vote were the directors of education from Brandon and Portage and there is no way of knowing how they would have voted. Would this have been the end of psychiatric nursing in Manitoba? The

superintendents may well have been trying to placate the MARN, or to demonstrate agreement with the recommendations of the Minister's Committee. But they were reneging on their earlier position, that the only way to have staff in the mental hospitals was to have their own training programme for psychiatric nurses.

When the first motion failed, another strategy was tried by Lowther who suggested, "We recommend to the Minister that he provide Bursary support to enable Psychiatric nurses to enter RN training."¹⁸² This motion barely passed. It is recorded that the vote was four to three, but with no comment from Tavener. Perhaps everyone present was concerned that if assistance was provided, anyone trained under this scheme may not stay in psychiatric nursing and provide service. One way to solve this may have been behind the thinking of Lowther's next motion, "That bursary holders . . . return to the parent institution . . . following which two years of services would be required to repay the Bursary support."¹⁸³ This was a more popular option and passed six to zero. Tavener was either apprehensive or angry about the decisions. He suggested, "The names of the voting members of this meeting be included in the minutes of the meeting."¹⁸⁴ This meeting also reaffirmed the motion from the superintendents meeting that a committee be formed to study psychiatric nursing. On one hand, they were prepared to go along with the trend to do away psychiatric nursing, but on the other hand, they wanted to study it.

Two reactions to these motions demonstrate the ambivalence surrounding psychiatric nursing following the Minister's Report. The first reaction was registered by Martyniw and the second by the Minister of Health. Martyniw, in an undated letter to Tavener and copied to the Minister of Health stated:

The Psychiatric Nurses Association of Manitoba strongly objects to the introduction by you of the motion calling for the implementation of a two year basic training period in general nursing and specialization in psychiatric nursing thereafter. . . . I understand this training proposal was forwarded to you by the Registered Nurses Association . . . the policies are not acceptable and . . . we cannot accept the findings of the Minister's Committee. . . . Nurses who are basically inclined to general nursing are seldom equally inclined to the psychiatric environment. . . . Psychiatric Nurses . . . may have become social workers or probation officers and this type of person is seldom motivated towards general nursing.¹⁸⁵

Although not well articulated and without any documentation to support his assertions, Martyniw highlighted a central argument, that the environment of care and those who choose to work in that environment are different from people who work in general nursing. Martyniw went on that it should not be necessary to equip oneself with an extra qualification in general nursing simply for the purposes of promotion:

The need for a high degree of general nursing skills in the psychiatric hospital . . . has passed. . . . [T]he new emphasis is on interpersonal relationships and psychiatric nurses have become specialists . . . why the need for general training?¹⁸⁶

In the same letter he also criticized the committee studying the supply of nurses, which was fifty percent registered nurses. He recommended, "Fifty percent be single qualified psychiatric nurses."¹⁸⁷ One of Martyniw's goals was always to have general and psychiatric nurses on an equal plane, but with a clear distinction between the two.

* * *

Dr. Johnson, who no doubt would have been informed of the letter to Tavener, may have been apprehensive about the Minister's reaction to Martyniw's letter or he may have recognized the potential for tension arising from the minutes of the Advisory Committee. In any case, he alerted Deputy Minister Dr. Morison:

There are two or three minutes included in these minutes which in my opinion, our Minister should note . . . No doubt Dr. Tavener . . . will be wanting to discuss . . . the future of the training of psychiatric nurses.¹⁸⁸

Dr. Johnson may have been quite happy to let Tavener deal with the situation as he retired very soon after this meeting and Tavener became Director of Psychiatric Services.

The Minister of Health, although in a more muted tone, also reacted to the motions made at the Advisory Committee meeting, “I decline to act on them until I have further clarification.”¹⁸⁹ He had read the motions made by Tavener and Lowther and concluded that he saw no difference, nor did he see the need for a committee:

My interpretation of the resolutions indicates to me a woolliness of thinking on the future of Psychiatric Nursing. . . . I am disturbed to think that doubt exists as to my appreciation of the psychiatric nurse. . . . As to their position I am still puzzled for surely they know what it is. Thus, what value is there in a Minister’s Committee?¹⁹⁰

The Minister of Health believed, “It would be better to meet with you, [Dr. Morison, Deputy Minister], Director of Psychiatric Services [Dr. Tavener] and the Chairman of the Minister’s Committee on the Supply of Nurses [Mr. Holland].”¹⁹¹

The Minister’s tone suggests he had no intention of following the recommendation that psychiatric nursing be discontinued. Yet neither was he willing to commit to an unexamined position. When Tavener received a copy of this memo, he was immediately defensive and deferential. He agreed that, “The Minister should decline to act without clarification . . . He is correct, the minutes of the meeting show woolliness of thinking.” But Tavener also wanted to explain some of the issues from his perspective:

The Psychiatric Nurses Association is satisfied that nobody loves them, including myself; although I believe I am known to be a supporter of theirs

(i.e known to others, not to the Psychiatric Nurses Association). Under their present President their attitude is militant and they are prepared to fight for what they consider to be a threat of extermination.

My reason for proposing an actual committee enquiry was that it seemed the only method of clearing the air in regard to this branch of nursing. It might accomplish:

- i allowing the Psychiatric nurses to voice their fears and problems to a formal body; they feel their voice was unheard in the prior report on nursing, that the report is being implemented to their detriment.
- ii allow other nursing groups e.g. the Manitoba Association of Registered Nurses the opportunity to 'put up or shut up' in regard to integration of nursing and what compromises they are willing to make.¹⁹²

What emerged from the summer of 1967 was a clear need to examine the education of psychiatric nurses and to have nursing educators more fully involved. A further brief was sent to the superintendents from the PNAM reiterating many points already made, but also decrying the American model of psychiatric nursing. They also observed, "The Hall Commission noted that mental hospitals were contracting and concluded that the demand for psychiatric nurses would therefore diminish. . . . but the demand for psychiatric nurses has increased."¹⁹³ The brief summarized the recommendations of the PNAM:

That the entrance requirement be raised to Grade XI

The course be shortened to two years

The basic sciences be raised to the RN standards

That the LPN programme be discontinued

That the education committee of the association be permitted to participate in preparation of any future curriculum.¹⁹⁴

These recommendations were not unreasonable, and the first four were already being considered by the superintendents, so when this brief was discussed at their meeting of November 1967, they were quite agreeable. The one item on the list

they had always been reluctant to consider was greater involvement of the association and nursing educators in the education of psychiatric nurses.

Tavener opened the discussion of Martyniw's memo with the observation, "The superintendents were reminded that we are faced with the necessity of doing something concerning psychiatric nurse training."¹⁹⁵ *Doing something* became a common phrase over the next year, although there seemed to be little vision of what needed to be done and who would do it. Tavener continued, "The Psychiatric Nurses Association is against changing the status of the psychiatric nurse. The MARN have a philosophy but no program to speak of."¹⁹⁶ A supplementary committee was to be established because, "We need to protect our supply of psychiatric nurses and therefore should publish a 'Red Book'."¹⁹⁷ Clearly, the superintendents viewed psychiatric nurses as an essential commodity to be protected, whereas the association, quite confident of its own worth, was more concerned with greater respect based on professional status and educational achievement. These were not necessarily conflicting goals. The Advisory Committee and the superintendents, up until this time, had considered themselves the authorities on psychiatric nursing education. Faced now with the necessity to *do something*, they seemed more willing to listen to suggestions from educators and the PNAM regarding the curriculum. It would not be accurate to say that this was the point at which the PNAM wrested away power from the Advisory Committee, nor that the Advisory Committee gave up its control of the curriculum. It is more likely the Advisory Committee recognized the amount of work entailed in curriculum revision, and with the educators and association willing and anxious to do it, it was a mutually beneficial, if unspoken, arrangement.

Other unspoken arrangements also occurred. There often appeared to be friction between Martyniw and Tavener, but there was also a grudging respect. In October 1967, an editorial appeared in the *Canadian Nurse* which examined the formation of an association of psychiatric nurses in Ontario. The editorial explored the genesis of psychiatric nursing in western Canada and then went on to deplore the practice, despite the fact it also observed, “Licensed psychiatric nurses have provided the bulk of nursing care in psychiatric institutions in Canada’s west.”¹⁹⁸ The article concluded by recommending the phasing out of these nurses.

Not unexpectedly, this brought responses from psychiatric nurses across the country, including two from Manitoba. Kellie from Portage observed that the need for psychiatric nursing was increasing rather than decreasing, while Martyniw, in his usual polemical style, went on at length.¹⁹⁹ Other supportive and not so supportive letters appeared. These must have been brought to the attention of Tavener.

At the December 1967 council meeting, a letter was read from Tavener referring to the letter in the *Canadian Nurse*:

I think you have expressed the views of the Psych Nurse as contrary to the editorial opinion. I hope your association will continue to be active in protecting the interest of your members and psych nurses, on which your programme is based.²⁰⁰

Such controversies about the need for, and nature of, psychiatric nursing were based on a number of persistent assumptions. First, as was stated in the editorial, “Mind and body are an entity and cannot be compartmentalized and treated separately.”²⁰¹ While this is true, cannot the same be said about general nursing? Martyniw was always quick to contend that the two or three months psychiatric nursing experience in general nurses training could not compare with the more

extensive training of psychiatric nurses in mental illness. The editorial admits that psychiatric nurses receive knowledge and experience in medical-surgical nursing in about the same proportion as general nurses receive training in mental illness, so the argument regarding separation of mind and body becomes a stalemate. Probably the reason for phasing out psychiatric nurses had more to do with the second assumption: that specialization in a field of nursing should be at the post-diploma level. This was the view of the CNA and most provincial nursing bodies, but at that time, there were not many opportunities for post-diploma education in psychiatric nursing.

Another common statement was that basic psychiatric concepts should be integrated throughout the entire curriculum. There was never a very clear explanation of what these concepts were. The editorial suggested that a patient with a physical illness may be vulnerable to a stressful environment. But is this mental illness? The distinction between mental illness and the emotional responses to physical illness needed to be more clearly articulated. This notion, that psychiatric principles should be applied to all patients, was not uncommon.²⁰² But does this mean that all patients have a psychiatric illness along with their physical illness?

The final assumption questioned why psychiatric nurses would be needed as mental hospitals closed and patients moved to community settings. Was this intended to mean that patients would no longer require special care? Or did it imply that the RNs would now be more willing to work with psychiatric patients? Was it being suggested that the change of the environment of care from mental hospitals to general hospitals and community settings would make psychiatric nursing more appealing? James Walkup argued that the rise of general hospital psychiatric units was an effort

to encourage physicians to enter psychiatry, not because it was necessarily better for the patients, but because it was more pleasant for the doctors.²⁰³ Could the same argument be applied to nurses? But rather than assume that the setting would determine the type of nurses, why was it not considered that psychiatric nurses could be educated to work with psychiatric patients regardless of setting?

These are central curricula questions:

What is the domain of concern for graduates of psychiatric nursing programmes?

What are the epistemological and ontological bases of the profession of psychiatric nursing?

How can the desired skills knowledge and attitudes be instilled?

The Emerging Curriculum and Curriculum Makers

The examination committee, a sub-committee of the Advisory Committee, was given the responsibility of *doing something* with the brief submitted by the PNAM.²⁰⁴ This committee met in December 1967 and “discussion opened on the subject of the MPNA brief to the Director of Mental Health Services.”²⁰⁵ This committee agreed with all the recommendations of the PNAM brief, and they developed a curriculum outline suited to a two year non-service oriented training programme.

In many ways, however, this new curriculum was little different from earlier ones. Courses were added and subtracted, titles were changed, and content was shuffled. When the revisions were presented to the Advisory Committee in May 1968, they too made adjustments which reflected changes in current terminology and medical practices, and of course, their own particular view of psychiatric nursing education. The term *motivation therapies* was substituted for *occupational therapies*,

the hours of instruction in *basic nursing* were reduced and increased in *medical-surgical nursing*, the course *drugs and solutions* was renamed *pharmacology*. The most significant change was that *psychiatry* as a subject was dropped, and *psychiatric nursing* was increased to 200 hours, the most it had ever received.²⁰⁶ For the first time, the number of hours devoted to psychiatric nursing exceeded the number devoted to basic nursing. Terry Gibson suggested that many of the procedures related to the medical treatment of mental illness, such as electro-convulsive therapy, were simply moved from basic nursing to medical-surgical nursing.²⁰⁷

The increase in the number of hours of psychiatric nursing represented a lessening of control of the content by psychiatrists and also a move to incorporate psychiatric nursing knowledge constructed by nurses. Psychiatric nursing textbooks took the place of *Notes on Psychiatry* by Dr. Schultz.²⁰⁸

The number of weeks in clinical areas was clearly stipulated in this new curriculum, and the assignments were made by the school of nursing, not the nursing office. This was to ensure that the students received ward experiences based on learning needs rather than hospital needs. Clinical instructors were sent to the wards so that students received direction rather than being dependent on busy, and sometimes disinterested, head nurses.

Despite these curriculum adjustments, there was very little substantive change. Changes such as renaming courses and rearranging content have been described by Stark and Lattuca as *tinkering*.²⁰⁹ Tinkering focuses on curriculum structure, changes in the number of hours, new lists “or other dimensions of the framework in which learning typically is arranged.”²¹⁰ Substantive curriculum

change, on the other hand, involves asking such questions as: What is worth knowing and what is the essence of our profession? What do we want the graduates to be able to think, do, and feel? In other words what are the philosophical and disciplinary underpinnings of psychiatric nursing?

For psychiatric nursing in Manitoba in the late 1960s, there was no philosophy of psychiatric nursing articulated in the curriculum, yet there was a vague sense of some distinct philosophical perspective. But the expressions of this perspective are often intuitive and anecdotal. Christopher Dooley, for example, cites a respondent as rejecting the notion that psychiatric nursing was somehow inferior to general nursing. The respondent asserted the inverse, “They (general nurses) gave their care, but we gave loving care.”²¹¹ Forty years after Martyniw had struggled to present the differences between psychiatric nurses and general nurses in the communications he had with the government, he was still trying to find a way to articulate it. In an interview in 2005, when asked what he thought the central idea of psychiatric nursing was, after a long pause he said, “Well the general nursing itself is mostly tasks . . . psychiatric nursing is how to deliver those tasks.”²¹² These responses represent an intuitive sense of something distinct, but something that cannot be easily articulated. This is also echoed by other authors who have struggled with the difficulty of stating what psychiatric nursing is.²¹³

These statements were in no way intended to suggest that other nurses did not provide loving care or were not attentive to the process of providing care. Rather, they demonstrate the difficulty of giving shape and form to their intuitions. Neither is

the task of translating such hunches and intuition into curriculum concepts an easy task.

Curriculum Concepts in the 1960s

There were numerous conceptualizations of curriculum in the 1960s, most developed for the generic field of education, but which were freely borrowed by nursing. The general conceptions of curricula at the time could be described as technical, practical, and critical.²¹⁴

The technical framework is generally accepted to mean that education is organized around four basic questions:

What is the purpose of this education?

How is content selected?

How are the learning experiences organized?

How is the learning evaluated?

This framework is based on the assumption that knowledge is fixed and can be transferred from the teacher to the learner.²¹⁵

The practical paradigm is more concerned with the solving of problems and meaning-seeking. This framework considers that teachers, learners, the subject matter, and the context of learning interact to solve problems and make sense of the world. The assumption is that humans construct knowledge and meaning from their own particular experiences.²¹⁶

The critical paradigm attends to the political, cultural, and historical context in which learning occurs and knowledge is created. The critical paradigm is not a single framework and it has been suggested there are multiple characteristics of this

curriculum paradigm. The assumption underlying this view is that knowledge is not fixed, but can be reconceptualized to encompass multiple perspectives. The changing nature of knowledge and political control of knowledge is a characteristic of this paradigm²¹⁷

The predominant model of nursing curricula in the 1960s was decidedly technical, based on objectives, identification of content, methods to achieve the objectives, and evaluation of learning. Amy Brown, in her text on curriculum development in nursing, states at the outset “the reader will find in this book the Tylerian rationale of curriculum applied to nursing.”²¹⁸ In great detail, Brown sets out how learning objectives and experiences are to be constructed in a variety of classroom and clinical settings. These outlines leave little room for personality differences in either nurse or patient or for the exploration of the meaning of the illness to the patient. Even the psychiatric nursing lesson plans focus on observing, interviewing, and recording, but little is said about emotional suffering of the patient. This pattern for the construction of nursing curricula in the 1960s became a model for psychiatric nursing curricula in the 1970s.

A New Curriculum Sub-committee

The Advisory Committee in 1968 possibly recognized the amount of work that would be involved in a curriculum review. They realized they needed someone, other than themselves, to do that work, or perhaps they were gaining confidence that the nursing educators were capable of conducting a curriculum review. For whatever reason, they determined at the May meeting:

A Curriculum Sub-committee composed of the three Directors of Nursing Education, 1 representative of the Psychiatric Nursing Association and 1

Director of Nursing . . . and it was agreed that the Curriculum Sub-Committee conduct a continuing review of the new two year program of Psychiatric Nursing Training . . . and that the Sub-Committee develop a detailed course content . . . for recommendation to the Education Advisory Committee.²¹⁹

In September, the Advisory Committee established the terms of reference for the committee:

- a) this is a working committee reporting to the Education Advisory Committee;
- b) the sub-committee is advisory and does not have power to set or implement policy;
- c) the sub-committee is expected to make recommendations to the Education Advisory Committee in regard to curriculum, course context,(sic) etc. in sufficient detail for decision making by that body.²²⁰

Although there is the appearance of a shift to give more control to the educators, the ultimate responsibility still lay with the Advisory Committee, but there was definitely a slow unraveling of the power relationship. By the end of 1968, there were new instructors in the mental hospital training schools. There were also an increasing number of male instructors with additional education. Men continued to play an important role in psychiatric nursing, not only in the organization of the association, but also in the ranks of the educators.²²¹ With better educated people and increased influence, new opportunities for curriculum development were emerging. But at the end of the first decade, attention had to be paid to the professional integrity of the association which was challenged by the Advisory Committee over the issue of responsibility for licensing.

A Licensing Crisis

The last three years of Martyniw's term were characterized by high and low points. One of the low points, which symbolized the ongoing tug for control between

the Advisory Committee and the association, started innocently enough with a letter from Lowther, Superintendent of Portage School. In December 1967, he wrote to the RPNAM:

Inquiring whether the association will register people coming from England holding a Certification of qualification in Mental Subnormality only. (sic). He is receiving applications from nurses in Britain . . . he would like to know the associations stand, and how he should reply.²²²

John Kellie from Portage stated, “These nurses do not meet our requirements.”²²³ The council requested that their lawyer look into this matter and he replied:

We regret, from the basic information you provide . . . it is difficult for us to render an opinion (sic). . . . We would think that generally . . . your act does not provide for admitting persons under the Association who are not qualified to practice as a Psychiatric Nurses in this Province.²²⁴

The situation obviously became critical. At the March 1968 meeting of the Education Committee of the RPNAM, it is recorded, “Urgent attention was paid to the matter of registration of nurses from the UK with certificate of Registered Mental Subnormal Nurse (RMSN). The discussion was extensive and the subject exhausted after two hours.”²²⁵

The summary of the discussion included the following points:

We have registered two people already. . . They are better prepared to work in the field of retardation. . . They are deficient in psychiatric nursing. . . They have already been recruited and will work for the same salary as psychiatric nurses. . . It may be in the interest to have these people under control of the Association.²²⁶

The committee recommended that these nurses be offered a restricted licence to work in Portage and that they complete a prescribed course and pass the provincial exams.²²⁷

In Great Britain, the separate registration for these nurses entitled them to work in facilities for the mentally retarded. In Manitoba, these facilities fell under the same government department and administrative control as mental hospitals. The training programme for psychiatric nursing students at the three provincial institutions provided them with skills and knowledge to work in both kinds of facilities upon gaining their licence.

Despite the political reality that in Manitoba care of mentally retarded and the mentally ill fell under the same government department, this created a dilemma for the association. They were the ultimate authority in granting a license to practice psychiatric nursing, as it was defined in Manitoba. They were not in agreement with issuing licences to these RMSNs from Great Britain, as they did not meet the criteria set out in the Manitoba act. But the dilemma became more than a matter of following the established criteria for registration. It also became a tug of war with the superintendents.

The lawyer responded to a further request:

The definition of 'psychiatric nursing' does include the services which would be performed by the Mental Subnormality Nurses and accordingly, in order for them to practice in Manitoba they should be registered under your act. . . But as they may not meet the qualifications . . . since your act does not provide for a limited licence.²²⁸

This should have been a clear indication that these nurses could not be licensed under the current act without further education. But, at the Portage institution, these nurses must have been proving their value, if not their credentials, as it is recorded in November 1968:

A letter was read from the Portage Unit, signed by T Street, secretary requesting that the Provincial Council ask the Advisory Committee to find a

way of making the R.M.S.N. (Registered Mental Nurse Sub-Normal Nurse) eligible for registration as quickly as possible together with any other overseas nurses that may presently not be eligible for registration.²²⁹

Apparently the Portage School took it upon themselves to provide the additional education to these nurses, and a letter of enquiry was sent to Tavener regarding this. The association also enquired about test results. Tavener's curt reply was reported at the March 1969 council meeting:

The results of the course . . . will be made known to the Education Advisory Committee by the Portage School . . . Your representative will have full opportunity to obtain needed facts . . . the assessment of training is a matter for the Education Advisory Committee the Committee has not at this time given approval to the course.²³⁰

Tavener was correct to a point. The Advisory Committee was the only body who *legally* needed to know the exam results, and it was their responsibility to approve the training schools. But this seemed to be a corruption of the spirit of the Training Act, which was to ensure certain educational standards were met, not to wield power. Whoever had allowed these nurses to come to the province, apparently with a promise of a licence, was now trying to rectify the situation. The issue was raised again at the annual RPNAM meeting, and it was pointed out by one member:

If the committee (advisory committee) issues certificates of qualification to these Portage students our Act states that the license (sic) must be issued.²³¹

This was correct. The effect of the amendments of 1963, about which their lawyer had warned them, was now being felt.²³² When the superintendents had the act amended in 1963, the effect was that if the Advisory Committee issued a certificate of qualification, the Association had no choice but to issue a licence.

The matter of the certificate of qualification was raised at the Advisory Committee meeting in May 1969. Lowther moved:

Certificates of qualification be issued to the nurses listed in Appendix 11 holding qualifications R.M.N.S. (England) or R.M.N.D. (Scotland).²³³

He provided an account of their psychiatric experience which ranged from twelve months to thirty-six months, and he also supplied the marks for the psychiatric nursing exams which he had administered.²³⁴ He was supported by Mr. Omichinski, director of nursing from Portage, who stated:

The care given by these staff to the retardate was at least equivalent to that given by the psychiatric nurse practicing at Portage.²³⁵

But the question was not whether they gave good care, but whether they met the criteria for registration.

Stewart Davidson, Associate Director of Nursing Education from Selkirk, asked to see the course given to these staff:

[He] was advised that discussion had taken place with the instructors prior to implementation of the course. The examination was held using material obtained from previous Provincial Examinations and an oral examination had been given by Dr. Lowther."²³⁶

The meeting adjourned and reconvened on June 3, 1969, with further discussion of the issue. Davidson asked if a limited licence could be issued allowing the British nurses to practice at Portage. This was not possible as the act did not permit it. John Burns, director of nursing from Selkirk, had a series of questions regarding the care provided:

Had other nurses with similar qualifications been registered?

Did they have enough experience in psychiatry?

Each was answered in the affirmative, and the question was put to a vote. The motion barely passed, five to four. The vote was recorded, and it is clear that voting took place along service versus education lines. Those in favour obviously were

concerned with providing care to patients at Portage while those against were more concerned with maintaining educational and professional standards.

The association sought legal counsel. In a memo addressed to Martyniw and the registrar, the lawyer, Ramsay, informed them that the RPNAM had the right to assess the qualifications of a psychiatric nurse trained outside Manitoba and quoted the changes to the act of 1968.²³⁷ His opinion at that time was:

The certificates of qualification as issued by the advisory Committee to the mental deficiency nurses were not made in accordance with the Act and therefore are unenforceable in terms of demanding the issue of licences by the committee.²³⁸

He reiterated this position at a council meeting in June, “The Advisory Committee does not have the authority to issue licence to anyone trained outside Manitoba.”²³⁹ Ramsay explained the complicated process. The Advisory Committee could only issue the certificate of qualification after one of the approved schools had issued a diploma confirming that the student had completed the required course of studies. The certificate of qualification was then issued to the student who in turn presented it to the association in exchange for a licence upon paying the fee. But the nurses from England had not been educated in Manitoba. Out of province nurses had to be evaluated by the association, the act said so.²⁴⁰ Somehow this process was circumvented by the superintendents.

In August 1969, Lowther informed the medical superintendents meeting:

The RMNS nurses from Portage have become very restless relative to delays in obtaining licensing. The Portage School has provided them with a diploma dated the same date as their certificate of qualification so that they may qualify for licensing in Manitoba. It was suggested that Dr Tavener write to the R.P.N.A.M. advising them of the dissatisfaction felt by this group and that the Superintendents would appreciate their licensing these nurses. . . . That serious consideration should be whether this licensing should be done

by the R.P.N.A.M.-perhaps there should be a college of nurses which would licence all nurses.²⁴¹

This parting shot would have been wasted on the superintendents who, no doubt, felt the same way.

In September, the RPNAM again requested Ramsay's opinion. This time he reversed his position:

The change in the Regulations-subsection 4-was read-'The Education Advisory Committee has the jurisdiction to assess the qualifications of persons applying for training in an approved training school, and to give full or partial credit for training which they have had.'²⁴²

Ramsay stated that in his legal opinion the RPNAM had no choice but to issue RPN licences to these people.²⁴³ Why did Ramsay reverse his position? It seems that a change in the regulations gave *notwithstanding* authority to the Advisory Committee. This allowed the Advisory Committee to permit a person, who did not comply with the entrance requirements set out in the act, to be enrolled as a student. The change was published in the Manitoba Gazette on May 31, 1969.²⁴⁴ With only four weeks intervening between the filing of the changes and the June meeting with the RPNAM, Ramsay may not have been aware of this fact. His failure to stay abreast of relevant changes possibly resulted in the termination of his services by the RPNAM in October 1969.²⁴⁵

Reluctantly, the RPNAM licensed the British Mental Subnormal Nurses, but not without trying to discredit the process. The RPNAM informed Tavener it was done under protest, he in turn responded with the challenge, "Produce evidence of undue pressure."²⁴⁶ They challenged the changes made to the regulations, "Mr. Pronyk mentioned that to his knowledge the changes in the regulations (allowing the

R.M.S.N.s to be registered) did not appear as approved in the minutes of the meetings of the Advisory Committee.”²⁴⁷ Finally, on learning that some of the unlicensed RMSN had been promoted and some had assumed the title Rehabilitation Counsellor, the RPNAM threatened both the employer (Portage School) and the employee with the legal consequences of working as a psychiatric nurse without a licence.²⁴⁸

There were no real winners and it left bitter feelings on both sides. But the political savvy gained by the association during this episode was a sign of the maturing of the association and it hardened their resolve to gain more control over their own affairs. It also raised a more fundamental question: “What is a psychiatric nurse?”

The End of the First Decade

The concern over these licensing issues overshadowed other events which had moved the association forward during this time. The office was opened and an office manager was hired, increasing the visibility of psychiatric nursing with the general public. Meetings were established on a more regular basis with Tavener. Dialogue was established with Brandon University (BU) and the University of Winnipeg (U of W) regarding courses for psychiatric nurses. Brandon University responded in March 1969 that their request for information had been turned over to the Senate Committee.²⁴⁹ A reply from the U of W was read at the council meeting of August 1968:

You will appreciate that in the first year of our existence as an independent institution has had many internal and external business to resolve (sic). This has been an extremely busy year and as a result some decision that that might otherwise have been reached sooner has to wait (sic).²⁵⁰

In March 1969, further correspondence from the U of W indicated that they were still willing to enter into discussions with the psychiatric nurses regarding university courses.²⁵¹ The relationship with these two universities became critical to the ongoing professionalization of psychiatric nursing during the second decade.

* * *

As the association entered its second decade, and Martyniw's tenure was drawing to a close, the 1970 annual meeting marked the opportunity for Martyniw to review the first ten years of the association, and set goals for the coming year. He congratulated the association for its accomplishments, especially the continuance of psychiatric nursing and claimed, "We have fought diligently against federal and provincial recommendations to phase out psychiatric nurses and won!" He mentioned the many briefs that had been presented and the "nagging and yelling" to get improved pay and classification for psychiatric nurses. He also identified future challenges:

One of the areas in which we still haven't succeeded, post-graduate education and we need to push harder in the field of community psychiatric nursing.²⁵²

During his final year he presented to the new Minister of Health ReneToupin, a brief on community psychiatric nursing. This brief included desired training, the expected skills of such a person, and the anticipated salary.²⁵³ Developing community psychiatric nursing became one of the major achievements of the second decade.

Martyniw's term as president concluded in 1971, but he stayed involved as a member of the education committee, and continued in a number of ways to advocate for psychiatric nursing. The official leadership of the association was turned over to the fourth male president, Jack Holleman.

Conclusion

In this chapter the evolution and professionalization of psychiatric nursing in Manitoba during its first decade has been examined. These were times of growth, as well as frustration, as the new association found ways to manage its business and establish a place for itself in the mental health system, but continued to be frustrated by the lack of control over their education. The second decade saw a number of political challenges to psychiatric nursing, which created new opportunities to articulate their distinctiveness. There was also a continuing shift in the control of psychiatric nursing education by the curriculum sub-committee, who skillfully inserted themselves into the educational process. The second decade also saw a more politically astute association and new curriculum frameworks. Men continued to play an important role in the affairs of the association, and increasingly in the education of psychiatric nurses.

Endnotes Chapter 4

1. Interview Myrtle Barnett, March 12, 2002. The dates given are approximates, provided by his widow, and his son Arthur. Apparently he had a difficult childhood in England and confided very few details to his family. The information is therefore not substantiated by documents but there seems to be general agreement amongst family members that this is Alf Barnett's story.

2. Ibid. This story falls into the realm of family lore but is worth noting that Boschma in her study interviewed the widow of Mr. Ted James of Alberta who had served in the navy between 1942 and 1945 and there is also a note in his obituary that he served in the Royal Canadian Navy during the war between 1942 and 1945. This is approximately the same time that Alf Barnett served. It is possible that this was the gentleman to whom Myrtle Barnett was referring when she said that Alf had met someone on the ship who was also a psychiatric nurse from the west, although she thought it was British Columbia. See Geertje Boschma, Olive Yonge, and Lorraine Mychajlunow, "Gender and Professional Identity in Psychiatric Nursing in Alberta, Canada, 1930-1975," *Nursing Inquiry* 12 (4) (2005): 243-255.

3. Doug Smith, Jock Bates, and Esylit Jones, *Lives in the Public Service: A History of the Manitoba Government Employees' Union* (Co-published by the Manitoba Government Employees' Union, 1993), 97, 133.

4. Ibid. Caption under photo, 110.

5. Caption under photo of Alf Barnett, *The Bison*, XII (1) (March 1959) 8. *Lives in the Public Service*, 133.

6. "Officers of the Canadian Association of Psychiatric Nurses Visit Manitoba," *The Bison*, X (2) (July, 1957), 14.

7. Geertje Boschma et al., "Gender and professional identity in psychiatric nursing practice in Alberta, Canada". Peter Nolan also observes the close relationship between union activities and male psychiatric nurses in Great Britain. Peter W. Nolan, "The Founding of Psychiatric Nurse Training and its Aftermath," *British Journal of Psychiatry* (159) (1991): 46-52.

8. This term is recorded in the reports presented at the 1954 and 1955 Annual CCPN Meetings. .

9. Celia Davies, "Professionalizing Strategies as Time and Culture Bound: American and British Nursing, Circa 1893," in ed. Ellen Condliffe Lagemann *Nursing History: New Perspectives, New Possibilities* (New York: Teachers College, Columbia University, 1983), 47-63, 49.

10. Statutes of Manitoba. Chapter 108, 1960. *An Act respecting the Psychiatric Nurses Association of Manitoba*, (hereafter called The Psychiatric Nurses Association Act). Section 4.
11. CRNM Archives, Minutes of MARN Board Meeting November 5, 1960.
12. Ibid.
13. CRNM Archives, Minutes of MARN Board Meeting, February 4, 1961.
14. CRNM Archives, Minutes of MARN Board Meeting, March 4, 1961. This letter was sent by John Martyniw who at that time had no official position in the Psychiatric Nurses Association although he became a central figure later in the 1960s. He was employed at Misericordia Hospital. Martyniw's letter stated "You the (MARN) consider the merits of an affiliation with the newly formed Psychiatric Nurses Association putting the Psychiatric Nurses on a supplementary register . . . Those of us in general hospitals are deeply concerned at the lack of professional status for Psychiatric Nurses." He had also sent a copy to Barnett. The MARN replied that the Registered Nurses Act did not provide for additional registries but they were willing to meet with officers of the Psychiatric Nurses to discuss problems.
15. See chap. 3, this study for discussion regarding the relationship with the Licensed Practical Nurses
16. Statutes of Manitoba, Chapter 54, 1960. *An Act to provide for the Education of Psychiatric Nurses* (hereafter called the Psychiatric Nurses Training Act), Section 5.
17. Ibid., Section 6.
18. Ibid., Section 3.
19. The Psychiatric Nurses Association Act, Section 10.
20. CRPNM Archives, Minutes of Council Meeting, May 24, 1960. Minutes of all council meetings are well maintained at the office of the CRPNM and are easily identified.
21. Ibid.
22. This was the customary way the graduates of the mental hospital programmes referred to themselves.
23. CRNM Archives, Minutes of MARN Board Meeting, November 5, 1960.

24. Anne Stanley's name appears in the Minutes of the LPN Advisory Council until the discontinuation of the LPN affiliation with the RPN training in 1969.

25. Evelyn McKenzie's name appears in the list of graduates from Brandon Mental Hospital in 1927.

26. CRPNM Archives, Minutes of Council, Meeting May 24, 1960.

27. PAM, GR 1555, 1280-2. In the file of the Education Advisory Committee a set of minutes dated August 19, 1960 were found. A letter attached to these minutes from Dr. Atkinson to Dr. Tavener dated November 8, 1961 stated "We discovered the minutes of this meeting here in our files I am forwarding you your copy now and also sending one to Dr. Johnson and Dr. Bristow." Obviously the minutes of the first few meetings of the Advisory Committee were not filed properly. In the minutes of this August 19, 1960 meeting a Superintendents Meeting of May 6, 1960 was referred to at which Advisory Committee business had been discussed. The minutes of May 6, 1960 Superintendents meeting have never been located.

28. This in fact proved to be the case. Throughout the next twenty years the minutes of the Superintendents meetings frequently reveal that discussions and decisions regarding the education of psychiatric nurses took place at those meetings rather than at the Advisory Committee.

29. PAM, GR1555, 1280-2, Minutes of Meeting referred to in note 27, this Chapter.

30. Ibid.

31. Personal communication Terry Gibson, February 6, 2007. She noted that during the war years the mental hospital was drained of male staff who were called into war service. In order to fill the gaps decent men were literally "hired off the streets".

32. The Psychiatric Nurses Association Act, Sections 5, 6, and 7.

33. PAM, GR 1555, 1280-2 Minutes of Meeting, August 19, 1960.

34. Ibid.

35. No minutes of a curriculum meeting of May 25, 1960 were located

36. CRPNM Archives, Minutes of Council Meeting, February 14, 1961.

37. Ibid.

38. PAM, GR 1555, 1280-4 The Minutes of Psychiatric Nursing Educators Meeting February 10, 1961 were attached to the March 8, 1961 Advisory Committee Minutes. The Association may not have known about this educators meeting.

39. CRPNM Archives, Minutes of Council Meeting, March 14, 1961.

40. CRPNM Archives, Minutes of Council Meeting, April 18, 1961.

41. PAM, GR 1555, 1280-4, Minutes of Psychiatric Nursing Educators Meeting, February 10 1961.

42. CRPNM Archives, Minutes of Council Meeting, May 31, 1961.

43. CRPNM Archives, Minutes of Council Meeting, September 22, 1960.

44. Ibid.

45. The psychiatric nurses sometimes referred to themselves as *registered* although in fact, legally, the term *registered* was not applied until 1968.

46. CRPNM Archives, Minutes of Council Meeting, October 27, 1961.

47. CRPNM Archives, Minutes of Council Meeting, November 17, 1961.

48. CRPNM Archives, Minutes of Council Meeting, January 26, 1962.

49. CRPNM Archives, Minutes of Annual Meeting, February 28, 1962.

50. CRPNM Archives, Minutes of Council Meeting, March 30, 1962.

51. Ibid.

52. CRPNM Archives, Minutes of Council Meeting, May 2, 1962.

53. Ibid.

54. CRPNM Archives, Minutes of Council Meeting, June 1, 1962.

55. CRNM Archives, Minutes of MARN Board Meeting, August 25, 1962. The PNAM was sometimes incorrectly referred to as MPNA.

56. CRPNM Archives, Minutes of Council Meeting, September 26, 1962.

57. CRNM Archives, Minutes of MARN Board Meeting, September 29, 1962.

58. CRPNM Archives Minutes of Council Meeting, September 26, 1962.

59. CRPNM Archives, Minutes of Special Meeting with Winnipeg Psychiatric Nurses, October 2, 1962.

60. For example: Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing," notes that when the Saskatchewan legislation was passed in 1948 the Saskatchewan Registered Nurses Association protested the use of the term *nurse*, 296. Again in 1954 the Canadian Nurses Association declared that Psychiatric Nursing was a specialty of General Nursing, 450. A similar situation arose in Alberta. The Alberta Registered Psychiatric Nurses Association was formed in 1950 and in 1951 a letter was received from the Alberta Association of Registered Nurses . . . "that the word 'Registered' in your title would conflict with the R.N. Association." Source: History Psychiatric Nurses Association of Alberta located in their archives in Edmonton, Alberta.

61. CRPNM Archives, Minutes of Council Meeting, March 13, 1964. At this meeting Dr. Tavener was an active participant. He was the Superintendent at Selkirk and became an advocate of psychiatric nurses.

62. Ibid.

63. Ibid

64. Ibid.

65. For example, Alice J. Baumgart and Janniece Larsen, *Canadian Nursing Faces the Future: Development and Change* (St. Louis, Missouri: The C. V. Mosby Company, 1988). Genevieve Knight Bixler and Roy White Bixler, "The Professional Status of Nursing," *The Canadian Nurse* 42 (1) (January 1946): 35-43. Kenneth S. Lynn ed., and the Editors of Daedalus, *The Professions in America* (Boston: Houghton Mifflin Co., 1965). Eliot Freidson, "The Futures of Professionalisation," in Margaret Stacy *Health & The Division of Labour* (London: Croom Helm, 1977). Marjorie McIntyre and Elizabeth Thomlinson, *Realities of Canadian Nursing: Professional, Practice, and Power Issues* (Philadelphia: Lippincott Williams & Wilkins, 2003). Amitai Etzioni, ed., *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers*. (London: Collier-Macmillan, 1969).

66. P. Schwirian, *Professionalization of nursing: Current issues and trends*, 2nd ed. (Philadelphia: J. B. Lippincott, 1998). 5.

67. Veronica Strong-Boag, "Making a Difference: The History of Canada's Nurses," *Canadian Bulletin of Medical History* (8) (1991): 231-248. Kathryn McPherson and Meryn Stuart, "Writing Nursing History in Canada: Issues and Approaches," *Canadian Bulletin of Medical History* 11(20) (1994): 3-22.

68. This framework of professionalization is an adaptation of two authors. Kathryn. McPherson, *Bedside matters: The transformation of Canadian nursing*,

1900-1990 (Toronto: Oxford University Press, 1996). Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996).

69. Howard M. Vollmer and Donald L. Mills, *Professionalization* (Engelwood Cliffs, New Jersey: Prentice Hall, 1966), 20-21.

70. Davies, "Professionalizing Strategies."

71. Pay Briefs were submitted to the Manitoba Government March 30, 1962, November 1, 1963, and January 31, 1964.

72. Rafferty, 1.

73. McPherson, *Beside Matters*.

74. BMHC Museum, Ernie Bunch, West Insulin Supervisor, *Insulin Shock Therapy Manual*, November 14, 1958.

75. CCPN Archives, Minutes of the Annual Meeting, June 20, 21, 22, 1962, Brandon, Manitoba.

76. CCPN Archives, Minutes of the Annual Meeting, June 19, 20, 21, 1963, Edmonton, Alberta.

77. CRPNM Archives, Minutes of Annual Meeting, January 29, 1965.

78. PAM. GR459, File Psychiatric Nurses Act 1959-1968, Elliott to Johnson February 14, 1963.

79. *Ibid.*, Johnson to Cabinet, February 19, 1963.

80. Legislative Assembly of Manitoba, Debates and Proceedings, Vol. V111 No. 60 (May 2, 1963), 1900. When the bill was read for the second time Hon. Johnson informed the house that "these make provision . . . that was overlooked in the original drafting of the legislation. . . . Makes it possible for an interim certificate to be issued." This of course was not quite accurate as other wording was also changed, specifically, *Certificate issued by an approved school* were struck out and *issued by the committee* inserted. This of course gave the power to control membership to the Advisory Committee.

81. Note 77, chap. 4, this study.

82. CRPNM Archives, Minutes of Special Council Meeting, July 17, 1964. Also Annual Meeting January 29, 1965

83. Interview Myrtle Barnett, March 12, 2002.

84. E-mail Barry Russell, September 8, 2007.
85. CRPNM Archives, Russell's address is attached to the Minutes of the Annual Meeting, January 29, 1965.
86. CRPNM Archives, Minutes of Council Meeting, May 28, 1965.
87. CRPNM Archives, Closed File, Barnett to Russell, April 9, 1965
88. Ibid.
89. This is inferred from passages in the letter from Barnett to Russell.
90. CRPNM Archives, Closed File, Barnett to Tavener, April 9, 1965.
91. CRNM Archives, Minutes of MARN Board Meeting, April 24, 1965.
92. CRPNM Archives, Minutes of Council Meeting, May 28, 1965.
93. CRNM Archives, Minutes of MARN Board Meeting, August 28, 1965.
94. CRPNM Archives, Proposal attached to Minutes of Council Meeting, September 28, 1965.
95. Ibid.
96. Ibid.
97. CRPNM Archives, Minutes of Council Meeting, October 29, 1965.
98. CRPNM Archives, Minutes of Council Meeting, December 21, 1965.
99. CRPNM Archives, Minutes of Annual Meeting, February 11, 1966
100. PAM, GR 1554, Minutes of Medical Superintendents Meeting, April 15, 1965. In fact the superintendents had already discussed such a move at the April 1965 meeting. It stated that there was to be a pilot for the students at Selkirk, where the LPN would be dropped. A maximum of three months affiliation at a general hospital to provide the necessary general nursing skills would be provided. The general hospital at their convenience would assign the affiliation. Of course the superintendents had no business making such psychiatric nursing education decisions. The Advisory Committee was the policy making body for psychiatric nursing education, *not* the superintendents. The superintendents were concerned with staffing issues. The length of the affiliation for the LPN programme took the students out of the institutions for longer than the superintendents wanted them to be gone. Their motivation to terminate the LPN programme was, therefore, based on pragmatism,

not philosophy. At the Superintendents Meeting July 29, 1965 it was decided to discontinue the LPN course at Selkirk.

101. CRPNM Archives, Minutes of Annual Meeting, February 11, 1966

102. PAM, GR 1555, 1280-4, Minutes of Advisory Committee Meeting, March 8, 1961.

103. Helen K. Mussallem, Nursing Education in Canada, 1965. Royal Commission on Health Services.

104. Ibid., 61.

105. PAM, GR 1555, 1280-4 Minutes of Meeting of Nursing Educators, February 10, 1960 attached to the Minutes of Advisory Committee Meeting, March 8, 1960.

106. Appendix G, Curriculum 1961-1963.

107. Ibid. Basic nursing and medical surgical nursing totalled 220 hours whereas, psychiatry and psychiatric nursing totalled 110 hours. This cannot be explained with the present information.

108. PAM, GR 1555, 1280-3, Tavener to Bristow, November 7, 1961, cc: Miss Fitzpatrick, Dr. H. S. Atkinson, Dr. E. Johnson.

109. PAM, GR 1555, 1280-4, Minutes of the Meeting of Advisory Committee, December 6, 1961.

110. Manitoba Legislative Library, Manitoba Gazette 92 (26), 200-202.

111. CRPNM Archives, Minutes of Annual Meeting, February 26, 1963.

112. PAM, GR 6224, Brandon Mental Hospital Annual Report 1962 (Hospital Copy).

113. Ibid.

114. PAM, GR 6224, Brandon Mental Hospital Annual Report, 1963 (Hospital Copy).

115. Ibid.

116. Peplau, *The Therapeutic Nurse-Patient Relationship*.

117. For a review of the development of nursing research see Afaf Ibrahim Meleis, *Theoretical Nursing Development and Progress*, 2nd ed., (Philadelphia: J. B. Lippincott Co., 1991).

118. Florence L. Huey, *Psychiatric Nursing 1946 to 1974: A Report on the State of the Art* (New York: The American Journal of Nursing Co., 1975).

119. Grayce M. Sills, "Research in the Field of Psychiatric Nursing 1952–1977," *Nursing Research* 26 (3) (May–June 1977): 201-207.

120. Appendix H, Curriculum 1968.

121. Alphonse Sootkoos, Editorial Introduction, *Journal of Psychiatric Nursing* (January 1963): 3.

122. PAM, GR 1555, 1280-4, Minutes of the Nursing Educators Meeting, April 14, 1966, attached to Minutes of Advisory Committee, May 3, 1966.

123. PAM, GR 1555, 1280-4, Minutes of Advisory Committee Meeting, May 3, 1966.

124. Interview John Martyniw, July 13, 2005.

125. Ibid. He was fortunate to get a position at Misericordia Hospital as he was not an RN. He said he "got on well with the Mother-Superior."

126. CRNM Archives, Minutes of MARN Board Meeting, March 4, 1961. Also see note 14 this chap.

127. Interview John Martyniw, July 13, 2005.

128. Ibid. He retired from Selkirk Mental Hospital in 1984.

129. CRPNM Archives, Minutes of Special Meeting, July 20, 1966.

130. CRPNM Archives, Minutes of Council Meeting, September 6, 1966.

131. Royal Commission on Health Services (hereafter The Hall Report) Volume 1, 1964.

132. Ibid., 582.

133. Ibid., 584.

134. Ibid.

135. Mussallem, 100. The use of inverted commas when discussing “psychiatric nurses” suggests the general nurses believed the psychiatric nurses were using the title inappropriately.

136. Ibid., 104.

137. Ibid., 108.

138. CCPN Archives, Minutes of CCPN Annual Meeting, September 25 & 26, 1964, Saskatoon, Saskatchewan.

139. CCPN Archives, Report of Alf Barnett attached to Minutes of Annual Meeting, September 25 & 26, 1964, Saskatoon, Saskatchewan.

140. CRNM Archives, Box 12 File 19, Witney to Wilson, November, 1965.

141. PAM, GR 1554, Minutes of Medical Superintendents Meeting, January 6, 1966.

142. Ibid.

143. Ibid.

144. Ibid.

145. Ibid.

146. Ibid.

147. CRPNM Archives, Minutes of Special Council Meeting, July 20, 1966. Minutes of Council Meeting, September 6, 1966.

148. CRPNM Archives, Minutes of Council Meeting, September 6, 1966.

149. PAM, GR 1554, Minutes of Medical Superintendents Meeting, November 17, 1966.

150. CRPNM Archives, Minutes of Special Meeting of Selkirk & Metro Councillors of the PNAM, December 6, 1966.

151. Province of Manitoba, Report of the Minister of Health’s Committee on The Supply of Nurses (hereafter The Minister’s Report) November, 1966, Recommendation 11.

152. Ibid., 115.

153. Ibid., 20. That a special diploma nurse program for qualified practical and psychiatric nurses be conducted and that the graduates of this course be eligible for registration as registered nurses.

154. PAM, GR 1554, Minutes of Medical Superintendent's Meeting, January 24, 1967.

155. Ibid.

156. The Minister's Report, Recommendation 66.

157. CRPNM Archives, President's Annual Report attached to Minutes of Psychiatric Nurse's Association Annual Meeting, Feb 16, 1967.

158. Ibid.

159. Ibid.

160. CRPNM Archives, Minutes of Special Meeting of Council, March 8, 1967.

161. CRPNM Archives, Martyniw to Witney, April 22, 1967, A Brief Regarding the Report of the Minister's Committee on The Supply of Nurses in Manitoba.

162. Ibid.

163. The Minister's Report, 144.

164. Ibid., 143.

165. CRPNM Archives, Brief Martyniw to Witney, April 22, 1967.

166. The Psychiatric Nurses Association Act of Manitoba, Section 8 (a).

167. The Psychiatric Nurses Association Act of Manitoba, Section 24. Notes 11, 12, 13, chap. 4, this study. This is what the MARN would have been referring to when they were concerned.

168. CRPNM Archives, Minutes of Council Meeting, June 22, 1967.

169. CRPNM Archives, Brief Regarding the Classification of Psychiatric Nurses in the Province of Manitoba, from The Psychiatric Nurses' Association in Conjunction with The Manitoba Government Employees' Association to Witney, June, 1967.

170. Ibid.
171. Ibid.
172. Ibid.
173. PAM, GR 1554, Minutes of Medical Superintendents' Meeting, June 22, 1967.
174. Ibid.
175. Ibid.
176. Ibid.
177. CRPNM Archives, Martyniw to Tavener, July 6, 1967.
178. Ibid.
179. PAM, GR 1555, 1280-4, Minutes of Meeting of Advisory Committee, July 13, 1967.
180. Ibid.
181. Ibid.
182. Ibid.
183. Ibid.
184. Ibid.
185. CRPNM Archives, Martyniw to Tavener, undated, circa July 20, 1967.
186. Ibid.
187. Ibid.
188. PAM, GR 1555, 1280-4, Johnson to Morison, July 28, 1967.
189. PAM, GR 1555, 1280-4, Witney to Morison, August 4, 1967.
190. Ibid.

191. Ibid. Tavener had assumed the position of Provincial Psychiatrist August 1, 1967. His appointment was announced in the minutes of the Superintendents' Meeting, April 5, 1967.

192. PAM, GR 1555, 1280-4, Tavener to Morison, September 22, 1967.

193. CRPNM Archives, Recommendations on the Future Training of Psychiatric Nurses in the Province of Manitoba, attached to the Minutes of the Special Council Meeting of the Psychiatric Nurses Association of Manitoba, October 27, 1967.

194. Ibid.

195. PAM, GR 1554, Minutes of Medical Superintendents' Meeting, November 21, 1967.

196. Ibid.

197. Ibid.

198. Editorial, *The Canadian Nurse* (October 1967): 25.

199. John Kellie. Letter to the Editor, *The Canadian Nurse* (December 1967): 4. John Martyniw. Letter to the Editor, *The Canadian Nurse* (December 1967): 4-5.

200. CRPNM Archives, Minutes of Council Meeting, December 14, 1967.

201. Editorial, 25.

202. Peplau. *The Therapeutic Nurse Patient Relationship*.

203. James Walkup, "The Early Case for Caring for the Insane in General Hospitals," *Hospital and Community Psychiatry* 45 (12) (December 1994): 1224-1228.

204. When the composition of this committee is considered it is evident that the membership is the same as the Advisory Committee, with the exception of Dr. Tavener.

205. The association was referred to incorrectly as the Manitoba Psychiatric Nurses Association (MPNA).

206. Appendix H, Curriculum 1968.

207. Appendix G, Curriculum 1961-1963. Appendix H, Curriculum 1968. Personal communication Terry Gibson, February 6, 2007. In the 1968 curriculum the

combined hours of basic nursing and medical surgical nursing still formed a significant portion of the curriculum, although with out more detail it is difficult to determine what the content of these courses was. There was still no obvious attention to the human suffering of mental illness.

208. For example Katharine McL. Steele and Marguerite L. Manfreda, *Psychiatric Nursing* 4th ed. (Philadelphia: F.A. Davis, 1953) and Louis J. Karnosh with the collaboration of Dorothy Mereness, *Psychiatry For Nurses*, 4th ed.(St. Louis: C.V. Mosby, 1953).

209. Joan S. Stark and Lisa R. Lattuca, *Shaping the College Curriculum: Academic Plans in Action* (Boston: Allyn and Bacon, 1997), 8.

210. Ibid.

211. Chris Dooley, “‘They Gave Their Care, But We Gave Loving Care’: Defining and Defending Boundaries of Skill and Craft in the Nursing Service of a Manitoba Mental Hospital during the Great Depression,” *Canadian Bulletin of Medical History* 21 (2) (2004): 229-251, 242.

212. Interview John Martyniw, July 13, 2005.

213. This intuitive sense that there is something *different* about psychiatric nursing has been noted already. For example, see the discussion in chap. 2 this study on efforts to identify differences. Also the statements made by McKerracher Note 131 and Roberts Note 132. chap. 2. These clumsy attempts to articulate the difference illustrate the difficulty and continue to be reflected in contemporary expressions.

214. William H. Schubert. *Curriculum: Perspective, Paradigm, and Possibility* (New York: Macmillan, 1986).

215. This model is typically described as the Tyler model which dominated curriculum theory during the 1950s and 1960s. Ralph W. Tyler, *Basic Principles of Curriculum and Instruction* (Chicago: The University of Chicago Press, 1949).

216. Schubert, 174. This *practical* is usually framed in terms of Schwab’s work though it may also include a hermeneutic paradigm, 182.

217. Ibid. 176, 182.

218. Amy Frances Brown, *Curriculum Development* (Philadelphia: W. B. Saunders, 1960), v.

219. PAM, GR 1555, 1280-4, Minutes of Advisory Committee Meeting, May 14, 1968. It is also worth noting that a new Director of Nursing Education had also recently been appointed at Selkirk. See note 221, below.

220. PAM, GR1555, 1280-3 Memo Tavener to Superintendents, September 30, 1968.

221. For example two of the male instructors in Brandon were able to obtain their R.N. after studying at the Brandon General Hospital. These were Richard Harris and Bud Smith. John Kellie was another male instructor who made important contributions to psychiatric nursing education in Manitoba. John Kellie had come to Portage from England in 1960. He held a registered nurse as well as a psychiatric nurse diploma from Great Britain. After coming to Canada he furthered his education by earning a BA, a Certificate in Adult Education and Masters of Education. He was the Director of Nursing Education at Portage in 1967 to 1989. He represented the RPNAM on the Ministerial Task Force. He also contributed to the CCPN Education Committee. In his obituary it was stated, "He was a quiet man with a huge intellect." *Update RPNAM Newsletter*, Fall, 2000, Obituary, 4. Gerald Pronyk was another instructor who made a significant contribution to psychiatric nursing education in the province. He graduated as an RPN from Selkirk in 1964. Dr. Kovacs Superintendent of Selkirk had given Pronyk the opportunity to attend the University of Saskatchewan. He achieved an RN and a BScN in 1968. He returned to Manitoba and became Director of Nursing Education at Selkirk from 1968 to 1972. His position as Director may well have been a factor in the loosening of control by the Advisory Committee. Pronyk went on to become Senior Nursing Administrative Officer position he held from 1972-1991. He was a strong advocate for the move to community psychiatric nursing. Source, Interview.

222. CRPNM Archives, Minutes of Council Meeting, December 14, 1967.

223. Ibid. Despite Kellie's protest, an anonymous informant says that he coached the British grads as to what would be on the examinations!

224. CRPNM Archives, Minutes of Council Meeting, February 13, 1968

225. CRPNM Archives, Minutes of Education Committee Meeting, March 16, 1968, reported to Council March 19, 1968.

226. Ibid.

227. Ibid.

228. PAM, GR 1555, 1280-4, Bancroft to Martyniw, June 28, 1968.

229. CRPNM Archives, Minutes of Council Meeting, November 1, 1968.

230. CRPNM Archives, Minutes of Council Meeting, March 7, 1969.

231. CRPNM Archives, Minutes of Annual Meeting, April 11, 1969.

232. Note 77, chap. 4, this study.

233. CRPNM Archives, Copy of Minutes of Advisory Committee Meeting, May 22, 1969.

234. Two appendices were attached to the Minutes of May 22, 1969. Appendix I gave the number of months the people had worked in psychiatric nursing and Appendix 2 gave the marks of their exams.

235. Ibid.

236. Ibid.

237. The Psychiatric Nurses Association Act revised 1968 section 15.4. This amendment gave the Association the “right to assess the qualifications of any individual coming from outside Manitoba.” During the debate in the house, one MLA (Mr. Molgat) asked if the Psychiatric Nurses were establishing a closed shop? On being reassured they only wished to be absolutely sure of qualifications, the matter at that time was dropped. Debates and Proceedings Vol. 1V no. 65, 1610. The association had tried to prevent the issuance of a licence to any one who they believed unqualified

238. CRPNM Archives, Memo from Ramsay attached to Minutes of Council Meeting, June 27, 1969.

239. Ibid.

240. Ibid.

241. PAM, GR 1554, Minutes of Medical Superintendents Conference, August 28, 1969.

242. CRPNM Archives, Minutes of Council Meeting, September 19, 1969.

243. Ibid.

244. Regulation 77/69. “Notwithstanding subsections (1) and (2) the Psychiatric Nursing Education Advisory Committee may permit a person who does not comply with subsections (1) and (2) to be enrolled as a student at an approved school.” Sections 1 and 2 set out the criteria for admission to a school of psychiatric nursing. This was another example of the superintendents finding ways to circumvent the authority of the association to regulate the issuing of licences.

245. CRPNM Archives, Minutes of Council Meeting, October 31, 1969.

246. Ibid.

247. Ibid.

248. Ibid.

249. CPRNM Archives, Minutes of Council Meeting, March 7, 1969.

250. CRPNM Archives, Minutes of Council Meeting, August 23, 1968.

251. CRPNM Archives, Minutes of Council Meeting, March 28, 1969.

252. CRPNM Archives, Minutes of Annual Meeting, April 3, 1970.

253. PAM, GR 459, H-14-21-1G Martyniw to Toupin, November 30, 1970.

CHAPTER 5

... MORE BOOKS ...

Introduction

In this chapter, events of the second decade which not only threatened the profession of psychiatric nursing but also created opportunities for further exploration and growth are described. This second decade differed from the first in that the day-to-day business required less attention; therefore, the association could concern itself with other matters. These included: establishing a firmer place for psychiatric nurses in the mental health system, articulating the essence and philosophy of psychiatric nursing, identifying the unique skills of psychiatric nurses, and developing a coherent curriculum.

The major shaping events of the second decade included: a change of government, a challenge by the MARN, strengthening the position of the national psychiatric nursing association through the development of a philosophy and objectives for psychiatric nursing education, the development of national standards of practice, and further bureaucratization of the RPNAM through the hiring of an executive director and the acquisition of property. In the context of these challenges and opportunities, two major curriculum revisions occurred, one in 1974, and another in 1979.

This chapter is divided into two sections. In the first, significant events and their interrelationship during Jack Holleman's term (1971-1979) are described. In the second, the last year of governance under the *old act* is described. December 3, 1980

saw the proclamation of a new act which gave a different form and direction to the profession and new opportunities for the continuing evolution and professionalization of psychiatric nursing in Manitoba.

The Holleman Years (1971-1979)

Jack Holleman, like John Martyniw, was an immigrant. He came to Brandon from Holland in 1952 and immediately commenced work at the Brandon Mental Hospital. He took the required classes, and graduated as an attendant in 1954.¹ In March 1969, he began participating in the affairs of the association. He was elected as second vice-president in June 1969, and assumed the role of first vice-president in September.² Following the 1971 annual meeting he was elected president and was acclaimed on three consecutive occasions (1973, 1975 and 1977).³ He describes his presidency as a busy and challenging time for the RPNAM and defining moments as participation in the Task Force hearings and work on the curriculum.⁴ During this time, the RPNAM expanded its office and hired an executive director who took on many of the duties formerly carried out by the volunteer executive and council. This also created a more visible public presence for the association.⁵

The period 1971-1979 was marked by a number of opportunities, challenges, and achievements. One of the first opportunities was political. In June 1969, the New Democratic Party (NDP) swept to power and brought a socialist vision to Manitoba politics.⁶ A year after the election, ReneToupin, the minister of the newly named *Department of Health and Social Development* published a document outlining, “A new framework within which our departmental policies and objectives can be carried

out.”⁷ The socialist philosophy of this government was evident in their expressed reasons for change:

The quality of the human condition varies widely in Manitoba . . . from those who face a new day with a feeling of security and hope to the fearful and insecure . . . from lives characterized by involvement, acceptance and love to those filled with alienation, rejection and hate . . . from people who sense their own worth and power to those so overwhelmed by feelings of inadequacy as to deny their humanity.⁸

It seemed that the mental health system and the care of the mentally ill would receive some much needed attention with this promising attitude.

The Clarkson Report

The new government’s vision for mental health and mental retardation services was published in 1973 as the *Clarkson Report*.⁹ This became the blue-print for all aspects of mental health care including deinstitutionalization of patients, redeployment of staff, and the education of psychiatric nurses. Refvik likens the Clarkson Report to the National Committee Mental Health Report of 1919 in that, “The Clarkson Report was critical not of the individuals within the system . . . but with the system itself.”¹⁰

Clarkson’s recommendations to fix the system were wide ranging. They included not only a change in strategies of care for the mentally ill and mentally retarded, but also changes in the management of the three provincial facilities. Highlighting the effects of institutionalization, the report concluded that the mental hospitals were too big, too isolated, and too hierarchical. Normalization, community care, and regionalization were recommended.¹¹ The report also proposed that mental retardation services be separated from mental health services and placed under separate direction.¹²

Concerning the management of the facilities, Clarkson recommended that the role of the medical superintendent should be abolished and replaced by a clinical director and an administrator. Further, the institutions were to be renamed *Mental Health Centres*. Not only was the old patriarchal role of the superintendent to be diminished in this new system, other remnants of the old asylum system were also to be eliminated. The practice of the superintendent living in residences on the grounds of the hospitals and being provided with garden produce, milk, and meat from the mental hospital farms, and maid and gardening services from the patients would cease. For eighty years the superintendents at Selkirk, Brandon, and Portage had been the ultimate authority over the treatment of patients, the education and control of male and female attendants and nurses, and the farms and groundskeepers. In return they had received lodging, food, service, and deference.

* * *

As if by chance, at the same time as new views on mental health were being formulated, one of the earliest vestiges of the old asylum system was being dismantled. As had their predecessors fifty years earlier, the medical superintendents of 1969 had to deal with institutional farm business. In June 1969 the superintendents met to discuss a proposal to phase-out the farms. The proposal included a count of the number of cattle and hogs on each mental hospital farm, recommendations on how the herds would be reduced and disposed of, and how the farm staff would be employed once the process was complete.¹³ If they saw the incongruity of discussing such issues alongside the development of a scientific planning committee to consider the latest treatments of mental illness, they did not mention it.¹⁴ But the days of the

old asylum-style mental hospitals, where superintendents were responsible for every aspect of institutional life, were coming to an end.

* * *

The shift in the philosophy and structure of the system of mental health services necessitated the development of new skills and attitudes, especially for psychiatric nurses. The report noted that improvement in the education of psychiatric nurses would inevitably mean improvement in service, and it recommended the transfer of schools of psychiatric nursing to community colleges. Clarkson also suggested that “the nurse training course should include a base year in community nursing and a specialist year in either psychiatric nursing or retardation work.”¹⁵ This was a novel idea, as no such plan had ever been suggested by either the RPNAM or the Advisory Committee. Having separate nurses and registries for psychiatric work and mental retardation work had never been part of the Manitoba philosophy. In fact, this had been at the root of the difficulties of registering the English nurses at Portage in 1969. The only western province which had a separate register for mental deficiency nurses was Alberta.¹⁶

The major recommendation of Clarkson was that care for the mentally ill should be provided in the community, and this would require trained personnel to carry out that care:

Of particular importance is the development of the Community Psychiatric Nurse. This professional should form the backbone of the new community service.¹⁷

The earlier suggestion that psychiatric nurses would become unnecessary as the institutions downsized was not only proving to be untrue; in fact, psychiatric nurses were to be pivotal in the new community plan.

* * *

Psychiatric nurses also demonstrated their adaptability by exploring other new roles. One of the ways in which the profession attempted to establish a place for psychiatric nurses was by supporting an innovative programme designed to provide relief to people suffering from anxiety, by the use of behavioral techniques. That the executive director and chief advocate of this programme was an RPN probably added to its attractiveness.¹⁸

The programme named *Group Guidance for Anxiety Relief* was run by Mr. Ken Karlenzig, RPN. Invited to speak to the RPNAM council in October 1972, he requested their support, both financial and in public relations. This was a chance to demonstrate that psychiatric nurses had unique skills to offer and the RPNAM latched onto the opportunity.¹⁹ Workshops were held in Portage, Brandon, Selkirk, and Metro Winnipeg to assist psychiatric nurses in learning these new behavioral techniques, and the RPNAM paid Karlenzig for these services.

Karlenzig, with the support of the RPNAM, wanted to extend this practice and approached the Department of Health and Social Development for financial support. The group had received funding from a government employment project in 1972, but it was to expire in October 1973.²⁰ Concerned about the immanent end of funding, the group wrote heartfelt letters to Minister of Health and Social Development Rene Toupin and the Premier Schreyer. In addition, many supportive letters were written

by sufferers of anxiety disorders who had been helped by the treatment approach.²¹ Minister Toupin was cautious, and apparently told the letter writers that he wanted to “eliminate any possibility of quackery.”²² This was unfortunate, as behavioral therapy was finding a place in mental hospitals at that time, and psychiatric nurses were becoming the primary therapists in this new treatment.²³

A review of the group and its request was made by a government official who concluded that the Department would not fund the programme.²⁴ This was unfortunate. It was ahead of its time as behavioral principles are now the usual approach for anxiety disorders. The training that had been provided, however, gave the psychiatric nurses a new view of themselves, a view that they could be independent practitioners with significant therapeutic skills to offer.

A second attempt to expand the role of psychiatric nurses was no more successful, but it too demonstrated further possibilities for the expansion of psychiatric nursing roles. Psychiatric nurses in neighbouring Saskatchewan had, through legislation, recently been granted the opportunity to be equal to registered nurses in supervisory positions in nursing homes for the aged.²⁵ This seemed a suitable place for the practice of psychiatric nursing. The requirements for intensive and sophisticated technical medical treatment were minimal, but there was frequently a need for the management of difficult behaviour brought on by the aging process or dementias.

Holleman wrote to the Minister Toupin in March 1972, listing five advantages of hiring RPNs for nursing homes.²⁶ Toupin responded in September. He began by pointing out that the education and training of *Registered Nurses* included obstetrics,

pediatrics, medical, surgical, and psychiatric nursing. He went on about health assessment, nursing care plans, and nursing assignments using language with which he was unlikely to be familiar.²⁷ The response was clearly orchestrated by the MARN, if not written by them.

Holleman did not reply until September 1973. In a carefully crafted letter he pointed out, again, that the education and skills of psychiatric nurses admittedly did not include training in pediatrics and obstetrics but pointedly noted, “We fail to recognize the necessity of these two subjects in a nursing home for the aged and infirm.”²⁸ Toupin, however, never had an opportunity to reply as he was moved from the health portfolio soon after. The new Minister of Health and Social Development, Saul Miller, curtly replied:

Changes in legislation are not contemplated as the Registered Psychiatric Nurses can now assume duties to any patient who is mentally disordered.²⁹

The meaning of this answer was unclear. But the whole issue demonstrated that as long as the word *nurse* was part of the title, the group who claimed propriety rights to the term *nurse* would always try to control the practice.

Success may not have been achieved as behavioral therapists or psycho-geriatric nurses at the time, but these subsequently became central roles of psychiatric nurses. On the other hand, the implementation of community psychiatric nursing did come about, although not without more dissension.

The Move to the Community

The planned move to the community created both opportunities and challenges. A curriculum had to be developed to prepare the new community

psychiatric nurses. This precipitated an examination of the core of their practice and further efforts to legally define the practice of psychiatric nursing.

A course was quickly designed to prepare graduate psychiatric nurses to function in this new role and to provide them with new skills and knowledge:

- a) To assist in meeting primary mental health needs of those in the community . . . who are unable to cope . . . or require specialized nursing care.
- b) To assist the individual to maintain an optimal level of functioning . . . after discharge from the hospital or institution.³⁰

As well as these rather general objectives, which built on the existing skills and knowledge of the psychiatric nurses, new concepts were introduced. These included prevention strategies, interviewing, and community development. Courses were to be delivered in Brandon and Selkirk in spring 1973.

* * *

The move to the community was not popular with everyone as Clarkson had predicted:

Major friction exists between the social work service and the psychiatric nurse service. This friction has existed for a number of years and stems from the continued opposition of social workers to the development of community psychiatric nursing. . . . It has to be recognized that the skills and knowledge of one group or profession are not the sole property of that group or profession.³¹

Conflict with social workers was not the only challenge. Public health nurses also viewed community work as their bailiwick and they believed that they could carry out many of the tasks identified for community psychiatric nurses.

Tavener had notified the appropriate division of the Department of Health and Social Development of the pending programme to educate community psychiatric nurses. He sought the assistance of the community operations division in providing

field experience for the students of the programme. Don Vernon, Deputy Minister of Community Operations, agreed to assist where he could and referred the request to Miss Janet Kennedy, Director of Public Health Nursing Services.³² Perhaps Miss Kennedy was not as supportive as had been hoped. Two weeks later Vernon sent a memo to Tavener with an attachment:

Paper prepared by my staff . . . There are some very basic questions being asked in this paper and I look forward to discussing same.³³

The paper cited a number of objections to any expansion of the roles of psychiatric nurses and argued that the move to a separate mental health community system would perpetuate stigma. The unknown author also went on that, "Illness is illness no matter the cause."³⁴ This, of course, is a fundamental issue. If mental illness is the same as physical illness, why has there always been so much tension around the nature of mental illness, its treatment, and how the person with mental illness should be cared for? Or perhaps the concern of this unknown author was that there was no place or space in the community for a new worker. The author continued:

Should we not be limiting the preparation of psychiatric nurses to those who will be needed in the institution . . . rather than fitting into a community program where their contribution is limited?³⁵

Tavener responded to Vernon:

The attached paper was obviously written by an old-style public health nurse and contains many of the old shibboleths, and areas of misconception. However, if attitudes are still like that discussion is even more necessary.³⁶

How such attitudes were dealt with is not a matter of record, but the programme went ahead and the first community psychiatric nurses entered the community in late 1973.

A second problem arose around the issue of how to classify these community psychiatric nurses. As there were no positions in the community designated as *community psychiatric nurse*, the very unwieldy government classification system had to be manipulated to accommodate them. In order to retain their *nurse* designation, they had to remain at a lower level of pay or be reclassified as a *rehabilitation counsellor*.³⁷ At a meeting of personnel staff, senior nursing officers, and hospital superintendents in December 1974 the issue was tackled. The senior nursing officers raised the concern that if the nurses were reclassified to rehab counselors and not required to maintain their nursing licence:

The delivery of service would be restricted in that those functions which are carried out exclusively by nurses could not be carried out by the rehab series unless the reclassified nurse was compelled to retain licensure.³⁸

They noted that the community psychiatric nurses were exceeding the scope of the duties of a rehab counselor, and if the psychiatric nurses wanted to be reclassified “it would be for pay purposes only, that it would not make the nurse into a ‘sub-professional’ social worker.”³⁹

But the issue was not resolved. The personnel branch felt compelled to rigidly adhere to the official job specifications and titles. The problem came to Tavener’s attention. In a memo to the head of personnel, Frank Maynard, he voiced his frustration:

It appears that our personnel officers are taking the position that the classification must be rehab counselor . . . I understand the reason is the necessity for changes in the class specifications. . . . It should be done immediately. It would be totally reprehensible to delay redeployment of nurses to community service on a technicality.⁴⁰

Maynard agreed with Tavener, but pointed out that as both the rehabilitation counsellors and the community psychiatric nurses were to be reclassified into a new series, *Health and Social Services Specialists*, the problem would be resolved. In fact, it created a whole new set of problems. Now the community psychiatric nurses were disadvantaged as they did not have a university degree. The title, *Community Mental Health Worker*, was to be used in this new classification but the educational qualifications for these positions called for a university degree. Gerry Pronyk, the senior nursing administrative officer from Selkirk, pointed out the shortcomings of this classification:

In view of the skills required . . . reservation is expressed concerning the capabilities of a BA who may not have any clinical courses . . . relating to the skills required. I would suggest that the BA with their clinical shortcomings. . . if deemed sufficient to carry out the tasks . . . then professionals (RPN) who have the skills . . . should be considered at a higher level.⁴¹

Pronyk's plea was unheeded and the head of the mental health services branch, Bob Creasy, sent a memo to field supervisor's indicating the field worker level of classification for the Community Mental Health Workers but "those with lesser qualifications will under-fill."⁴² Pronyk's response was swift. Along with an outline of the courses in psychiatric nursing education and the details of the special skills of psychiatric nurses he observed:

You are still advocating that RPNs should underfill . . . It would appear that Registered Psychiatric Nurses are doomed to have the mold of worker ants never to have the recognition for their inputs, energies and skills. . . . Qualifications, not the job being done, appears to be the distinguishing features between the Health and Social Service Specialist III and IV. . . . Please find enclosed a paper which emphasizes the similarity between social work and nursing. . . the difficulty of separating into level III and IV is of great concern.⁴³

The back and forth bickering between personnel and the mental health staff went on for nearly a year until another meeting was called to resolve the issues, although there were no psychiatric nurses at the meeting! The mental health directorate and the personnel branch struggled with the issue of a body of knowledge required for community mental health work and the relative merits of a Bachelor of Social Work (BSW) degree versus RPN education. The personnel branch concluded that the body of knowledge was difficult to identify and that the education of both groups, BSW and the RPN, contained certain but different skills. They then turned their attention to the issue of the need for psychiatric nurses to retain a licence and concluded:

It appears that the only aspect of some community worker positions which may require an active licence for legal reasons is that area respecting injections. In that only an RPN is able to perform these duties is it a valid expectation that he or she maintain an active licence when the BSW does not perform these responsibilities. . . .Arrangements can be made for BSW community workers to have someone else administer injections . . . it appears reasonable that an RPN trained worker [*without a licence*] could have the same arrangements made and thereby eliminate the requirements to maintain an active licence.⁴⁴

Tavener responded angrily:

Injections are not the only thing that relates specifically to an RPN in the [her] practice of nursing. It may be fairly presumed that any counseling of patients, observations of side-effects of drugs etc are influenced in type and calibre by the training of an individual . . . to deny any differences of various professions . . . a nonsense approach.”⁴⁵

The faculty at the Brandon Mental Health Centre (BMHC) School of Nursing also reacted:

It remains unexplained why a BSW requires the minimum amount of experience in the mental health field. . . . We . . . fail to see how such a degree will equip a Community Mental Health Worker with the required practical skills for mental health delivery while the social work curriculum does not

show any evidence to this effect. . . . To make the assumption that Registered Psychiatric Nurses require a practicing licence for the sole purpose of giving injections, points out the dangers of not including all professionals in these deliberations.⁴⁶

Clearly, other professionals had a very narrow view of what psychiatric nurses could do. These actions and reactions demonstrate not only the difficulty of defining psychiatric nursing, but also the need to distinguish itself from other professions, especially in the context of a work environment in which others were performing similar job functions. The move to the community brought these issues into sharper focus. Psychiatric nurses needed to identify their contribution to the mental health system vis-à-vis the claims of social workers and public health nurses, and they had to find a way to articulate their unique skills. It was in this socio-political context that psychiatric nurse educators began developing a new strategy for defining the distinctiveness of the profession through the articulation of an educational philosophy and objectives.

Philosophy and Objectives of Psychiatric Nursing Education

The development of a philosophy and objectives for psychiatric nursing education, no doubt, reflected a general trend in nursing scholarship in the 1960s and 1970s; the articulation of philosophical statements regarding the nature of nursing, and the development of nursing theories and unique nursing knowledge. Reflections on the evolution and meaning of nursing philosophies identify various philosophical positions underlying nursing research and nursing knowledge.⁴⁷ Afaf Meleis adds that emergent theories were also used to guide curriculum development.⁴⁸ The National League for Nursing in the United States made theory-based curriculum a requirement for accreditation. Guides were developed on how to incorporate

philosophy into curriculum development and planning. There was another movement in the pedagogical curriculum literature at the time, reconceptualization, which could have had an influence on nursing education, although it seems to have been ignored by nursing educators.⁴⁹

Philosophical perspectives in curriculum development are also described in the education literature. For example, Schubert states, “Philosophy lies at the heart of the educational endeavor. This is [most] evident in the curriculum domain . . . for curriculum is a response to the question of how to live a good life.”⁵⁰ Can this be reframed to identify the philosophical perspective of a professional psychiatric nursing curriculum?

What were the philosophical perspectives of psychiatric nursing? What is the *good life* for a psychiatric nurse?

* * *

The process of the articulation of a philosophy and objectives for psychiatric nursing education was the goal of a group of psychiatric nursing educators from the four western provinces and Ontario who met in Winnipeg in 1972.⁵¹ The task seemed designed to answer the questions that nagged at the psychiatric nurses:

Who are we? What do we do? What do we know? What do we believe?

The philosophy is lengthy and written in the style of the time. It contains statements of belief related to education, psychiatric nursing education, and nursing, though surprisingly, not to psychiatric nursing:

We believe that education denotes the deliberate methods of training and direction used by a society to include its ideals of life and culture in its maturing individual members and thus to perpetuate itself.

We believe that education in psychiatric nursing is to prepare the psychiatric nursing student for full participation as a professional person in the promotion of mental health.

We believe that nursing contains two broad and easily definable areas: the *technical clinical* (italics added) approach-*bedside nursing care*; and the *psychological social approach* (italics added) of the individual's understanding of his problems, presenting him as a person with a difficult lifestyle-*psychiatric nursing care*.

We believe that both areas contain their own areas of specialization-medical specialty and psychiatric nursing-therefore it is necessary to prepare nurses to specialize at the diploma level in both areas.⁵²

The two statements regarding education clearly focus on the socialization of the student into the profession, while the two statements regarding nursing are obvious efforts to distinguish psychiatric nursing from general nursing. No references are given for the definition of education or nursing, so it must be assumed that these were the work of the committee. The use of the term *technical* may have reflected feelings about the Hall Report which had recommended only two kinds of nurses, one a technical nurse, and the other a professional nurse. The Hall Report also called for the elimination of psychiatric nursing as a distinct profession. On the other hand, the authors of this philosophy were obviously trying to distinguish between skills that were visible and measurable and those that were intangible and ephemeral. Overall, the philosophy sounds more like a plea for recognition of psychiatric nursing than a philosophy of education. But over thirty years later when Ross Stewart, one of the authors of this philosophy, was asked to comment on its currency, he said he would not change anything.⁵³

The objectives articulated at that meeting could be summarized as:

- promoting progressive standard of psychiatric nursing,
- uniformity of programs,

- better understanding of the work of psychiatric nurses
- working with others to promote mental health.
- upholding the code of ethics.
- fostering the formation of programs across Canada.

The national committee also made recommendations regarding the length of the course and the ratio of classroom to clinical hours. They recommended that 70 per cent of the instruction be in psychiatric nursing and related social sciences and that *no more* (italics added) than 30 per cent of the clinical instruction should be spent on the physical aspects.⁵⁴

It is unlikely that these percentages represented any fundamental belief that this was how a human being was divided. It was more likely a mechanism to illustrate that psychiatric nurses had a far greater proportion of knowledge about mental illness and the mentally ill than general nurses had. These objectives, like the philosophy, relate more to the promotion of the profession than its practice. The possibility that these may have been political statements as much as philosophical ones cannot be dismissed.

* * *

Despite the limitations, the national work on the philosophy and objectives provided the provinces with a template on which to model or develop their own philosophical statements. Manitoba was also struggling with the development of a philosophy and objectives in 1972. The tasks related to curriculum revision had been divided amongst the three institutions and Portage had been assigned to develop the philosophy and objectives. But it must have been a frustrating experience as the

process was not connected to the selection of content and there were no round-table discussions among the educators. Kellie from Portage wrote to Stanley in Brandon:

This is the best we could come up with regarding philosophy and objectives . . . The philosophy as adopted by the PNAC was not incorporated . . . contains a dichotomised view of nursing, i.e. physical and psychiatric. Jesus! But we should have started with philosophy and objectives first!⁵⁵
The frustration is obvious. But despite the difficulties, a philosophy and

objectives were articulated and there is a note in the sub-committee minutes of April 1974 that, “Philosophy, Course Theme and Objectives for the Psychiatric Nursing Program (sic) as revised be presented . . . for inclusion in next curriculum.”⁵⁶

The Manitoba philosophy reads:

We the Faculty of the Approved Schools of Psychiatric Nursing believe that all men have a right to health and happiness.

We believe that the psychologically troubled and the mentally retarded have a right to a full share in health and happiness.

We believe that it is the duty of all men to assist others in achieving this goal.

We believe that we can help to achieve these goals by assisting in the education of others.

We further believe that education consists of guiding individuals in acquiring knowledge and is a process that continues throughout life.⁵⁷

This philosophy is a curious mix of an ontological view of man and a philosophy of education and lifelong learning. It seems to be based on the assumption that the rendering of assistance is the duty of every man (sic) and that education will help in this goal. But there is no reference that such assistance is the core of the practice of psychiatric nursing; in fact, psychiatric nursing practice is not even mentioned.

The objectives state:

To assist the student in gaining a knowledge of nursing based on the social, physical, and biological sciences to the extent that he or she can meet the nursing needs of persons with problems of psychological adjustment.

To encourage a student to aspire to a high ethical standard in his or her professional and personal life.

To encourage a student to develop his or her individual abilities to their full capacity.

To prepare the student to participate effectively as a professional member of the Health Team.⁵⁸

These objectives relate to the knowledge development of the student and the acquisition of professional behaviors. There is little to indicate the role of the psychiatric nurse in a therapeutic relationship with a person with mental illness, but the new curriculum included a section on communication skills.⁵⁹ No doubt, as a reflection of the prevailing attitude of the time, the term *problems of psychological adjustment* is used rather than the term *mental illness*. Nevertheless, the psychiatric nursing section focused on psychopathology. But the question remains, “Do persons with problems of psychological adjustment require psychiatric nursing care”?

What is mental illness? This is the question that has intrigued the field of psychiatry for centuries. By defining life events and emotional distress as mental illness, psychiatry has broadened its scope of practice. Is the emotional distress caused by mental illness the same as that brought on by the loss of a loved one? The authors of these curriculum objectives seemed caught in a dilemma. By softening the language to reduce the stigma associated with the term *mental illness*, they also created a less defined area of practice. Using the term *problems of psychological adjustment* rather than *mental illness* opened the door for new interpretations of the

role of psychiatric nurses. This was reflected in the conflict precipitated by their entry into community mental health. When the practice of psychiatric nursing was confined to the institutions, psychiatric nurses cared for the most seriously mentally ill patients detained in the institutions under the Mental Health Act. The nurses, like the patients, were out of sight. In the community, they were expected to care for a greater number of people with a greater number of emotional and even existential issues. These factors: The Clarkson Report, the move to the community, challenges to psychiatric nursing to define itself outside the institutional walls, and the development of a philosophy and objectives laid the groundwork for a major review of how psychiatric nurses should be educated in Manitoba and culminated in a substantial curriculum in 1974.

A Substantial Curriculum

The curriculum sub-committee, which had been established in 1968 by the Advisory Committee, decided at their October 1973 meeting:

An entire curriculum review will have to be made to formalize the inclusion [of community concepts] officially. It is recommended that a general curriculum review be completed by June 1974. . . . The members from the various schools request permission to have a monthly workshop to undertake the overall review of our basic curriculum. . . . The committee recommends that each school of nursing focus their attention on the Psychiatric Nursing portion of the curriculum including the community aspects and bring forth recommendations for the integration of these two portions within the 201 hours of the Psychiatric Nursing portion.⁶⁰

Although the curriculum sub-committee has not left many records, the curriculum itself is a testament to its work. If earlier curricula were criticized on the grounds that they were one page lists of courses, the same could certainly not be said of the 1974 curriculum. The 1974 curriculum was a solid document in size and scope,

although not markedly different in structure and substance. There was no central theme or organizing framework, rather, there was a more extensive list of content.

The curriculum had fifteen distinct sections, if previous curricula had suffered from minimalism, this one may have suffered from what Amy Brown calls *academic mitosis*. Brown describes this as “the division of content into more and more segments.”⁶¹ This was the greatest number of sections that had ever been in a psychiatric nursing curriculum in Manitoba, and it also had the most amount of detail.

The sections:

Anatomy and Physiology, 90 hours
 Nursing arts, 100 hours
 Medical surgical nursing, 148 hours
 Mental Retardation, 50 hours
 Microbiology, 16 hours
 Motivational therapy, 50 hours
 Nutrition, 24 hours
 Pharmacology, 70 hours
 Professional adjustments, 48 hours
 Psychiatric nursing, 211 hours
 Behavior analysis, 35 hours
 Developmental psychology, 35 hours
 Introductory psychology, 70 hours
 Theories of personality, 20 hours
 Sociology, 60 hours⁶²

Each of the fifteen subjects were carefully and meticulously laid out and each lesson plan gave an *objective*, a *lesson outline*, *content*, *correlation* with other lessons, and a *guide* which appears to be page numbers in text books, titles of films and readings. The combined number of hours devoted to nursing arts, medical-

surgical nursing, and microbiology added up to a greater number than those devoted to psychiatric nursing, although behavior analysis and motivational therapy could be considered as psychiatric nursing skills. It seems the recommendation of the national education committee that there be a 30/70 split between medical nursing and psychiatric nursing was more difficult to achieve than anticipated.

The split between basic nursing and psychiatric nursing represents a dilemma. Both general and psychiatric nurses claimed to give *wholistic* care and each criticized the other for not being attentive to the whole person, but this curriculum framework did nothing to support an wholistic position. It was not based on an integrated view of a human person. Rather, it was based on a prevalent curriculum assumption of the time, that curriculum meant content and content belonged in specific places. It also adopted the position that a patient was an object to be acted upon, as most of the lesson plans gave instructions to the student psychiatric nurses on how to manage a patient's actions. There was no expressed concept of the experiences or suffering of the patient. That is not to say that these were not considered; they just did not appear in the curriculum. It answered the question, "What must a psychiatric nurse know and do?" But, because the question was never asked, it did not state what kind of person the psychiatric nurse should be.

There were increasing efforts to refine the way in which the knowledge component of the curriculum was presented and evaluated. At the November meeting of the sub-committee on curriculum, Elisabeth Hartig, Director of Education from Selkirk, presented *Bloom's Taxonomy* as a framework for constructing the examinations which were to be based on the objectives of the course.⁶³ The

committee agreed that educational objectives in the cognitive, affective, and psychomotor domains were part of the nursing curriculum, but that the objectives in the affective and psychomotor domains were not easily tested.⁶⁴ An examination of the 1974 curriculum reveals a heavy emphasis in the lesson plans on students' ability to *recognize, describe, and explain* phenomenon, but there is little on the application of principles. Reference is made to the nurse/patient relationship, but it does not hold a central place in the curriculum document. This is a continuing dilemma of psychiatric nursing education. How can the intuitive humanistic connection, so essential to psychiatric nursing, be stated in curriculum language?

* * *

The 1974 curriculum review was followed by another in 1979 which moved the education of psychiatric nurses closer to an academic and professional framework. It introduced standards of practice, a conceptual model, and the nursing process. But before the curriculum of 1979 was launched, three interrelated events occurred which illustrate the ongoing challenge to define and defend psychiatric nursing. The first was a proposal by the MARN to develop a position paper on nursing education in Manitoba. The second was a counterproposal by the RPNAM to develop its own position paper on psychiatric nursing education. The third was a government task force to examine all nursing education in the province. The MARN document, *Challenge and Change*, called for the elimination of both RPNs and LPNs; the RPNAM research paper *Breen Report* was quietly shelved; and the government *Task Force* rejected the suggestion that the RPNs and LPNs should be eliminated. In fact

the *Task force* recommended substantive changes to the control and context of psychiatric nursing education.

Proposals and Counter Proposals

The starting point for *Challenge and Change* was the Minister's Committee on the Supply of Nurses. It had been published in late 1966, and then apparently abandoned. Witney, Minister of Health who had commissioned the study, was moved out of the health portfolio in September 1968 and the new Health Minister, Johnson, did not follow up on the report. When the New Democrat Party (NDP) swept to power in the provincial election in June 1969 it was no doubt swept off the table, but it was not entirely forgotten.

In November 1970, the MARN sent a letter to the new Minister of Health, Rene Toupin, informing him of their decision to revisit the Minister's Report and "re-establish a task force to re-examine recommendation made concerning the education of nurses."⁶⁵ There were various reactions to news of the impending review by the MARN. The president of the Licensed Practical Nurses, Marion Dyck, expressed concern at rumors circulating that the MARN was recommending phasing out of LPNs.⁶⁶ Minister Toupin replied "we have no intention of discontinuing the course at the present time."⁶⁷ The Deputy Minister, Dr. Tulchinsky, met with the MARN in October and described the meeting as a painful experience and the views of the MARN on nursing education as shockingly retrogressive.⁶⁸ The new president of the RPNAM, Jack Holleman, also wrote to the Minister bringing to his attention, "There are two nursing associations in Manitoba whose functions will come under the

observations of this committee.”⁶⁹ It seems the proposed task force of the MARN was unpopular before it even began.

These criticisms did not deter the MARN. In 1974, they established an “ad hoc committee to formulate a position paper on nursing education in Manitoba.”⁷⁰ The executive director of the MARN wrote to Tavener, chairman of the Advisory Committee, requesting “any information in the form of facts, trends, changes that would contribute to the development of the paper.”⁷¹ Tavener wisely sent copies of the *Terms of Reference* to the committee members before he responded. No one was particularly satisfied.⁷² Dr. Lowther, Superintendent from Portage was concerned that the needs of clients at the Portage School would be neglected by the MARN study.⁷³ Dr. Moyes, Superintendent at Brandon observed that the MARN is proposing “to speak for nursing . . . there is no indication the other branches of nursing [RPN and LPN] will have any input.”⁷⁴ Terry Gibson, Senior Nursing Officer from Brandon, expressed surprise that the recently formed *Council of Nurses in Manitoba* was not consulted. She suggested that the proposal be supported but as a joint project not an MARN project.⁷⁵

The curriculum sub-committee also reacted:

The committee felt that while appreciating the request . . . we feel that psychiatric nursing is of sufficient scope and significance to the promotion, restoration and maintenance of health that the public would be more distinctly and better served by the preparation of a separate Position Paper by those engaged in psychiatric nursing and that we should thank them for their consideration. The committee recommends that funding be considered for a research team . . . also recommends that the Education Advisory Committee jointly prepare a Position Paper with the RPNAM.⁷⁶

This statement is remarkable. It not only suggests a growing cooperation between the Advisory Committee and the RPNAM, but also that the sub-committee

on curriculum was slowly taking over more of the responsibilities of the Advisory Committee. The members of the sub-committee were more in touch with the day to day concerns of psychiatric nursing and there were new members who were better educated and more knowledgeable about nursing education. The Advisory Committee was slowly lessening its control over psychiatric nursing education.⁷⁷

The Breen Report

The decision of the RPNAM to commission a research report which would provide information for a position paper was an expensive undertaking and was not without controversy. At the council meeting February 21, 1975 it was moved that the MARN be informed that the RPNAM would develop its own position paper and Jose de Cangas, a new counselor from Selkirk, was authorized to contact a research organization with a working budget of \$10,000.00. The idea was presented to the general membership at the annual meeting of 1975. Not unexpectedly, it generated much discussion. When it was put to a vote it was defeated.⁷⁸ But it seems the four membership units were contacted and local meetings were held to explore the issue further. At a special meeting held May 13, 1975 Holleman opened, "This meeting tonight is called to decide what we will do. It is realized that all units have had a meeting . . . to get the feedback."⁷⁹

The responses from the units are instructive. Portage was in favour, Metro branch in Winnipeg voted in favour. Selkirk, following an explanation, voted for going ahead. Brandon voted against it. Mrs. Opper, the council representative from Brandon, provided an explanation:

General consensus was that nursing couldn't be subdivided and that we each have a functional role. Feel that there should be more input into the RN

proposals, that further opportunities should be explored in cooperation with the other nursing bodies. They would like to see the possibility of having equal representation on a joint nursing paper and then, if not, we could go ahead on our own.⁸⁰

This is an interesting statement. Not only did it go against the general belief that psychiatric nursing was distinct, it is possible that it also reflects a trend that had always been prevalent in Brandon. Because of the old *combined programme* of the 1940s and 1950s there had always been a culture that strongly supported dual qualifications. It may also have been influenced by the fact that during the early 1970's in Brandon there had been success in having psychiatric nurses sponsored to take their general nurses training (RN) at the BGH. Allowance was made for their psychiatric nursing and about ten RPNs had received their RN diploma. This certainly boosted the number with dual qualifications, and, no doubt, they formed a sub-group who viewed a single nursing body favourably.⁸¹ The relationship between BGH and BMH had always been amiable and there were still nursing instructors at BMH who had graduated from the combined programme with BGH in the 1950s. No doubt personal relationships were also a factor. This culture of cooperation may have influenced Brandon's negative vote, but whatever underpinned the Brandon position, it stimulated further discussion. The minutes continue:

Nursing should not be split. Point bought that there is indeed a difference between R.P.N.'s and R.N.'s. If we go along with the R.N.s we will be unable to point out what exactly R.P.N.s are unless we do it on our own first. The RPNAM does not have any qualified people to conduct research.⁸²

This confused statement indicates two points of view. Is there only one kind of nursing or is the RPN different from the RN, and, if so, how, and who should decide? No doubt fuelled by the controversy over the qualifications of community

psychiatric nurses, the minutes of the special meeting also registered the following observation, “What is happening in Manitoba we can talk all year and then we will end up so limited functionally that we dry up professionally.”⁸³ The concern about the profession was evident and when the question was put to a secret ballot, the great majority voted in favour of the research proposal.

* * *

The research project was awarded to Lawrence Breen and Associates. The study began May 1975 and was completed February 1976. The aims of the study were fourfold:

- 1) To assess the functional role of the R.P.N. vs that of the R.N. in the mental health field.
- 2) To assess the relationship between the functional role of the RPNs and their educational training.
- 3) To assess the perceptions of other professionals in the health care field of the effectiveness and functional role of the RPN.
- 4) To assess the employment and utilization expectations of the 1976 graduating class and the degree to which these expectations coincide with employment and utilization in the health care field.⁸⁴

Clearly the first three objectives were designed to identify differences between the two types of nurses, provide the RPNAM with a picture of their unique status in the mental health field and with a usable statement to demonstrate their distinctiveness. A questionnaire was designed to elicit information regarding five nursing activities:

- General nursing duties:
- General patient oriented duties:
- Duties pertaining to mental health care:
- Duties pertaining to professional enhancement:

- Duties pertaining to the patient's family and community.⁸⁵

Despite a complex statistical analysis the data did not reveal anything the researchers could claim as significant although they observed, "there appear to be several important trends which bear further comment and general consideration."⁸⁶ They did caution against attaching too much practical significance to the minor differences. With regards to the first objective the report states:

The results of this part of the study are so consistent as to make statistical analysis unnecessary. It was supported with an unequivocal statement from one director of nursing 'R.N.s and R.P.N.s function identically.'⁸⁷

The results concerning the second objective were equally disappointing. The RPNs spent most of their time performing general nursing and patient oriented duties. The authors concluded that the RPNs performed duties that would be expected of any nurse.⁸⁸

With regard to the perception of other professionals they did not evaluate the RPNs as highly as they evaluated themselves. Finally, and not unexpectedly, the student's view of themselves differed from practicing RPNs.

These results were disappointing. The RPNs were not seen as contributing any unique skills to the field. Breen suggested that the RPNs may contribute indirectly to this themselves:

This conclusion is based on the fact that many R.P.N.s have dual qualifications, having full R.N. as well as R.P.N. training. While this may add to the job security of the R.P.N. they may at the same time blur the distinction between the R.P.N. and the R.N. . . . Implicit in this is the suggestion that having only R.P.N. training is not 'as good as' . . . training in combination.⁸⁹

Overall, the RPNs practicing in general hospital settings were not seen by their employers, their colleagues or themselves as contributing anything special to the

care of patients with mental illness, despite their specialized training. The researchers suggested that the extensive training in special skills to care for the mentally ill was either unnecessary or misunderstood. They suspected the latter to be the case and made recommendations based on that view. That the training become less institutional and that the RPNAM do a better job of explaining the distinctive skills of the RPN, which of course it had been trying to do for a number of years. Breen therefore placed the responsibility for interpreting the mixed findings in the hands of the RPNAM.

The report was not the brightest moment in the history of psychiatric nursing in Manitoba. Annette Osted, in an interview, said she believed that the methodology was flawed although it seems to have less to do with methodology and more to do with the fact that the findings did not provide a definitive description of psychiatric nursing. It answered the questions posed by the research, but not the questions the RPNAM was asking itself. Osted agreed that the report was shelved and was only referenced briefly in a subsequent position paper to the *Task Force*. It has never been used since.⁹⁰

Jack Holleman, the president under whose authority it was commissioned, had a very poor recollection of the report. On the other hand, *Challenge and Change* and the *Task Force* stood out very clearly in his mind as defining moments in the evolution of psychiatric nursing in Manitoba.

Challenge and Change

The MARN document entitled *Challenge and Change* was published in April 1976, two months after the Breen report. Not unexpectedly, the paper called for the

elimination of psychiatric nurses as well as practical nurses and focussed on the development of two kinds of nurses, a two year diploma or *technical* nurse and a four year degree or *professional* nurse. The arguments for the elimination of the psychiatric nurses were similar to previous ones. The need for programmes leading to the preparation of psychiatric nurses was obsolete.⁹¹ The underlying assumption was that as mental health care moved out of large institutions, psychiatric nurses would be unable to transfer their skills to community settings. By this time, however, psychiatric nurses had been in the community for three years.

One of the first reactions to Challenge and Change was from the Minister of Health, Larry Desjardins. He wrote to the Deputy Minister identifying certain points in the report, including the elimination of LPNs and RPNs adding, “The latter aspects of the report cannot be endorsed.”⁹² The future of psychiatric nursing seemed much more secure with this endorsement by the Minister. Nevertheless the head of Mental Health Services, Bob Creasy, expressed concern. In a memo to Tavener he stated, “We should have considerable anxiety about the future training of psychiatric nurses.”⁹³ The Minister also objected to the implementation committee recommended by the MARN and instead set up his own task force to examine nursing education in Manitoba.

The Task Force

The Task Force established under Justice Joseph O’Sullivan included representatives from a variety of stakeholders and, unlike the Minister’s Committee of 1966, included a representative from the RPNAM.⁹⁴ The MARN grumbled that they should have had a much greater representation on the committee⁹⁵ and Dr

Tavener complained that the Advisory Committee was not represented.⁹⁶ The Director of the School of Nursing at the University of Manitoba, Dr. Helen Glass, added her discontent, “The Task Force does not have sufficient . . . persons . . . who can explain, clarify and interpret nursing.”⁹⁷

Despite the protestations, the Minister replied that he had no intention of changing the membership of the Task Force. This was not to be a forum for the MARN but a comprehensive review of all nursing education in the Province.⁹⁸

The Task Force heard almost thirty submissions and read hundreds of pages of text.⁹⁹ These hearings and submissions created the opportunity for the psychiatric nurses to examine and articulate their own position. It was one of the most public forums they had ever had as the hearings were open to the general public and the press.¹⁰⁰ Whatever tensions existed between the RPNAM and the Advisory Committee were set aside in order to ensure the best possible hearing for psychiatric nurses. A supportive letter came from Dr Tavener to Justice O’Sullivan. After praising nurses generally, he spoke of the need for the Registered Psychiatric Nurses:

The story of recruiting generally trained nurses to mental hospitals is one of poverty of response, inadequacy of training and a state of neglect of input for this broad sector of the sick. . . . It seems to me that the abolition of types of nursing are a very distinct threat to the care of the mentally ill and mentally retarded. Such abolition would only be tenable if coupled with a firm and detailed commitment to replace the supply of qualified persons. I know of no such plan. In the absence of any presented plan . . . it would seem unconscionable to do anything but retain a specific training . . . mode for psychiatric nurses¹⁰¹

Tavener was probably right. There was no specific plan to replace psychiatric nurses although this was the philosophical position of the MARN. However the

MARN offered to establish opportunities for the *phasing in* of both LPNs and RPNs into the general nursing fold.¹⁰²

* * *

Presentations regarding psychiatric nursing came from the three institutions, the RPNAM and the advisory committee. Detailed notes were kept of the proceedings and from these a picture emerges of some of the challenges and opportunities to which psychiatric nursing had to rise.¹⁰³ Questions were asked concerning the difference between general nursing and psychiatric nursing, whether they should even be called nurses, and how they related to social workers in the community.¹⁰⁴

The Task Force also touched on the emerging interest in psycho-geriatrics and the role of RPNs in that area. At the hearings the RPNAM tried again to express their ability to offer nursing care to patients in nursing homes. Trying to distinguish between the needs of the *geriatric* patients and those called *psycho-geriatric* patients was no easier now than when they had tried to explain it to the Minister in 1972.¹⁰⁵ Without using the language of *technical nursing* versus *psychiatric nursing*, the message was still clear, psychiatric nursing was concerned with aspects of care that were not as easily defined as physical nursing care, causing one of the members of the panel to quip, “Are you worried about who carries the bedpan?”¹⁰⁶

* * *

The task force also brought into the public sphere the question of university education for psychiatric nurses. University education was a goal of the RPNAM based on a commonly held belief of the time that full professional status could only be attained through academia. The University of Manitoba was not amenable to

psychiatric nursing education at university, but both University of Winnipeg (U of W) and Brandon University (BU) were receptive to the idea.¹⁰⁷ Psychiatric nursing students from Selkirk were taking psychology, anatomy and physiology, and sociology at the U of W just as the students from Brandon were receiving these courses from BU.¹⁰⁸

Brandon University in particular had a record of an agreeable and productive relationship with the Schools of Nursing from BMH and BGH. Throughout 1970 and 1971 BU, BGH and BMH held planning meetings which culminated in a proposal to establish a regional school of nursing and an associate degree programme at BU.¹⁰⁹ Despite the fact that the proposal caused some political conflict¹¹⁰ and the University Grants Commission rejected it, the hope of nursing education at Brandon University did not die in 1971.¹¹¹

In 1972 Brandon University established an innovative programme called Bachelor of General Studies Degree (BGS). It was designed to provide a programme with greater accessibility, diversity, flexibility, and transferability. It was particularly accessible to mature students and those who already had either college education or other diploma education.¹¹² The programme gave both general nurses and psychiatric nurses 42 credits towards this 90 credit hour degree. In this way some of the nursing instructors from BMH earned a university degree.¹¹³ Even though the value of such a degree to psychiatric nursing may be questionable it was clearly a convenient way to obtain higher education.

* * *

Both BMHC and BU submitted briefs to the Task Force regarding university education for psychiatric nurses.¹¹⁴ At the urging of the Task Force, these two institutions along with BGH met to develop a more comprehensive joint proposal. The records of the meetings held in March, April, and May 1977 show that the university was sensitive to the concern that “this programme not be compromised through any ‘coring’ system or ‘expediency factors’.”¹¹⁵ It was particularly important to the psychiatric nurses that there be no loss of identity, although Paine expressed some doubts about proposing two entirely separate degrees. However, the working committee concluded that two degrees were not necessarily undesirable.¹¹⁶ The minutes from the six meetings indicate that comprehensive discussions took place around the qualifications of instructors and the number required; the title of the degree; whether or not it should be linked with the University of Manitoba nursing programme; and the library requirements. The work on this proposal was almost completed by the end of May. On May 30, 1977 Robin Giles, Dean of Science, informed Justice O’Sullivan:

Brandon University, in conjunction with the Schools of Nursing at the Brandon Mental Health Centre and Brandon General Hospital intend to submit . . . a revised more detailed proposal for the establishment of a School of Nursing at Brandon University. The major departure from the original is that we propose the establishment of baccalaureate programmes in nursing and psychiatric nursing.¹¹⁷

The revised proposal was submitted to the Task Force on June 16, 1977. It contained curricula, course outlines, flow charts, staffing requirements, and a budget. This comprehensive proposal was also presented to a meeting of Brandon University Senate on August 29, 1977. This meeting had been called for the purpose of considering Letters of Intent to be submitted to the Board of Governors for

endorsement, before being presented the University Grants Commission.¹¹⁸ Dr. Giles, of the Faculty of Science supported this proposal:

The B.P.N [Bachelor of Psychiatric Nursing] is a new programme to Canada. There are more people entering psychiatric hospitals these days than there are people needing medical care and he [Dr. Giles] felt that Brandon University, as an institution, can offer more skill and professional help by graduating students with the necessary skills to assist these kinds of patients.¹¹⁹

It was a win-win situation. The psychiatric nurses were moving closer to their goal of university education and BU was proud of its innovative programmes.¹²⁰ This revised proposal received particular mention in the final report of the Task Force.

Unfortunately it was not approved by the University Grants Commission.¹²¹

* * *

The Task Force Report was almost ready for publication in October 1977 when the government changed at the election of October 24, 1977. Two days later the new Minister of Health, Bud Sherman, sent a note to the new Minister of Education, Keith Cosens, "I feel that it would be advisable to permit the task force to fulfill its mandate, especially since its report is near completion."¹²² Cosens agreed and Sherman sent a note to O'Sullivan confirming their desire to receive the report as soon as possible. The report was formally submitted to the government on December 16, 1977.¹²³

The authors of the report noted there was a keen public interest in the proceedings and the Task Force attempted to achieve thorough discussion, to examine issues from many perspectives and to "Look critically at both cherished traditions and innovative proposals."¹²⁴ They added that the existence of other organized bodies [LPNs and RPNs] of nurses outside the MARN were not a hindrance:

The Task Force therefore rejects at the outset of its report the suggestions that have been made by the Manitoba Association of Registered Nurses that it should 'phase in' the categories of Licensed Practical Nurses and Registered Psychiatric Nurse.¹²⁵

Obviously with this strongly worded statement the future of psychiatric nursing was secured. Other references to psychiatric nursing were scattered throughout the report. In regards to the control of psychiatric nursing education the Task Force tackled one of the thorny issues that had dogged the RPNAM since its beginning, the structure and function of the advisory committee:

The education advisory committee has been criticized in regards to its composition; its membership is largely representative of the three mental health centres. . . . There is no official involvement on the Committee of nurse educators or mental health groups in the community. . . .The advisory committee is not advisory to the RPNAM. Therefore unlike the MARN is not accountable for the education of its members.¹²⁶

This was precisely the point that the RPNAM had been making since its inception. It seems they were finally heard. The recommendation of the Task Force was that representation on the advisory committee be broadened by legislation.¹²⁷

With regard to university education for psychiatric nurses the report singled out for particular mention the Brandon proposal:

A unique initiative has come from nursing educators in the City of Brandon, affording an opportunity to develop a system of nursing education which will combine diploma Registered Nurse training preparation of Registered Psychiatric Nurses, and degree nurse training. The entire structure would be under the auspices of Brandon University.

The entry of a university into nursing education in this way would be unique in Canada. The Task Force commends the formulators of the proposal and recommends that it should receive approval and public funding.¹²⁸

Nevertheless, the task force was cautious about bestowing two distinct degrees:

One point in the Brandon University proposal the task force cannot accept is the proposal that the nursing program should result in two separate degrees, one in nursing and the other in psychiatric nursing. The Task Force thinks it

would be regrettable to increase the separation between professional nurses engaged in physical health care and those engaged in mental health care. . . The Task Force therefore urges Brandon University to reconsider . . . propose having one degree in nursing with course content that will vary.¹²⁹

While in some ways it would seem to make sense to have an integrated programme with different streams of nursing, the psychiatric nurses were apprehensive. The Task Force may not have been aware of the recent experience of psychiatric nurses in Saskatchewan where such a model had not been successful and merging the streams of nursing had resulted in the loss of psychiatric nurses in that province.¹³⁰ Psychiatric nurses had always been concerned about the loss of identity as a distinct profession, but had always struggled with how to articulate the distinctiveness. The concept of having one core programme with different streams highlights an untested assumption that the person with mental illness requires the same kind of nursing care as a person with physical illness. This was the assumption underpinning such statements as “illness is illness no matter the cause” and “a nurse is a nurse is a nurse.”¹³¹ But can this be true? The dissension generated around mental illness suggests that there is something different about mental illness and those who care for the mentally ill. If it were the same, there would be no issue. Even the psychiatric nurses themselves were ambivalent about this as evidenced by the separation of their curriculum into *basic nursing* and *psychiatric nursing*.¹³²

The Task Force also touched on the emerging use of conceptual models in nursing education and practice. They observed that “a nursing model was a conceptual way of looking at the nurse’s role while an educational model would be a guide in curriculum development.”¹³³ As there was no consensus as to the meaning of models they refrained from making any recommendation other than that there should

continue to be diversity in nursing education.¹³⁴ The use of a curriculum model became an important component in the development of the 1979 psychiatric nursing curriculum.

* * *

The report also recommended a Commission of Nursing Education be established. Such a commission should function as a coordinating body while respecting the roles of the individual nursing associations.¹³⁵ The primary role of the commission was to “Have full and final power to allocate whatever public funds are available for nursing education among the various educative bodies.”¹³⁶ But there were other objectives for the proposed commission. It was expected to maintain a broad picture of provincial nursing needs and to foster diversity. It was certainly expected that the three nursing bodies would act in a collegial manner:

The success of the proposed commission will depend on a number of factors. . . . But most of all will be the spirit which is brought . . . by those who are appointed.¹³⁷

The psychiatric nurses had achieved one of their goals; that they sit at the table as equal partners with the MARN.

* * *

With the assurance of the continuation of psychiatric nursing, at least in the immediate future, the RPNAM could turn its attention to the enhancement of other symbols of professional growth. Despite the amount of time and energy consumed by the Task Force, other business and professional activities had been conducted in the 1970s.

The association by this time had an effective committee structure which conducted much of the day-to-day business. One such committee was *salary review* which concerned itself with the issue of salaries and bargaining with the government. This was always contentious as the role of the association in union activities was not always clear. There was often tension between professional activities and union activities, no doubt as a remnant of the association's early days when the financial welfare of the members was an important professionalizing strategy.¹³⁸ As the association compared itself with general nursing, equal salaries became a symbol of professionalism. Not all the executive were happy with this situation and Martyniw observed dryly, "Some annual meetings were more like union meetings than professional meetings."¹³⁹

On the other hand, their political consciousness was developing. In early 1975 when plans were announced to build a gaol on the grounds of BMHC, the council sent a letter of protest to the government. Presumably they were concerned with the connection between the gaol and the mental hospital which aroused images of earlier asylum days when incarceration was the major means of management of the mentally ill.¹⁴⁰

They continued to question general hospitals and the unions as to why RPNs were not allowed to be in charge on psychiatric units in general hospitals.¹⁴¹ The response of the Health Sciences Centre (HSC) was that RNs were hired because they had experience in acute care settings whereas RPNs only had experience with long term and custodial care. Obviously, there was still a lot of a misunderstanding as to the skills of psychiatric nurses and Dr Tavener gave his support by writing to HSC.¹⁴²

This was not unlike another issue that arose during this time regarding the competence of psychiatric nurses to release bodies in personal care homes. The Manitoba Health Services Commission apparently questioned the ability of psychiatric nurses to carry out this task!¹⁴³

One of the most significant events during this time was the hiring of an executive director in October 1976. This idea had first been broached at the annual meeting of 1975 although it went no further at that time.¹⁴⁴ But with the increase in the workload on the volunteer council and committees, it was becoming increasingly obvious that more paid staff was necessary. At the 1976 annual meeting the issue was raised again and it was resolved that an executive director be hired within three months.¹⁴⁵ A special meeting was held on July 22, 1976 to establish a selection committee for the hiring process and also to establish short term and long term goals for the association. The goals included, defining nursing and psychiatric nursing, defining what is unique about psychiatric nursing, and the development of a set of beliefs about man, health, society, nursing, and teaching and learning.

The first goal, to hire an executive director, was much more easily achieved than answering the philosophical questions posed by the other goals. Annette Osted was hired in October, 1976.¹⁴⁶ This turned out to be a fortuitous move as the attendance at the task force hearings in early 1977 demanded a large investment of time which would not have been possible by the volunteer council.

There were also national activities which took time and energy. The RPNAM was involved in discussions with the other western provinces on licensing reciprocity and the establishment of standards of practice. The standards were particularly

important, not only for establishing reciprocity, but also because they became a framework on which to build a curriculum. The executive of the RPNAM at a meeting in June 1977 recommended that any curriculum revision be based on the PNAC Working Paper on Standards of Practice. This item was to be taken to the Advisory Committee meeting by the RPNAM representative.¹⁴⁷ This statement represented a further subtle shift in relations between the Advisory Committee and the association. Where previously the Advisory Committee had dictated curriculum policy to the association, now the association was gaining control of the curriculum through professional strategies such as the development of standards of practice.

A Bigger and Better Curriculum

The greatest strides in the advancement of psychiatric nursing may have taken place in the work of the curriculum sub-committee during this time. In July 1976 the sub-committee determined a thorough examination of the educational process was necessary including the development of a philosophy, overall objectives, model, and a framework for content and evaluation.¹⁴⁸ No doubt bolstered by the positive reception of the Task Force and the work with U of W and BU on psychiatric nursing education, the curriculum sub-committee and faculties of the three schools of nursing worked throughout 1977 and 1978 to develop an even bigger and better curriculum.

There were four significant changes in the 1979 curriculum which represented changes in approach to psychiatric nursing education. First, both clinical and theoretical instruction was expressed in academic credit hours rather than actual hours and weeks. Second, the philosophy expanded from five statements to nine and now included the concepts of the meta-paradigm of nursing. Third, was the introduction of

a curriculum model which visually identified how the content of courses related to one another. Fourth, was the organization of the objectives around practice concepts and the nursing process.

The expression in credit hours was a move to align the curriculum with its academic aspirations as well as with the courses the students were already taking at university. The change to credit hours also facilitated a better match between theory and clinical practice with the recommended ratio of two hours of clinical experience to one hour of theory.¹⁴⁹

The 1979 philosophy differed from the 1974, not just in length but in content. While still maintaining the statements concerning human worth and dignity, it now included statements regarding health, society and psychiatric nursing, obviously influenced by the recently articulated meta-paradigm of nursing:¹⁵⁰

1. Man is of infinite worth whose optimum well-being, psychological, physical, social and spiritual is to be protected, promoted, restored, and preserved.
2. Respect for the rights and dignity of man is fundamental to the achievement of optimum health and happiness.
3. Man has a right to optimum health and happiness.
4. Health is a state of optimum psychological, physical, social and spiritual well-being of an individual, and further, we believe health to be a state of dynamic equilibrium and is not considered as static in the life of the individual.
5. Society is a network of reciprocal interacting relationships resulting in the preservation of the primary values of its members.
6. Psychiatric nursing education can assist society in developing optimum health of its members.

7. Learning is a process of changing the behavior of an individual. The change is due to the learning experience, not maturation, and lasts beyond the learning experience.

8. Teaching is an integral part of the learning process and results in specific behavioral changes in the learner.

9. Psychiatric nursing is a professional helping process which assists man to protect, promote, restore and preserve optimum health.

The concepts of the meta-paradigm of nursing, (i.e. man, health, society and nursing) had been identified by Torres and Yura in their work on general nursing curricula. These were generally agreed upon as the basic concepts of nursing.¹⁵¹ Their inclusion in this philosophy demonstrates that the psychiatric nurses were trying to incorporate more nursing knowledge into their curriculum, but how these concepts were adapted for psychiatric nursing is not identified.

The curriculum constructors also included a curriculum model which was a new innovation and was modest by some standards. But it too represented a shift to the incorporation of knowledge which was generated by nursing research. The model did not show linkages between concepts as a conceptual model might do, rather it was based on the organization of subject matter into disciplinary patterns. This differed somewhat from the description of Kelley regarding conceptual models in curriculum development:

A conceptual framework is a clear and concise narrative or diagram depicting the basic concepts or ideas of a faculty that give shape and form to the curriculum.¹⁵²

Four outer circles represented biological, sociological, psychological, and maturational subject matter which impacted the core of the model. The core consisted of two categories of nursing, *general nursing arts and sciences* and *psychiatric*

nursing mental health nursing interventions. The pattern of dividing nursing into basic nursing and psychiatric nursing was frequently at the heart of tension between general nurses and psychiatric nurses. This curriculum format did nothing to dispel the split between mind and body. The distinguishing feature between psychiatric nursing and general nursing seemed to be in the amount of subject matter relating to mental illness and psychiatric nursing.¹⁵³

The final significant change in the 1979 curriculum was that the objectives were organized around three practice principles, rather than goals for the student to accomplish, as the 1974 curriculum had done.

The three objectives of the 1979 curriculum:

The promotion of mental health
 The application of the nursing process in the provision of care
 Participation as a professional in the mental health team

These were simpler statements than the 1974 objectives but they were more focussed. Rather than stating what the student should accomplish in their training these three objectives defined what a psychiatric nurse was expected to accomplish in professional practice and how the practice was to be carried out.¹⁵⁴ The promotion of mental health was obviously a fundamental goal of psychiatric nursing and could have been the core concept of a conceptual framework. This was the first time the nursing process had been identified as a systematic approach to the provision of care although failure to state it as psychiatric nursing process demonstrated the ongoing dilemma of the claim to distinctiveness while obviously freely borrowing from general nursing theory and frameworks. Professional practice goals were more clearly

delineated in this curriculum and were based on the newly articulated national standards of practice.

* * *

The development of these standards of practice was an achievement for the national body. They were the work of a national psychiatric nursing education committee under the chairmanship of John Crawford and sponsored by the PNAC.¹⁵⁵ This committee was diligent in its work. The proposed standards were circulated to a number of professional colleagues in medicine and nursing who were asked to make comments. Dr. Lipinski, of the Canadian Psychiatric Association, congratulated the committee on its work and offered a number of comments. One of the more intriguing comments related to the obvious efforts of the committee to stay focussed on identifying measurable behaviours of both patients and psychiatric nurses, which were so important in the era of scientism. The physician wondered, along with the committee:

If there is any way to focus on the intangibles of experience, such as *intuition* (italics added) and a host of other “clinical skills” which seem to defy measurement. There is often a tendency to bypass the value of such concepts because they are difficult to measure. However, all of us know that such factors exist, and I do not think it is correct to neglect them.¹⁵⁶

Psychiatric nursing was trying to establish itself as a legitimate profession despite the fact its domain of practice was not easy to define. This statement must have been heartening to the educators who knew that intuition was an important skill in psychiatric nursing, but had usually refrained from saying so publicly.

Other letters from reviewers complimented the PNAC committee on the work and also offered warnings. The committee had based the Canadian standards on the

Standards of Practice for Psychiatric Nurses of the American Nursing Association (ANA).¹⁵⁷ One of the reviewers questioned the wisdom of trying to adapt standards from the American to the Canadian context.¹⁵⁸ The standards were clearly based on the nursing process and this was a further point of concern for the same reviewer who suggested that as written they were more “academic than practical”¹⁵⁹. While it is true that psychiatric nurses may not proceed in the step-by-step fashion outlined in the document, the standards still provided a basis for the provision of care and were incorporated into the next curriculum.

Of the sixteen standards, the first nine related directly to the care of patients while the remaining seven concerned the professional behavior of a psychiatric nurse.¹⁶⁰ Whatever the perceived limitations of these standards, they still represented a significant contribution to the growth of the profession.

* * *

In spite of the significant changes to the curriculum and the development of standards a question remained, “In what way does the manipulation of content, readjustment of objectives, and establishment of standards make a difference to the person suffering with mental illness?” These were not questions addressed publicly by nursing educators of the time. There were no references to intuition, suffering or emotional pain. Nevertheless this curriculum was a turning point in the education of psychiatric nurses in the province. It was constructed solely by nursing educators and with an obvious nursing rather than medical framework. Nevertheless, it still had to be approved by the Advisory Committee.

When it was presented to the Advisory Committee in July 1979 it was moved:

The curriculum be approved for use in beginning in September and that the chairman would notify the Minister, the Deputy Minister, the RPNAM and the three Schools of Nursing.¹⁶¹

It seemed unnecessary to notify the RPNAM and Schools of Nursing as they had been working together on this curriculum for three years. Nevertheless it may have been the Advisory Committee's way of showing that it was still officially in charge. Despite the fact that both the Government and the RPNAM were involved by this time in revising the legislation that governed all nursing in the province there was no acknowledgement of this fact. This was the last working meeting held before the implementation of the new act a year later and it seems inexplicable that no mention is made of the pending change to the legislation.

Tom Street: The Final Year: Are We Ready?

The fifth male president, Tom Street, had been the registrar for two years when he was elected president in June 1979, just as the new curriculum was coming off the press. He inherited from Jack Holleman, an association in good financial shape, with the day to day business being managed by office staff, and the development of the profession by the executive director. Street, unlike the previous presidents had never known psychiatric nursing without the structure of an act. He had graduated from the Portage School in 1967. Like some of his contemporaries he drifted into psychiatric nursing because he needed a job for a few months, and stayed for thirty years, but unlike others, he had no family connection to psychiatric nursing or to the institution at Portage.¹⁶²

One of the concerns which piqued his interest in the association was the dilemma which arose when unprofessional actions on the part of psychiatric nurses

were handled ineffectually by the Manitoba Government Employees Association (MGEA). The MGEA was the body officially responsible for employee behavior, and Street felt that, as a union, they functioned more to protect the job of the employee, rather than the dignity of the patients or integrity of the profession. The mechanism for disciplinary action at that time was that the executive met to discuss cases presented to them and involved the RPNAM lawyer as necessary.¹⁶³ In June 1977 the disposition of two complaints are reported and it was recommended that the disciplinary procedures be examined and different models explored.¹⁶⁴ Despite the limitations, the strategies and procedures must have been effective as the following year a decision by the disciplinary hearing was appealed, but the disciplinary decision was upheld by the court.¹⁶⁵ But Street was not fully satisfied and he continued to explore ways to improve the process. It was an onerous task, but he firmly believed that it was necessary if the RPNAM was to be recognized as a professional body.

One of the hallmarks of professionalism is having a code of ethics and standards of practice, and a disciplinary process to be applied if standards are breached. Did they recall Mr. Russell's dismay fourteen years earlier when the first recorded incident of inappropriate action on the part of a psychiatric nurse could not be dealt with effectively?¹⁶⁶ There had certainly been a maturing of the profession since that time.

* * *

When Street became president, there were only eighteen months remaining under the *old act* although he was unaware of this fact at the time. The second year of

his presidency was dominated by the preparation and passage of the new act and became the defining feature of his presidency.¹⁶⁷

The RPNAM had wanted a change in legislation for some time, but the moment never seemed right. In 1977 the by-law committee had prepared a draft but the council recommended that “no changes in the act take place at this time.”¹⁶⁸ They were cautious as they were unsure of what recommendations might be contained in the Task Force Report.¹⁶⁹ At the council meeting of December 8, 1978 Osted reported on a meeting with government regarding the Task Force. They discussed nursing education, psychiatric nurses in nursing homes, and legislation:

The question about legislation came as quite a surprise and since we could not make a policy statement of that magnitude, our answer was more of a watch and wait comment, at least for the present time. We stated that although we had professional legislation as a long-term goal we were not looking at this for the immediate future.¹⁷⁰

But the government had other plans and was proceeding to bring about changes to all three nursing acts. Osted confirmed in an interview that the recommended change to the legislation had come as a surprise because of the speed with which it had happened.¹⁷¹ Street believed that because the government wanted all nursing legislation considered at the same time and were planning to proceed anyway the association had no choice.¹⁷² Whatever the reason, the RPNAM found itself thrust into revision of the act throughout 1979 and into 1980.

* * *

The government wanted to deal with the three nursing bills concurrently so that similar principles could be applied.¹⁷³ The principle to which they referred was, “The only validity of a professional society is the protection of the public and service

to the public.”¹⁷⁴ This was a further move towards contemporary professionalism, public accountability.

The three bills were presented to government in the summer of 1980 and following first and second readings were referred to the Standing Committee on Private Bills. The committee hearings were thorough and went on for three days and often into the night.¹⁷⁵ By dealing with the three bills simultaneously, it was easier to highlight the similarities and differences between the three nursing bodies. At times, the politicians who comprised the committee seemed woefully ignorant of the differences between them, but their questions provided the three nursing bodies the opportunity to be heard and to clarify their own view of themselves and to educate the politicians.

In an odd twist to the politics of nursing in Manitoba, the LPN group was subjected to a more grueling interrogation than either the RN or RPN delegations. The committee recognized that the LPNs differed from the other two groups in having less professional autonomy and being required to be supervised by RNs. Throughout the hearings, the committee came to equate the RPN and RN and place the LPN at a different level.¹⁷⁶ “The LPNs being in a tier somewhat less than the other two . . . it was necessary to indicate those people could do anything that the LPN can.”¹⁷⁷ The view that RNs and RPNs were equal was the position that Martyniw had striven for ten years earlier.¹⁷⁸

Osted and Street attended the hearings and participated in the section related to the psychiatric nursing legislation. At the first session, Street identified the major changes to the bill which focused on greater accountability to the public.¹⁷⁹ One of

the more significant changes was that the practice of psychiatric nursing would no longer be tied to the Mental Health Act.¹⁸⁰ This increased the scope of the practice of psychiatric nurses to a wider variety of patients, those formally identified as mentally ill and also those experiencing other forms of mental distress. When the practice of psychiatric nursing was confined to the mental institutions, the domain of practice was restricted to those patients who were viewed legally as mentally ill. With this proposed change, psychiatric nurses could work with persons in nursing homes, correctional facilities, and in addiction treatment centres.¹⁸¹ This move was in line with the general trend to a broader understanding of mental disorders and the blurred distinction between mental illness and mental distress. Coming to understand the implications of this trend could clarify the domain of practice of psychiatric nursing.

Street and Osted responded to questions dealing with the disciplinary process, professional misconduct, and the management of the schools of psychiatric nursing education. Regarding the schools the committee seemed concerned that the new board would have the power to refuse approval to any school of psychiatric nursing if the standards were not met. They seemed reassured that there would be a mechanism for maintaining the current schools and a proper process for evaluating any future schools.¹⁸²

When the three bills came to the house for committee reports and third reading, much better informed politicians answered questions from their colleagues. The three bills passed unanimously and on July 29, 1980 received royal assent.¹⁸³

* * *

The new legislation also affected the Advisory Committee which had legally been in control of psychiatric nursing education for twenty years and was to be disbanded under the new legislation. The Advisory Committee was now having to give up its last vestige of power, although it had been less involved in the development of new curricula since it had established the curriculum sub-committee in 1968 and there is no evidence it ever interfered in the work of the sub-committee.

The first acknowledgement of the pending change was in August 1980 when Tavener sent a memo to the committee members:

With the passage of the new act . . . our committee ceases . . . We now need a meeting to wrap up our business. . . We need to
 Complete the examination process for this year
 Complete decisions on accumulate funds
 Say good bye to each other.¹⁸⁴

The funds to which he was referring were accumulated from the student's fees and expenses related to examinations. He anticipated, "We will have to report these funds to the Minister of Finance for disposal."¹⁸⁵ The disposition of funds was not the only concern however. Street wrote to Tavener and asked for a meeting with the agenda item being the transfer of authority from the Advisory Committee to the new board of RPNAM.¹⁸⁶ This letter was passed to Grant Reid, Tavener's assistant. Scrawled along the side in Tavener's distinctive handwriting was the question "Are we ready?" He may have been asking if the committee was ready to give up its functions or if all the legal pieces were in place. Street and Osted also report that they too were asking themselves if they were ready to assume these responsibilities.¹⁸⁷ Whatever the meaning, the phrase had a finality to it.

Perhaps the realization that this was the end of an era may have caused Tavener to rethink the idea of handing over the remaining funds to the Minister of Finance. In a deferential memo to the Minister of Health, Tavener explained the process for transferring the authority to the RPNAM and added:

Following the meeting I would like to hold a dinner to be paid for from the funds remaining in the committee account and to which would be invited the present and former committee members and observers all of whom have worked diligently and faithfully on behalf of the committee. To do this I need and would appreciate receiving your approval.¹⁸⁸

This request was Tavener's last act of authority in a process that must have been a significant part of his professional career for twenty years.

The last meeting of the Advisory Committee was held on November 6, 1980. The minutes have a wistful tone to them. Tavener opened with the observation that with the proclamation of the new act the committee would cease to exist. The former act had been proclaimed in 1960 and therefore the committee was "going out of business on its 20th anniversary."¹⁸⁹ It is not mentioned in the minutes however that Tavener was almost the only remaining member of the original committee.¹⁹⁰ The final business was conducted and it was noted that ministerial authority to charge the cost of the dinner to the committee funds is on file. Lowther thanked Tavener for his leadership and contribution to the advancement of psychiatric nurses training.

Tavener in turn:

Thanked the committee members for their dedication and hard work. . . . [T]he committee has been instrumental in doing good things for psychiatric nursing. He expressed his belief that training would be in good hands when passed to the R.P.N.A.M. and asked that the R.P.N.A.M. representatives take the committee's heartfelt good wishes back to the Association.¹⁹¹

Ready or not, the RPNAM was now responsible for the education of its members.

Conclusion

The first meeting of the newly named *Board of Directors* of the RPNAM was held on December 4, 1980. The president noted that the Registered Psychiatric Nurses Act had been proclaimed on December 3, 1980. The first item of business on the new board's agenda was the possession date on December 15, 1980 of the office building that had been purchased. The second item, perhaps as a vote of confidence, was an increase in the salary of the executive director.¹⁹² The future seemed secure fiscally, administratively, and professionally. The association had evolved in twenty years from kitchen tables to property owners. They had come into being through political goodwill, but through their own persistence and some good fortune, they had established a place for themselves in the mental health system of Manitoba.

Legislatively, psychiatric nurses were a distinct profession and were now also responsible for their own educational standards. The place they still had to achieve was in the world of academia, the world of the disciplines where unique bodies of knowledge are developed and acknowledged by the rest of the academic world. Despite the confidence in their gains in the professional world, were they uneasy about their place in the world of the disciplines? Will the next professionalizing strategy be the articulation of a unique ontological and epistemological framework, based on an alternative world-view of mental illness, the mentally ill and those who care for them?

Endnotes Chapter 5

1. Interview Jack Holleman, February 7, 2007.
2. CRPNM Archives, Minutes of Council Meeting, June 27, 1969.
3. CRPNM Archives, Minutes of Council Meetings, June 4, 1971, May 18, 1973, May 23, 1975, June 17, 1977.
4. Interview Jack Holleman, May 15, 2007.
5. Annette Osted was hired as Executive Director October 1976. She was a psychiatric nurse who had graduated from Selkirk Mental Hospital in 1967.
6. Legislative Library of Manitoba. On June 25, 1969 an election was held and the New Democratic Party (NDP) emerged for the first time as the largest party in the legislature, winning 28 out of 57 seats.
7. PAM, GR 459, W-4, A Re-Organization Concept for the Department of Health and Social Development, December, 1970.
8. *Ibid.*, 2, 3.
9. Dr. J. C. Clarkson and M.D.T. Associates, Mental Health and Retardation Services in Manitoba: A Report to the Minister of Health and Social Development Province of Manitoba, 1973 (hereafter The Clarkson Report).
10. Refvik, *History of the Brandon Mental Health Centre*, 146.
11. The Clarkson Report, 78.
12. *Ibid.*, 1.
13. PAM, GR 1554, Minutes of Medical Superintendents Meeting, June 26, 1969. PAM, GR 459, H-16-19-1B, Report on the Phase Out of the Institutional Farms at the Hospital for Mental Diseases at Brandon and Selkirk, April 1970.
14. PAM, GR 1554. Attached to the June 26, 1969 Minutes of Medical Superintendents Meeting is a Report of the Scientific Planning Committee which was formed to develop a scientific and teaching program and to make arrangements for the visit of a distinguished researcher or teacher in the field of mental health.
15. The Clarkson Report, 1.
16. Alberta has maintained a separate association called Alberta Mental Deficiency Nurses' Association.

17. The Clarkson Report, Recommendation 3, 2.
18. Karlenzig graduated as a Psychiatric Nurse from Selkirk Mental Hospital in 1964.
19. CRPNM Archives, Minutes of Council Meeting, October 27, 1972.
20. PAM, GR 459, 1-1-8C, Cels to Toupin, June 27, 1973.
21. PAM, GR 459, 1-1-8C, Karlenzig to Schreyer, May 23, 1973. Members of the Group to Toupin, May 14, 1973. Holleman to Toupin, May 29, 1973.
22. PAM, GR 459, 1-1-8C, Toupin to McKenzie, June 26, 1973.
23. In the 1970s BMH developed an active Behavior Therapy Unit and many of the long term wards used the principles of Behaviour Therapy with good success. At The Manitoba Developmental Centre, Portage it became particularly important as a tool for managing behavior. Psychiatric nurses became very active in this new form of treatment.
24. PAM, GR 459, 1-1-8C, Cels to Toupin, June 27, 1973.
25. PAM, GR 459, 8-3-74-1-3, Holleman to Toupin, March 8, 1972.
26. Ibid.
27. PAM, GR 459, 8-3-74-1-3, Toupin to Holleman, September 9, 1972.
28. PAM, GR 459, 8-3-74-1-3. Holleman to Toupin, September 24, 1973.
29. PAM, GR 459, 8-3-74-1-3, Miller to Holleman, March 29, 1974.
30. PAM, GR 1555, 1280-1, Psychiatric Nursing in the Community. Curriculum presented to Advisory Committee January 19, 1973. Also see Appendix I for a suggested curriculum for the community course.
31. The Clarkson Report, 74.
32. PAM, GR 1555, 1280-1, Vernon to Tavener, February 7, 1973.
33. PAM, GR 1555, 1280-1, Vernon to Tavener, February 20, 1973.
34. Paper attached to memo, Vernon to Tavener, February 20, 1973.
35. Ibid.

36. PAM, GR 1555, 1280-1, Tavener to Vernon, February 23, 1973.

37. Rehabilitation Counsellor was a government classification for individuals who assisted clients in the community. They did not have to have a nursing diploma and were sometimes referred to as mini social workers.

38. PAM, GR 2124, 1104-3, Meeting on Classification of Nurses, December 9, 1974.

39. Ibid.

40. PAM, GR 1555, 1280-1, Tavener to Maynard, August 21, 1975.

41. PAM, GR 2124, 1104-3, Pronyk to Dimirsky, February 19, 1976.

42. PAM, GR 2124, 1104-3, Creasy to Supervisors, May 19, 1976.

43. PAM, GR 1555, 1280-1, Pronyk to Creasy, May 28, 1976.

44. PAM, GR 459, N-5, Review of Job Standards Meeting, May 24, 1977.

45. PAM, GR 1555, 1280-1, Tavener to Creasy, July 20, 1977.

46. PAM, GR 1555, 1280-1, Faculty School of Nursing, Brandon Mental Health Centre to Creasy, July 21, 1977.

47. Susan R. Gortner, "The History and Philosophy of Nursing Science and Research," *Advances in Nursing Science* 5 (2) (January 1983): 287-292. Dorothy E. Johnson, "A Philosophy of Nursing," *Nursing Outlook* 7 (4) (April 1959): 198-200. Afaf Ibrahim Meleis, *Theoretical Nursing Development and Progress* 2nd ed. (Philadelphia: J. B. Lippincott, 1991). Mary Cipriano Silva and Daniel Rothbart, "An Analysis of Changing Trends in Philosophies of Science on Nursing Theory Development and Testing," *Advances in Nursing Science* (January 1984): 1-13.

48. Meleis, 30, 42.

49. National League for Nursing 1975 *Faculty-Curriculum Development Part VI: Curriculum Revision in Baccalaureate Nursing Education*. Gertrude Torres and Helen Yura, *Today's Conceptual Framework: Its Relationship to the Curriculum Development Process* (New York: National League for Nursing, 1974). The reconceptualization literature is described in William F. Pinar, William M. Reynolds, Patrick Slattery and Peter M. Taubman. *Understanding Curriculum: An Introduction to the Study of Historical and Contemporary Curriculum Discourses* (New York: Peter Lang, 1995). The main thesis of this genre of curriculum theory is that the Tyler rationale has reached the end of its utility because of the frailty of knowledge, and its technical approach to education see chap. 4 in particular.

These authors viewed contemporary curriculum discourses as the reading of texts, such as gender, race, and politics for example. Nursing educators have seemed reluctant to stray from the mechanical Tylerian curriculum framework which certainly offered a systemized approach to education but which also discouraged critical thinking.

50. William H. Schubert, *Curriculum: Perspective, Paradigm, and Possibility* (New York:Macmillan, 1986), 116.

51. P.N.A.C. Education Committee Recommendations, *The Canadian Journal of Psychiatric Nursing* XIII (3) (May-June 1972): 8-10. The Education Committee of P.N.A.C. met in Winnipeg April 8, 1972. The committee consisted of John Martyniw, Chair, Manitoba; Joseph Leins, PNABC; J. Johnson, PNAA, M Schreder, SPNA; Jessie Weir, RPNAM; Rose Dyson, PNAO. The Canadian council of Psychiatric Nurses CCPN) had changed its name to Psychiatric Nurses Association of Canada (PNAC) in 1965

52. P.N.A.C. Education Committee Recommendations for Philosophy and Objectives. Appendix J.

53. Personal communication Ross Stewart, May 30, 2007.

54. P.N.A.C. Education Committee Recommendations, The full objectives and recommendations Appendix J.

55. McKee Archives, Brandon University, SB 47, File 3, Kellie to Stanley, April 27, 1972.

56. PAM, GR 1555, 1280-2, Minutes of Sub-committee on Curriculum Meeting, April 10, 1974.

57. McKee Archives, SB 47, Minimum Curriculum for Psychiatric Nurses Education, Province of Manitoba. Revision approved by the Education Advisory Committee, May 1974. Philosophy, np.

58. Ibid., Objectives, np.

59. The 1974 curriculum included 40 hours of instruction in Interpersonal Relationships in the Psychiatric Nursing Section. The lesson outlines included communication skills and barriers, self awareness, observation, helpful attitudes, problem solving, group techniques, interviewing, counseling and public speaking. Obviously with this much content there was little time for the development of the more subtle nuances of communication.

60. PAM, GR1555, 1280-2, Minutes of Sub-committee on Curriculum Meeting, October 10, 1973.

61. Brown, *Curriculum Development*, 38.
62. McKee Archives, SB 47, Minimum Curriculum Outline, np.
63. Benjamin S. Bloom, ed., *Taxonomy of Educational Objectives: The Classification of Educational Goals: Handbook I: Cognitive Domain* (New York: David McKay, 1956). David R. Krathwohl, *Taxonomy of Educational Objectives: The Classification of Educational Goals: Handbook II: Affective Domain* (New York: David McKay, 1956).
64. PAM, GR 1555, 1280-2, Minutes of Sub-committee on Curriculum Meeting, November 22 1974.
65. PAM, GR 459, H-14-21-1A, Cunnings to Toupin, November 2, 1970.
66. PAM, GR 459, H-14-21-1A, Dyck to Toupin and Miller, June 10, 1971.
67. PAM, GR 459, H-14-21-1A, Miller to Dyck, June 15, 1971.
68. PAM. GR 459, H-14-21-1A, Tulchinsky to Toupin, October 4, 1971.
69. PAM, GR 459, H-14-21-1A, Holleman to Toupin, December 1, 1971.
70. MARN 1974, ad hoc committee on Nursing Education in Manitoba.
71. PAM, GR 1555, 1280-1, Tod to Tavener, January 15, 1975.
72. PAM, GR 1555, 1280-1, Tavener to Advisory Committee Members, January 24 1975.
73. PAM, GR 1555, 1280-1, Lowther to Tavener, January 28, 1975.
74. PAM, GR 1555, 1280-1, Moyes to Tavener, February 7, 1975.
75. PAM, GR 1555, 1280-1, Gibson to Tavenver, February 10, 1975.
76. PAM, GR 1555, 1280-2, Minutes of Sub-committee on Curriculum Meeting, January 31, 1975.
77. Elisabeth Hartig was an R.N. She served as Director of Nursing Education at Selkirk Mental Hospital (SMH), 1972 to 1980. She had little psychiatric nursing experience but she had a good background in. nursing education. Jose de Cangas was an English trained psychiatric nurses and general nurse. He came to the SMH school of nursing approximately 1967 and soon after obtained a Bachelor of Science in Nursing from Saskatoon. He was a nursing instructor at SMH and became Director of Nursing Education at Brandon in 1976.
78. CRPNM Archives, Minutes of Annual Meeting, April 19, 1975.

79. CRPNM Archives, Minutes of Special Meeting, May 13, 1975.
80. Ibid
81. The majority of the nursing instructors at BMHC were dually qualified with both RPN and RN diplomas.
82. CRPNM Archives, Minutes of Special Meeting, May 13, 1975.
83. Ibid.
84. CRPNM Archives, Lawrence J. Breen and Associates, The Perceived Role of the Registered Psychiatric Nurse in the Mental Health Delivery System of the Province of Manitoba, A Report submitted to the Registered Psychiatric Nurses Association of Manitoba, March 1, 1976.
85. Ibid., 4.
86. Ibid., 29.
87. Ibid., 2.
88. Ibid., 11.
89. Ibid., 29.
90. Interview Annette Osted, May 22, 2007.
91. Manitoba Association of Registered Nurses, Nursing Education: Challenge and Change, April 1976, 115.
92. PAM, GR 459, N-7, Desjardins to Tulchinsky, April 1976
93. PAM, GR 459, N-7, Creasy to Tavener, October 4, 1976.
94. The Task Force was to be called Joint Ministerial Task Force on Nursing Education under the leadership of Justice Joseph O'Sullivan. John Kellie, RN, RPN, BA, and Director of Nursing Education, Manitoba School, Portage la Prairie, was selected to represent the RPNAM.
95. PAM, GR 459, N-4, McPherson to Desjardins, September 30, 1976.
96. PAM, GR 459, N-4, Tavener to Desjardins, October 28, 1976.
97. PAM, GR 459, N-6, Glass to O'Sullivan, February 21, 1977.
98. PAM, GR 459, N-4, Desjardins to O'Sullivan, November 1, 1976.

99. See full report Joint Ministerial Task Force on Nursing Education (hereafter The Task Force Report), February 1977.

100. "Psychiatric nurses criticize proposal," *The Tribune*, Saturday, February 12, 1977, 3. "Nursing branch backed as distinct profession," *Winnipeg Free Press*, Friday, February 11, 1977. "Retention of psychiatric nurse training urged," *The Brandon Sun*, February 11, 1977.

101. PAM, GR 459, N-4, Tavener to O'Sullivan, March 3, 1977.

102. The Task Force Report, 6.

103. Annette Osted attended most of the Task Force hearings and kept detailed notes which have been preserved in the Archives of the CRPNM (hereafter The Task Force Presentations).

104. RPNAM presentation to the Task Force, February 11, 1977.

105. Note 25, chap. 5, this study.

106 The Task Force Presentation, February 11, 1977, 8.

107. PAM, GR 1280-2, Hartig and Pronyk to Dr. John Clark, Dean of Arts at University of Winnipeg April 18, 1977. They pointed out that the students from Selkirk Mental Health Centre had been taking Psychology, Sociology, and Anatomy and Physiology at the U of W for some time and suggesting that discussions should be held regarding a four year programme leading to a Bachelor of Psychiatric Nursing. Hartig reported to the curriculum sub-committee in May she felt the reception was positive and a committee was established with the University of Winnipeg. Brandon Mental Health Centre School of Nursing had been in discussion with the Brandon University in 1970 and 1971. These discussions resumed in 1977.

108. Ibid., Also The Register from Brandon notes that in 1969 students began taking, Psychology, Sociology and Zoology (Anatomy and Physiology) at Brandon University for audit or credit. In 1973 these course had to be taken for credit and in 1975 Behaviour Modification was added.

109. Private collection Terry Gibson. Discussions were held between the faculties of the Schools of Nursing at the General and Mental Hospitals in Brandon. In April 1970, Mrs. Jeanne Irving from Everett Community College, Washington held a workshop in Brandon about Associate Degree Programmes. Associate Degree was a method of nurses gaining degree education and was common in the United States. A workshop was held between the faculties June 29-July 17, 1970 to plan for a Regional School of Nursing. The plan was based on the associate degree model. Further meetings were facilitated by Shirley Jo Paine, Director, School of Nursing BGH. An Instructor was seconded from BMH to help. The minutes suggest a true spirit of cooperation existed between the two schools of nursing and the university. A

proposal was submitted to the Senate of Brandon University in December, 1970. . McKee Archives. RG6, BU fonds; 6.1 Senate Minutes Box 2, December 1970.

Paine believes that the proposal was turned down by the University Grants Commission because the concept of an associate degree in nursing was unfamiliar. Interview Shirley Jo Paine April 23, 2007. Phone call Robin Giles May 19, 2007. Giles was Dean of Science at Brandon University and was very supportive of the plan.

110. PAM, GR 459, H-14-21-1. Correspondence between Lorimer and Dulmage highlights the political conflict. Lorimer wrote to Dr. Dulmage, President of Brandon University, January 19, 1971 noting that there were plans in Winnipeg to establish a two-year diploma course in nursing at Red River Community College “It would hardly seem likely to me that we would establish one pattern in Winnipeg and a different pattern in Brandon.” Dulmage replied on January 29, 1971 observing that he was aware of the Red River College community college nursing diploma programme but was not aware of any policy in this connection. He went on “I would, however, respectfully submit that there may be differences in the Brandon and Winnipeg situations.”

111. McKee Archives, RG 6, 2.3.2. BU fonds Box 1, File 2, Minutes of Senate Meeting, March 24, 1971. The President reported on the conflict between the Minister of Education and the Minister of Health regarding nursing education and that the proposal to the Grants Commission was held up until the conflict was resolved. PAM, GR 5331, Minutes of the University Grants Commission meeting, June 18, 1971. The University Grants Commission decided that the nursing education policy should be resolved by the government before further discussions with Brandon University took place. On June 24, 1971 the University Grants Commission notified Brandon University that they would not approve the proposal for the Regional School of Nursing.

112. McKee Archives, RG 6, 6.2.4, BU fonds Box 1, File 1, Bachelor of General Studies Committee.

113. Private collection Terry Gibson, Wong to Cranna, February 21, 1973. Dr. Wong, Vice President, Brandon University, informed Miss Cranna, Education Director at Brandon General Hospital that the newly formed Bachelor of General Studies Committee had decided that nurses with an R.N. would qualify for 42 credit hours towards a BGS. The same was granted to Registered Psychiatric Nurses.

114. Private collection Terry Gibson. Brief from Brandon Mental Health Centre to the Task Force Hearings February 4, 1977. Brief from Brandon University to the Task Force Hearings February 4, 1977.

115. Private collection Terry Gibson, Minutes of Meetings March 3, March 16, April 13, April 28, May 12, May 25, 1977.

116. Private collection Terry Gibson, Minutes of Meeting April 28, 1977. Paine Interview April 23, 2007.

117. Private collection Terry Gibson, Giles to O'Sullivan May 30, 1977.

118. McKee Archives, RG 6, BU fonds Senate Minutes 6.1 Box 5, File 3 Minutes of Special Meeting of Senate, August 29, 1977.

119. Ibid.

120. Brandon University has a record of creating innovative programs such as the Bachelor of General Studies (BGS) and education programmes for native teachers such as Brandon University Native Teachers Education Project (BUNTEP).

121. PAM, GR 6852, University Grants Commission Minutes, October 22, 1977: "That the commission advise Brandon University that no further action be taken with regard to this program until the current Task Force on Nursing Education report has been considered by the Provincial Government."

122. PAM, GR 459, N-6, Sherman to Cosens, October 26, 1977

123. The Task Force Report.

124. Ibid, 1.

125. Ibid., 6. Justice O'Sullivan was a "Brandon boy" who was particularly interested in the Mental Hospital. He used to go there to play cards with patients and read to them. He was generally respectful of psychiatric nurses as he saw the valuable work they did. Informal conversation with his brother Patrick O'Sullivan.

126. Ibid., 14.

127. Ibid., 130.

128. Ibid., 96.

129. Ibid., 99-100.

130. See Martin, "Determinants of Destiny,"

131. Note 34 this chap. this study. See also for example, February 10, 1977, The Task Force Hearings. A panel member asked "Do you agree a nurse is a nurse?"

132. These terms were used in the 1974 and 1979 curricula.

133. The Task Force, Chapter XII.

134. The Task Force, 108.

135. Ibid., Chapter V11.

136. Ibid., 56.

137. Ibid., 61

138. CRPNM Archives, Pay Briefs of June 28, 1974 and January 31, 1975 presented to Manitoba Government.

139. CRPNM Archives, Minutes of Council Meeting, December 12, 1975.

140. CRPNM Archives, Minutes of Council Meeting, May 23, 1975.

141. CRPNM Archives, Minutes of Special Meeting, February 3, 1977.

142. PAM, GR 1555, 1280-2, Minutes of Special Meeting, April 6, 1977.

143. CRPNM Archives, Minutes of Annual Meeting April 21, 1978.

144. CRPNM Archives, Minutes of Annual Meeting, April 19, 1975.

145. CRPNM Archives, Minutes of Annual Meeting, April 23, 1976.

146. Annette Osted was a registered psychiatric nurse who graduated from Selkirk Mental Hospital in 1967. She was an active member of the council and was also Chairman of Communications and the Journal Committee, of P.N.A.C. She was employed as a R.P.N. in the psychiatric unit of the Winnipeg General Hospital from 1967 to 1969. She was editor of Prism (R.P.N.A.M. publication). She was the first female executive director of a Provincial Psychiatric Nurses Association. In British Columbia Dwight Wenham was the Executive Director. In Saskatchewan Henry Beauregarde held the position. She credits both these men with mentoring her. She has been a powerful advocate for psychiatric nursing and at this time has served as the Executive Director longer than any of the other three provincial executive directors. She was very involved in the work to get university education for psychiatric nurses at Brandon University.

147. CRPNM Archives, Minutes of Executive Meeting, June 13, 1977.

148. PAM, GR 1555, 1280-4, Minutes of Sub-committee on Curriculum, July 16, 1976.

149. PAM, GR 1555. 1280-2. When the 1979 curriculum was presented to Tavener, Miss Hartig included an explanatory note comparing the 1974 and 1979 curricula. The clinical hours and realignment of content were two of the points made by Hartig.

150. For comparison with the 1974 philosophy, see page 279, this chap.

151. Gertrude Torres and Helen Yura, *Today's Conceptual Framework: Its Relationship to the Curriculum Development Process*, 4-6.

152. Jean Kelley, "The Conceptual Framework in Nursing Education," in *Faculty-Curriculum Development Part VI* (New York: National League for Nursing, 1975): 15-20.

153. Appendix K, 1979 Curriculum model and explanation.

154. PAM, GR 1555. 1280-2, 1979 Curriculum.

155. PAM, GR 1555, 1280-3, Pronyk to Tavener. Pronyk notified Tavener that the Manitoba standards committee had worked on Standards I-IV and there would "have to be further meetings to seek agreement with the remaining standards as are being prepared by Saskatchewan, Alberta, and B.C." Feb 10 1976. The task of pulling together the work of this diverse group was given to the P.N.A.C. Education Committee under the chairmanship of John Crawford. He was an RPN and a psychiatric nursing educator in British Columbia.

156. PAM, GR 1555, 1280-1, Lipinski to Crawford, February 23, 1977.

157. BMHC Museum. Standards Committee on Psychiatric Nursing. *Working Paper on Standards of Practice*. Psychiatric Nurses Association of Canada; 1977. Unpublished Paper. In the introduction acknowledgement is made to the American Nurses Association for permission to use their "Standards of Psychiatric-Mental Health Nursing Practice, 1973."

158. PAM, GR 1555, 1280-1, Tregunna to Niskala and forwarded to Crawford, October 9, 1976.

159. Ibid.

160. Appendix L, Standards of Practice.

161. PAM, GR 1555, 1280-2, Minutes of Advisory Committee, July 5, 1979.

162. Interview Tom Street, May 14, 2007.

163. CRPNM Archives, Minutes of Council Meeting, May 28, 1976. No details pertaining to the cases were given. January 23, 1976 a four step process had been outlined.

164. CRPNM Archives, Minutes of Council Meeting, June 17, 1977.

165. CRPNM Archives, Minutes of Council Meeting, May 26, 1978.

166. Note 86, chap. 4, this study.

167. Interview Tom Street, May 14, 2007.

168. CRPNM Archives, Minutes of Council Meeting, March 11, 1977.
169. Ibid.
170. CRPNM Archives, Osted report attached to the Minutes of Council Meeting, December 8, 1978.
171. Interview Annette Osted, May 22, 2007.
172. Interview Tom Street, May 14, 2007.
173. The Legislative Assembly of Manitoba, Debates and Proceedings. Vol. XXV111, No. 111, (July 15, 1980), 5680.
174. Ibid., 5683.
175. The Legislative Assembly of Manitoba Standing Committee on Private Bills, July 16, 17, 18, 1980. July 16 they met until 2am. Friday July 18the committee reconvened at 8pm following a supper break. In 1960, when the first bill came to the house, no records were kept of Standing Committee proceedings. The records of the 1980 Standing Committee hearings therefore are particularly important. It can be seen the amount of explanation in which the RPNAM had to engage to support its position. These minutes also illustrate how the politicians responded to new information regarding nursing education in the province.
176. Legislative Assembly of Manitoba, Standing Committee on Private Bills, (July 18, 1980), 146.
177. Ibid
178. Note 179, chap. 4, this study.
179. Legislative Assembly of Manitoba, Standing Committee on Private Bills, (July 16, 1980), 32.
180. Ibid., 33.
181. Ibid., 32.
182. Ibid., 34.
183. Legislative Assembly of Manitoba, Debates and Proceeding. Vol XXV111, No. 134, (July 29, 1980), 6143, 6204.
184. PAM, GR 1555, 1280-2, Tavener to Committee, August 1, 1980.
185. PAM, GR 1555, 1280-2, Tavener to Reid, August 6, 1980.
186. PAM, GR 1555, 1280-2, Street to Tavener, September 23, 1980.

187. Interview Tom Street, May 14, 2007, and Interview Annette Osted, May 22, 2007.

188. PAM, GR 1555, 1280-3, Tavener to Sherman, October 10, 1980.

189. PAM, GR 1555, 1280-2, Minutes of Advisory Committee, November 6, 1980.

190. Tavener was the only remaining member of the original committee. However, Elinor Samels from Portage had been an original council member, had participated on various committees at the provincial and national level since 1960 and was still an active participant.

191. PAM, GR 1555, 1280-2, Minutes of Advisory Committee, November 6, 1980.

192. CRPNM Archives, Minutes of First Board of Directors Meeting, December 4, 1980.

CHAPTER 6

... AND BEYOND ...

Introduction

This study was an examination of the evolution and professionalization of registered psychiatric nursing in Manitoba, Canada, from 1955 to 1980. This examination revealed the contingent and politicized nature of psychiatric nursing, as well as the tenuousness of the profession, and the persistence with which the psychiatric nursing leadership of the first two decades strove to establish registered psychiatric nursing as part of the mental health system. In Manitoba, as in the other three western provinces, and unlike eastern Canada, Registered Psychiatric Nursing (RPN) is a distinct profession.

The most comprehensive study to date on psychiatric nursing in Canada is that of Veryl Tipliski who examined the development of education for psychiatric nursing in three Canadian provinces. She argued that the unique Canadian situation of two kinds of psychiatric nurses arose out of conflict. The male medical superintendents of the mental hospitals, and provincial nursing leaders each wanted to control psychiatric nursing education. In the west, the superintendents prevailed, but efforts to move this model east was halted at the Ontario-Manitoba border by actions attributed to the Registered Nurses Association of Ontario (RNAO).¹ Tipliski offered a gender explanation and argued that the western phenomenon, exemplified by the rise of psychiatric nursing in Saskatchewan, was the result of the reluctance of the female nursing leadership to stand up to the powerful male superintendents of the

mental hospitals.² Gender, however, fails to explain why the female nursing leaders of Ontario secured one model of psychiatric nursing, while in Saskatchewan a different model was secured. This suggests that there must be differences between nursing leadership in Ontario and Saskatchewan or, alternatively, that other factors influenced the outcomes.

Another explanation of the western phenomenon, as exemplified in Manitoba, is offered by Christopher Dooley. He suggested that the graduates of the *combined programme* at Brandon Mental Hospital (BMH) in the 1940s claimed a unique occupational identity based on their ability to manage difficult behaviour in unpredictable environments. He argued that this identity contributed to the establishment of the distinct profession in Manitoba.³ However, it was not the female graduates of this programme who worked to achieve distinct professional status in Manitoba.

The present study has offered an alternative explanation for the evolution of psychiatric nursing in Manitoba to those of Tipliski and Dooley. It posits that a number of socio-political, regional, legislative, gendered, and intellectual factors coalesced to form the distinct profession in this province. Implicit in this explanation is the suggestion that alternative disciplinary and educational paradigms for registered psychiatric nursing should be considered in the future.

This concluding chapter is divided into four sections. In the first, the framework of the study is reviewed; in the second, the questions are revisited and the answers are synthesized; in the third, important developments after 1980 are identified; and in the fourth, directions for future research are suggested.

The Framework

The purpose of a Foucauldian genealogical analysis is to create a usable past and a hopeful future through the identification of breaks, discontinuities, contingencies, and the *particular forces* which have given different meanings to social institutions and professions, such as psychiatric nursing. Rabinow observes that although Foucault is regarded as the “philosopher of discontinuity”,⁴ he also considered continuities. Long lines of continuity intersected by sharp lines of discontinuity provide a scaffold or flexible grid of interpretation for historical events and processes.

In this study, the continuity is that those who have been deemed mentally ill have always been cared for, taken care of, ignored, neglected, or managed in one form or another. The pattern of management has rested on the particular view of mental illness at the time, which determined both the titles of the caregivers as well as the nature of the care.⁵ The breaks and ruptures are the points at which the nature of the care took different forms for ideological or philosophical reasons, often under the guise of humanitarianism or progress. During the period of this study, the caretakers of the mentally ill assumed the title *psychiatric nurse* and established themselves as a professional body in Manitoba. The nature of the caring was determined by the political and the medical beliefs about mental illness, models of nursing education, and the gender and professional aspirations of the psychiatric nursing leaders. The scaffolding for this study was constructed from three interrelated themes:

- The socio-political, intellectual, and gendered *contexts* from which psychiatric nursing arose in Manitoba.

- The *decisions* made regarding the content, context, and control of the education of psychiatric nurses.
- The politicized and gendered *strategies* employed by the leaders to gain professional recognition.

The Questions of the Study and Synthesis of Findings

The scaffolding identified above has proven helpful in addressing the questions of this study, synthesizing the findings, and demonstrating the contingent and politicized nature of psychiatric nursing and psychiatric nursing education in Manitoba. The questions, as developed in Chapter 1, are as follows:

- What socio-political factors of the late 1950s led to the legislation of March 1960, in the Province of Manitoba, that created the new professional group, Psychiatric Nurses Association of Manitoba (PNAM), and who were the men and women involved in bringing it about?
- How did the legislation influence the evolution and professionalization of Registered Psychiatric Nursing in Manitoba?
- What role did men play in the development of psychiatric nursing when nursing is generally considered *women's work*?
- How did the disciplinary frameworks and traditions of general nursing influence the education and professionalization of psychiatric nursing?
- What educational processes and curriculum models guided the education of the new profession?
- What foundations were laid for the continuing evolution of the profession?

The socio-political, legislative, gendered, and intellectual factors identified by these questions contributed to the evolution and professionalization of registered psychiatric nursing in Manitoba in unique ways. These factors also laid the groundwork for further evolution of the profession after December 1980, which is the end-point of this study.

* * *

Psychiatric nursing education in Manitoba in the mid 1950s had characteristics of both the eastern and western Canadian models. It is argued that three sets of socio-political factors (described in Chapter 3) influenced the establishment of the western model of psychiatric nursing education. The first factor was the space created by the lack of interest in psychiatric nursing by the Manitoba Association of Registered Nurses (MARN). The second factor was the bond which formed with the three psychiatric nursing associations already established in western Canada, especially amongst the male leaders. The third factor was the political will to establish the profession in Manitoba.

It is argued that it was not necessarily the lack of MARN leadership or gender issues alone that accounted for the emergence of the distinct profession. There is no evidence that the MARN felt intimidated by the medical superintendents and deferred to them in the matter of the education of psychiatric nurses. The MARN had never taken much interest in the mental hospitals, unless they perceived a particular change as threatening to themselves. For example, in 1936, Dr Atkinson, superintendent of the Portage Home for the Feeble-minded, wanted to start a training programme for nurses. The MARN protested this initiative, but they seemed more concerned by the

fact that they had not been consulted rather than that the care to the feeble-minded might be improved by this training.

A second occasion on which the MARN could have demonstrated an interest in the training of psychiatric nurses was in 1954 when they were notified that the combined programme at BMH was to be discontinued by 1957. Despite the reality that all the instructors at BMH were Registered Nurses (RN), and they had good relationships with their colleagues at the Brandon General Hospital (BGH) and the local MARN chapter, the MARN board did nothing to assist in maintaining this programme. This was particularly unfortunate in light of the fact that the Canadian Nurses Association (CNA) had encouraged the development of a similar programme in British Columbia as a response to what was seen as the dilemma of western psychiatric nursing.⁶ The project in British Columbia was not successful, and it could have benefited both the CNA and the MARN to foster and maintain the successful programme already in place in Brandon.

Another occasion, (described in Chapter 4), on which the MARN expressed a concern about the rise of an alternative form of nursing care in the mental hospitals was at the enactment of legislation to establish the profession of psychiatric nursing in 1960. The response of the MARN was to determine whether or not the new legislation interfered with the right of RNs to practice psychiatric nursing in general hospitals. They decided it did not, and took no further action.

In 1976, (described in Chapter 5), the MARN challenged the need for a separate system of psychiatric nursing education. The MARN supported the belief, also held by the CNA, that psychiatric nursing should be a specialty of general

nursing. But this seems to have been more rhetoric than reality as there were very few general nurses in Manitoba willing to work in mental hospitals. In addition, they had only minimal education in care of the mentally ill. Recalling the early days of registered psychiatric nursing in this province, Gerald Pronyk says there was very little resistance from the MARN except at the time of *Challenge and Change*.⁷ It seems disinterest was one of the factors that helped create the space for the emergence of the separate profession in Manitoba.

A second set of factors that tilted Manitoba to the western model of psychiatric nursing was the relationship which formed with the psychiatric nursing group in Saskatchewan and the support and encouragement of the Canadian Council of Psychiatric Nurses (CCPN) which was based in western Canada.⁸ The move to a distinct profession in Manitoba began about the time Gladys Fitzpatrick came from Saskatchewan to BMH as Director of Nursing. Fitzpatrick had been the Director at North Battleford Mental Hospital where there was an active chapter of the Saskatchewan Psychiatric Nurses Association (SPNA). She may well have brought the ideology of a separate profession with her. It is recorded that she fostered the development of such a group in Brandon. There had been overtures from the CCPN to interested male attendants in Manitoba, but it was not until after Fitzpatrick's arrival that a more concerted effort took place.⁹ Her influence has never been formally acknowledged.

Further encouragement came from Saskatchewan. Two executive members of the CCPN, Max Schreder and Duke Leflar, resided at Weyburn. They visited Manitoba in 1957 to encourage the formation of an association. Perhaps because they

were men, these visitors appealed more easily to the emerging male leadership in Manitoba. Distance may also have been a factor. The drive from Weyburn to Brandon is about three hours, whereas Toronto is a formidable two day drive. Any influence from the east may well have been dampened by distance. There was also support from the other three western provinces, each of which had a male president.¹⁰ It is argued that the emergence of psychiatric nursing in Manitoba had more to do with ease of travel, regionalism, and male collegiality, than ideology.

The third set of factors concerns the politics of psychiatric nursing in Manitoba. The common and popular mythology gives credit to a number of male attendants for rallying themselves, and seeking and gaining legislation for psychiatric nurses. However, without the support of the medical superintendents, the likelihood of success would have been much less. Very shortly after the initiation of the first talks in Brandon in 1957, it became known that Dr. Pincock, Provincial Psychiatrist, had already enquired into different forms of legislation in the other western provinces. He recommended that the Alberta model was the most suitable for Manitoba.¹¹ The legislative form selected by Dr. Pincock and the superintendents, and drawn up by the legislative counsel, Mr. Rutherford, suited their own purposes. It left them in control of the education of psychiatric nurses. However, this was not the preferred form of Mr. Wilson, the lawyer who was acting for the psychiatric nurses.¹²

* * *

The legislation both facilitated and hindered the development of full professional status for the PNAM. Although the legislation was viewed as a progressive step by the new association, (described in Chapter 4), the *Psychiatric*

Nurses Association Act soon proved ineffectual in certain circumstances. The control of membership, one of the criteria of professionalism, was interfered with by the superintendents. The responsibility had been given to the approved schools of nursing for issuing the certificate of qualification to eligible students. But, at the request of the superintendents, this was rescinded three years after the act was implemented.¹³

Again, in 1969, by manipulating the regulations, the superintendents took away the legislated right of the PNAM to assess the credentials of out-of-country applicants. The ability of the association to establish criteria for professional membership was hampered by such interference.

On the other hand, the legislation was a public testament to the emergent professionalism of the group, which they invoked whenever they could. It also facilitated the initiation of standards, provided a framework to discuss further professionalizing strategies, and it gave the PNAM the right to form professional relationships with the psychiatric nurses associations in the rest of western Canada.

The second way in which the legislation had an impact on the profession was through the *Psychiatric Nurses Training Act* which established the Education Advisory Committee. This committee was given control over psychiatric nursing education which differed little from that previously held by the superintendents. The Advisory Committee wielded this power until 1968 when it established a curriculum sub-committee. The terms of this new curriculum sub-committee allowed more involvement of psychiatric nursing educators, some of whom had gained additional educational qualifications and many of whom were men. Two of the directors of

education at the time were men. At Selkirk, Gerald Pronyk was director; at Portage, John Kellie¹⁴

* * *

Men played a particularly significant role in the evolution of registered psychiatric nursing in Manitoba, just as they had in the other western provinces. The first five presidents of the new association were male, and men also held the important position of registrar. While women were certainly part of the association in the 1960s, it was men who took visible leadership roles. This would not have been uncommon at that time in situations where both men and women were members of a group. As Street simply says “that was the way things were in the fifties and sixties.”¹⁵

Men also achieved positions as directors of nursing as well as of education.¹⁶ Pronyk explains that, during his time as nursing director at Selkirk, the turnover of female staff was much greater than for the male staff. He suggests that, as in other professions, men were frequently a more stable part of the workforce.¹⁷ This obviously created more opportunities for advancement and, hence, positions of power.

The significant number of male staff in mental institutions seems to have had less to do with the need for strength, the popular explanation, and more to do with necessity. The mental institutions were strictly divided by gender and male patients had to be cared for by male staff. Street says that in the 1960s at the Portage School “even the cooks on the male side of the institution were male.”¹⁸ Dooley argues that the mental hospitals were also a suitable place of employment for young rural men.¹⁹

Given the presence of men, either to provide care or because they needed a job, it is not unexpected that they wished to have some form of recognition. Initially, the men were motivated by the desire for status and respect, as well as better pay, and saw the organization of an association as a way to achieve this. On the other hand, the senior female nursing staff who were RNs, had little need of an association for professional purposes. They were already registered with the MARN. Although the female non-registered nursing staff did not have any professional organization, they seemed less concerned about this than the men did. There were, however, some notable exceptions.²⁰

One of the strategies of the male leaders to achieve professional status was to seek a pay and classification system which identified the psychiatric nurse as a distinct class of worker. This, no doubt, reflected the union influence of the early leaders. They were familiar with the Manitoba Government Employees Association (MGEA), the bargaining agent for government employees, and saw it as a mechanism to help them gain recognition. In the early days of the association they often appealed to the MGEA to assist them to gain professional status. But the union culture was often at odds with the professional aspirations of the leaders. This was highlighted in the early days when certain members complained about the professional fees and wanted them deducted from their pay cheques in the same manner as their union dues. The response to this request was “*professionals* do not have fees deducted like union members”!²¹ However, it was not all about money and status. Many of the male leaders wished to see improvements to the education of psychiatric nurses, they

wanted to restrict membership to those who had attained certain standards, and they also wanted recognition for their own unique psychiatric nursing skills.

* * *

Nursing may have been a title of convenience rather than an accurate descriptor of the art and science of caring for the mentally ill. As described in Chapter two, psychiatric nursing arose in asylum environments, usually at the behest of the superintendents. The superintendents wished to be viewed in the same way as their medical colleagues in general hospitals. Having *trained nurses* in the *mental hospitals* was part of this process of the *medicalization* of insanity.²² This medicalization sometimes included surgical and intrusive procedures such as leucotomies and electro-convulsive therapies. Patients receiving these treatments required the same nursing care as any surgical patient. Nursing, therefore, became the accepted paradigm for those who worked alongside medical practitioners in mental hospitals. The title *nurse* gave credibility to the female assistants and to their roles.

When legislation was achieved in 1960, *psychiatric nurse* was the title of both men and women who became licensed. The title nurse was not uncontested. In Saskatchewan, Alberta, and British Columbia the use of the title was challenged.²³ In Manitoba, the use of the adjective *psychiatric* was consciously employed, not only to distinguish the profession, but also to avoid conflict with the dominant category of nursing, the RN.²⁴

As well as the title, other concepts were borrowed from the paradigm of nursing such as style of uniforms, control of young female students in nurses' residences, and most of all, the language of nursing. At times this was of help to the

new profession, at other times it confused the distinctiveness of psychiatric nursing. Explaining the distinctiveness of psychiatric nursing has always been a challenge. For example, at the Task Force hearings the psychiatric nurses had to respond to such statements as, “Why do you call this profession (psychiatric nursing) nursing at all?” and, “A nurse is a nurse is a nurse!”²⁵

Psychiatric nurses have found their own ways to explain psychiatric nursing.

For example, Pronyk observed:

When talking about a general illness like a fracture or a medical condition you are really talking about the physical condition. Whereas mental health [illness] is essentially a condition that results when people are unable to cope with society or what society has to offer so they develop a whole range of mental illnesses whether it is hereditary based (and the jury is still out on that). In order to deal effectively with the mentally ill client you need to develop the necessary communication skills to win their trust, their respect, have them feel comfortable, so the patient feels. “This is somebody I can work with” and in conjunction with medication can be in a position to manage the feelings of paranoia and delusions and can return to society and be a productive member. It is not like dealing with a broken leg which is going away tomorrow.²⁶

Susan Wood, in her study of psychiatric nursing education in Saskatchewan, identified the term *accompaniment* to describe the particular kind of relationship between psychiatric nurses and patients.²⁷ Annette Osted explained psychiatric nursing by stating, “We deal with people. We deal with feelings, with emotions, with the soul.”²⁸ Janissa Read, a psychiatric nurse, claimed there was a spiritual component to the practice of psychiatric nursing that was hard to define. She believed, “We will always need a legal and political definition because what we *really* do cannot be categorized.”²⁹

Sometimes the intangibility of what psychiatric nurses *really* do makes it difficult to explain to others:

It is hard to sell intangibles. Giving injections is something tangible that everyone understands. It is hard to sell *connections with other human beings* because people like to relate to the CAT scans, artificial heart valves and chemotherapies. When you look at the mentally ill there just aren't those things.³⁰

* * *

Despite the difficulty of explaining psychiatric nursing, and the view that it is a distinct profession, many concepts from general nursing were adopted in the development of psychiatric nursing curricula and materials. When the nursing educators were allowed to be more involved in curriculum development it evolved from a one page list of courses to a highly complex document. A philosophical shift was also reflected in the curriculum. Kellie observed that the curriculum moved from a medical model to a psychosocial nursing model.³¹ But even as curriculum revisions took place between 1968 and 1979, the influence of nursing and the dominant Tyler curriculum framework remained evident.³²

Elisabeth Hartig, director of education at Selkirk Mental Hospital (SMH), reported, in 1978, on a workshop in which she demonstrated the incorporation of the Standards of Practice into the curriculum. She opened by stating, "The model of curriculum development presented was that of Ralph W. Tyler."³³ Hartig also insisted that every learning objective in the curriculum must be related to a standard of practice.³⁴ The persistence of the classic Tyler model in curriculum planning for psychiatric nursing education and the strict adherence to a rigid set of objectives may, however, have limited the examination of alternative educational frameworks.

The nursing content of the curricula was divided into two sections, basic nursing and psychiatric nursing. Initially, it was not easy to identify what was meant

by psychiatric nursing. It seemed to be predominantly knowledge of mental illness. Until 1968, the number of hours devoted to psychiatry exceeded those devoted to psychiatric nursing. Subtle shifts occurred in the 1974 curriculum with the inclusion of the therapeutic nurse/patient relationship. Medical diagnoses were dropped as the classificatory system of mental illness and behavior patterns were substituted. Nursing process became part of the vocabulary of the 1974 curriculum although, oddly, it was only applied to the medical-nursing section. The objective states, "Utilizes the nursing process appropriately in providing medical-surgical nursing care."³⁵ Nursing process did not appear in the psychiatric nursing section. Nevertheless, this curriculum represented a significant milestone in the evolution of psychiatric nursing education. As described in Chapter five, a curriculum model and standards of practice were added to the 1979 curriculum.

The general nursing content is easily identified, although the extent to which general nursing knowledge is required for psychiatric nursing has always been in doubt. The discontinuation of the *combined programme* in 1957 suggests that the general nursing content was either unnecessary, or had only political value. Had the general nursing content been essential for care of patients with mental illness, the superintendents would never have allowed the discontinuation of the programme. Ten years later, when John Martyniw was president, the same fate befell the Licensed Practical Nursing (LPN) portion of the psychiatric nurse's training. Martyniw was particularly adamant about discontinuing the LPN. His reasoning was undoubtedly political. He viewed nursing in Manitoba as hierarchical and believed that being an LPN was a liability for psychiatric nurses. Nevertheless, the same general nursing

content of the LPN programme remained in the revised 1968 psychiatric nursing curriculum, but the students from then on did not receive the LPN diploma. This certainly illustrates that curricular content may serve a political as well as a knowledge purpose.

The context of care also influenced the educational process. The context goes beyond the content outlined in the curriculum and transmitted in the classroom. Learning the art of nursing was often part of the experience gained in ward settings. In an environment in which a significant portion of therapy consisted in the management of daily life, the development of basic living skills, and the articulation of life issues and emotional distress through *talk therapy*, the required nursing skills were not easy to define. Defining and protecting a domain of practice is an act of professionalization.

* * *

Identifying and claiming a unique domain of practice was an important goal of psychiatric nurses in Manitoba in the 1960s and 1970s. Through legislation, they gained distinct professional status, and through persistence and certain fortuitous decisions, they achieved respect and a place in the mental health system. Defining their unique domain of practice may be more challenging. In what way did these accomplishments of the first two decades form the foundations for the continuing evolution of the profession? The foundations laid during the first twenty years were contingent, political, and regional. They resulted from the jolts and surprises of history. But if the past is not fixed then many possible futures may be envisaged.

What future was on the mind of the outgoing Advisory Committee chair, Dr. Tavener, and echoed by the president, Tom Street, and executive director, Annette Osted, when they asked themselves in 1980, “Are we ready?” The question signaled a transition to a new phase in the evolution and professionalization of registered psychiatric nursing in Manitoba. Were psychiatric nurses *ready*, not only to manage their own affairs, but also to continue to evolve professionally and build new models of practice and education on the foundations laid in the first twenty years?

Post 1980 Developments

Following the 1980 legislation, the profession continued to evolve. New socio-political, gender, and educational factors influenced the direction of the profession. Some were the result of professionalization efforts of the RPNAM, while others reflected changes to the political, medical, and nursing views of mental illness and its care. Although a full account of these developments is beyond the scope of this study, some of these are highlighted here to illustrate the ongoing challenges to the profession and point to directions for future research.

* * *

The new act gave authority to the RPNAM to control its own education, and a partnership was formed with Brandon University (BU). This university continued to show leadership in the education of psychiatric nurses. In 1986, BU offered a post-diploma degree to RPNs called Bachelor of Science in Mental Health (BScMH). In 1995, Brandon offered the first undergraduate degree in psychiatric nursing in Canada called Bachelor of Science in Psychiatric Nursing (BScPN). To achieve these goals, registered psychiatric nurses had to develop new political and negotiating skills.

Other political and medical events impacted the continuing evolution and professionalization of registered psychiatric nurses in the 1980s and 1990s. As the large mental institutions closed or downsized, new community models of care were established. These changes necessitated the development of new skills for psychiatric nurses. Continuing medical research into brain functioning and the medicalization of more and more events of everyday life also affected psychiatric nursing practice.

Nursing scholars responded differently to changing concepts of the meaning and management of mental illness, and the personal experiences of those deemed mentally ill. Some scholars welcomed the biological approach to mental illness, such as Susan McCrone, who stated, “It seems that psychiatric nursing, like psychiatry, has returned to an era where the brain has become the focus of investigation.”³⁶ Others, like Jan Horsfall, cautioned against such a medical epistemology that considered a disordered mind as the result of a damaged brain. She wondered, “What is a nurse to do if mental illness is caused by neurotransmitter depletion or excess and medication is meant to rectify the uptake at the receptor level?”³⁷ Reducing emotional experiences to chemical reactions at synapses, and emotional suffering to *bad chemistry* takes away from the humanity of both patient and nurse. These questions are also philosophical in nature: Is the brain the mind?

Laura Dzurec suggested that it has become more acceptable to examine such philosophical questions as the mind/body problem. She also asserted that there is more openness in discussing existential and spiritual issues.³⁸ Colin Holmes suggested a shift from a materialist epistemology. He reflected on alternatives to natural science foundations for nursing, especially psychiatric nursing, which he says

should employ a phenomenological approach. He also adds, “I detect a long over-due desire to help clients clarify and meet their spiritual needs (often framed in terms of Frankl’s will to meaning).”³⁹

Canadian psychiatric nursing scholars have begun to focus on issues unique to psychiatric nursing. For example, John Simpson explored what caring meant to people with developmental disabilities.⁴⁰ Michel Tarko developed a substantive theory of the meaning of spirituality as experienced by people with schizophrenia.⁴¹ Renee Robinson explored the perception of adjustment of individuals with severe and persistent mental illness who had been moved from institution to community, and the role that community resources, such as recreation and housing, played in successful adjustment.⁴²

These varying perspectives illustrate the complexity of understanding mental illness, which can range from a chemical imbalance in the brain to an existential crisis. Individuals deemed mentally ill may experience these phenomena simultaneously, and, at the same time they may be challenged to learn to live safely in a world that does not always value them. People with mental illness, and their care-providers, must also negotiate community environments that are not always friendly towards the mentally ill. Psychiatric nurses, as careproviders, therefore, require perspectives and skills that are flexible, creative, intuitive, as well as politically sophisticated.

New approaches to practice must be guided by appropriate skills and knowledge developed through suitable educational practices. The development of such complex perspectives and skills requires an examination of the epistemological

and ontological underpinnings of psychiatric nursing practice and education, and how such philosophical perspectives could be reflected in the curriculum. As meanings of mental illness change, and language and knowledge becomes less stable, traditional curriculum frameworks which view knowledge as scientific, immutable, and transmittable may be less satisfactory to the present day education of psychiatric nurses.

Traditional educational frameworks have been challenged in recent curriculum literature. Phenomenology, postmodernism, hermeneutics, and aesthetics, for example, offer alternative perspectives on knowledge creation and the educational process.⁴³ Such approaches seem well suited to the development of perspectives and skills for the practice of psychiatric nursing.

Changes in approaches to practice are not only influenced by changes in understanding of the illness experience but also by political and economic considerations. Just as psychiatric nursing in the asylums of the past was a response to different medical and political contingencies, so too the practice of psychiatric nursing today is guided as much by patient needs as by the present climate of accountability and the move to evidence-based practice.

Psychiatric nurses have always practiced according to the best knowledge of the day but evidence-based nursing practice is now more of an expectation than ever. Evidence-based practice is described as the “integration of best possible research evidence, with clinical expertise and patient needs to facilitate clinical decision making.”⁴⁴ Developing and utilizing research evidence in the practice of registered

psychiatric nursing is a new frontier which is now opening up as graduate studies programmes are being developed and the profession continues to evolve.

Directions for Future Research

The findings of this study have revealed a complex past, beset by trials and triumphs. Psychiatric nursing in Manitoba was, and still is, a political construction. But it can continue to evolve professionally, move beyond its legislative distinctiveness, and contribute in a meaningful way to the understanding of the experience of those deemed mentally ill. It can engage in a thoughtful examination of its historical and philosophical roots, define itself at the epistemological and ontological levels, and undertake research that contributes to a unique body of knowledge.

There are a number of areas that remain to be explored. First, the gender composition of the profession has changed. Today there are only about half the number of men practicing psychiatric nursing as there were in 1960, while women have become more involved in leadership positions. Second, psychiatric nurses' roles have continued to expand. These distinct roles need to be more clearly articulated. Third, changing concepts of mental illness and contexts of care have had an impact on the practice of psychiatric nursing. These changes in practice require different educational preparation and an examination of different educational strategies. In particular, alternative curriculum models need to be explored. Fourth, alternative forms of knowledge, such as that derived from art and literature might be incorporated into the curriculum. Fifth, spiritual and existential frameworks for understanding emotional suffering could become central to the practice of psychiatric

nursing education and practice. Finally, biographical studies of acknowledged and unacknowledged leaders of the profession could help illuminate what has been achieved in the past.

These future research directions suggest that in order for this profession to grow and evolve, it must continue to examine its roots, icons, practices, and philosophy.

Endnotes Chapter 6

1. Tipliski, "Parting at the Crossroads: The Development of Education for Psychiatric Nursing."

2. Ibid. chap 5.

3. Dooley, "When Love and Skill Get Together."

4. Paul Rabinow, *The Foucault Reader* (New York: Pantheon Books, 1984): 9.

5. It was not the purpose of this study to enter into a philosophical discussion of the meaning of mental illness. There is a long tradition of changing concepts of the meaning of mental illness and speculation as to its causes. These assumptions about the nature and cause of mental illness have always determined how the mentally ill should be treated. See for example: Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. Micale and Porter, eds., *Discovering the History of Psychiatry*. F.G. Alexander and S.T. Selesnick, *The History of Psychiatry: An Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present* (New York: Harper&Row, 1966). G. Zilboorg, *A History of Medical Psychology* (New York: W.W. Norton, 1941).

6. Note 1, chap. 3, this study.

7. Interview Gerald Pronyk, July 12, 2007.

8. Notes 136 and 138, chap. 3, this study.

9. Note 139, chap. 3, this study

10. The first president of the British Columbia Association, which was formed in 1947 was Wilf Pritchard. In Saskatchewan the first president in 1948 was Bill Vowles. In Alberta in 1950 Ted James was the first president. Men continued to be leaders in each province for a number of years.

11. Note 148, chap. 3, this study.

12. Note 152, chap. 3, this study.

13. Notes 78, 79 and 80, chap. 4, this study.

14. Note 221, chap. 4, this study.

15. Interview Tom Street, May 14, 2007.

16. For example, at Portage throughout the 1960s and 1970s, three men were Directors of Nursing. These were Amie Omichinski, Bryon Flatman, and Morris Irwin. In Brandon, Art Russell became Director of Nursing in 1969. In Selkirk, John Burns was Director of Nursing from 1964-1972 followed by Gerald Pronyk, who was Director from 1972-1991.

17. Interview Gerald Pronyk, July 12, 2007.

18. Interview Tom Street, May 14, 2007.

19. Dooley. *Needle Nurses or People Persons*. Paper presented.

20. There were some notable women in psychiatric nursing in Manitoba. Elinor Samels graduated from Portage School, Psychiatric Nurse Training programme in 1946. She was actively involved in the development of the PNAM during the late 1950s. She was on the first council in 1960 and was a member of the Education Advisory Committee. She was still involved in the Education Committee in 1980. Marlene Fitzsimmons, who graduated from Portage in 1962, was very active in the association and became the first female president in 1983. She has achieved awards for outstanding contributions to the profession.

21. Interview Remi Beaudette November 27, 2006. Beaudette recalls in 1960 complaints were made about the annual fee of ten dollars. CRPNM Archives, Minutes of Annual Meeting, January 29, 1965.

22. For example, when major changes were instituted at the asylums in Manitoba in 1919, the new superintendents identified the importance of having trained nurses. All psychiatric nursing studies stress the importance of having *nurses* as the working title and paradigm of choice. Also see Church, Boschma, Nolan, Prebble.

23. All four western provinces reported experiences of conflict around the title nurse. The Saskatchewan situation has been described by Kahan, *A Different Drummer* and Martin *Determinants of Destiny*: In Saskatchewan this became an issue and optional titles were suggested. In British Columbia a note was made in the minutes of the first meeting in 1947 that the general nurses expressed concern about the use of the title. A similar situation occurred in Alberta.

24. Note 61, chap. 4, this study.

25. CRPNM Archives Task Force Hearings, February 10, 1977.

26. Interview Gerald Pronyk, July 12, 2007.

27. Wood, "Changing Times,"

28. Annette Osted, "A Narrow Line—Empathy but not Involvement," *The Canadian Journal of Psychiatric Nursing* X111(3) (May-June, 1972): 5.
29. Interview Janissa Read, October 6, 2007. Read is a psychiatric nurse who also has an RN. She graduated from BMHC in 1977. She took the additional nursing education "for the sake of learning more" but also because she was working in eastern Canada. Her perspective on having both the psychiatric nursing and general nursing training is that "being a psychiatric nurse first, makes you a better general nurse. Read had also been the RPNAM representative on the Education Advisory Committee in 1977.
30. Interview Gerald Pronyk, July 12, 2007.
31. Kellie, "A History of the School of Nursing: The Manitoba Developmental Centre."
32. There were three major curricula revisions conducted by psychiatric nursing educators during the period of the study, one in each of 1968, 1974 and 1979. Each one became progressively more complex and detailed. Although the content was updated the basic structure remained the same.
33. Elisabeth Hartig. "Developing a Psychiatric Nursing Curriculum Incorporating the Standards of Practice for the Registered Psychiatric Nurse," *The Canadian Journal of Psychiatric Nursing* X1X (1) (January-February 1978) 6-7. 6.
34. Ibid.
35. 1974 Curriculum, Medical-Surgical Nursing section.
36. Susan Mc Crone. "The Impact of the Evolution of Biological Psychiatry on Psychiatric Nursing," *Journal of Psychosocial Nursing* 34 (2) (1996): 38-46. 44, 45.
37. Jan Horsfall. "Psychiatric Nursing: Epistemological Contradictions," *Advances in Nursing Science* 20 (1) (1997): 56-65, 59.
38. Laura Dzurec. "Poststructuralist Musings on the Mind /Body Question in Health Care." *Advances in Nursing Science* 26 (1) (2003): 63-76.
39. Colin Holmes. "Alternatives to Natural Science Foundations for Nursing." *International Journal of Nursing Studies* 27 (3) (1990): 187-198, 195.
40. John Simpson. "An Interpretation of the Concept of Caring by People with Developmental Challenges." (master's thesis, Brandon University, 1996).

41. Michel Tarko “A Grounded Theory Study of the Experience of Spirituality among Persons Living with Schizophrenia.” (Ph.D. diss., University of British Columbia, 2002).

42. J. Renee Robinson “Rural Mental Health Services for People with Severe and Persistent mental illness: Organization and Effectiveness.” (Ph.D. diss., University of Manitoba, 2005).

43. William F. Pinar, William M. Reynolds, Patrick Slattery and Peter M. Taubman. *Understanding Curriculum: An Introduction to the Study of Historical and Contemporary Curriculum Discourses*, This work gives a particularly comprehensive view of multiple curriculum discourses, all of which could be examined for their potential contribution to psychiatric nursing education.

44. Alba DiCenso, Donna Ciliska and Gordon Guyatt. “Introduction to Evidence-Based Nursing.” In *Evidence-Based Nursing: A Guide to Clinical Practice*. (St. Louis: Elsevier Mosby, 2005) 4.

Appendix A



UNIVERSITY
OF MANITOBA

OFFICE OF RESEARCH
SERVICES
Office of the Vice-President (Research)

244 Engineering Bldg.
Winnipeg, MB R3T 5V6
Telephone: (204) 474-8418
Fax: (204) 261-0325
www.umanitoba.ca/research

APPROVAL CERTIFICATE

28 June 2005

TO: Beverley Hicks (Advisor D. Hlynka)
Principal Investigator

FROM: Stan Straw, Chair
Education/Nursing Research Ethics Board (ENREB)

Re: Protocol #E2005:037
"From Barnyards to Bedsides to Books: An Examination of the
Transitions in Psych. Nursing Education"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note that, if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Appendix B

AN AGREEMENT RESPECTING DISCLOSURE OF INFORMATION
FOR RESEARCH PURPOSES UNDER SECTION 47 OF
THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

BETWEEN:

THE GOVERNMENT OF MANITOBA

- and -

BEVERLEY HICKS

Prepared by:

**Civil Legal Services
Department of Justice
7th Floor - 405 Broadway
Winnipeg MB R3C 3L6**

An Agreement Respecting Disclosure of Information for Research Purposes under Section 47 of *The Freedom of Information and Protection of Privacy Act* dated September 26, 2005.

BETWEEN:

THE GOVERNMENT OF MANITOBA,
represented by the
Minister of Health

(called "Manitoba")

-- and --

BEVERLEY HICKS

(called the "Researcher")

WHEREAS:

- A. The **Researcher** has requested access to certain information, including personal information, in the custody or under the control of the Department of Health of Manitoba for research purposes;
- B. The Access and Privacy Officer for the Department of Health, the designated officer of the Department of Health for the purposes of *The Freedom of Information and Protection of Privacy Act* of Manitoba (C.C.S.M. c. F175), has approved disclosure of personal information to the **Researcher** for the research purpose described in subsection 2.01 of this Agreement, in accordance with the provisions of section 47 of *The Freedom of Information and Protection of Privacy Act*, subject to the **Researcher** entering into this Agreement;

MANITOBA AND THE RESEARCHER AGREE AS FOLLOWS:

SECTION 1.00 - DEFINITIONS AND INTERPRETATION

1.01 In this Agreement:

- (a) "Copied Information" means information that the **Researcher** has copied in accordance with section 3.02(a) of this Agreement;
- (b) "Department" means the Department of Health of Manitoba;

- (c) *"The Freedom of Information and Protection of Privacy Act"* means *The Freedom of Information and Protection of Privacy Act* of Manitoba, C.C.S.M. c. F175, as amended from time to time;
- (d) "Information" means any information which is provided to the **Researcher** by **Manitoba**, or acquired by the **Researcher** from **Manitoba**, in any manner, form or medium, and includes any notes taken by the **Researcher** and any Copied Information and includes Personal Information;
- (e) "Personal Information" has the meaning given to that term in *The Freedom of Information and Protection of Privacy Act* and includes
 - (i) any information about an identifiable individual;
 - (ii) an individual's name, address, date of birth; and
 - (iii) and any other information about an individual which, alone or in combination with other information, could lead to the identification of that individual.

1.02 The requirements and obligations in this Agreement respecting the Information:

- (a) apply to all Information provided to the **Researcher** by **Manitoba**, or received by the **Researcher** from **Manitoba**, in whatever manner, form or medium;
- (b) apply whether the Information was provided or received before or after the signing of this Agreement; and
- (c) continue to apply after the termination or expiration of this Agreement.

1.03 The following schedules form part of this Agreement whether attached hereto or incorporated by reference in this subsection:

Schedule "A" – List of Records to be Accessed by the Researcher

Schedule "B" – Security Arrangements (Subsection 5.02)

Schedule "C" – Certification of Destruction of Information (Subsection 6.03)

SECTION 2.00 - RESEARCH PURPOSE

2.01 The **Researcher** has requested access to Information in the custody or under the control of the Department for the following research purpose:

- Conducting a research thesis concerning the evolution, education and professionalization of psychiatric nurses in Manitoba from 1955 to 1980.
- Completion of the Ph. D. dissertation concerning the evolution, education and professionalization of psychiatric nurses in Manitoba from 1955 to 1980.

The research proposal has been reviewed and approved by the University of Manitoba and is being completed under the supervision of Dr. D. Hlynka of the Department of Education of the University of Manitoba.

2.02 The **Researcher** shall have access to the information from October 1, 2005 to no later than October 1, 2006. The Information requested by the **Researcher** from the Department under subsection 3.01 will be required on or about October 1, 2005.

2.03 Prior to Manitoba providing any Information to the **Researcher**:

- (a) the Education/Nursing Research Ethics Board must approve the **Researcher's** ethics protocol;

SECTION 3.00 - ACCESS TO INFORMATION BY THE RESEARCHER

3.01 Access by the **Researcher** to the Information in the custody or under the control of the Department, set out in Schedule "A" to this Agreement by Manitoba Archives file and box number, for the research purpose described in subsection 2.01 of this Agreement has been approved subject to the terms and conditions of this Agreement.

3.02 Subject to the terms and conditions of this Agreement, the **Researcher** may have access to the Information described in subsection 3.01 in the following form and manner:

- (a) the **Researcher** shall have access to the Information and may identify and make copies of information ("Copied Information") that she determines to be relevant to her research purpose as described in subsection 2.01 of this Agreement;

- (b) The **Researcher** shall make arrangements to view the records in consultation with staff at Archives of Manitoba, Department of Culture, Heritage & Tourism:

3rd floor, 200 Vaughan Street
 Winnipeg, MB. R3C 1TC
 Phone: (294) 945-1785

- (c) the **Researcher** may take notes on the Information that she has access to under this Agreement; and
- (d) the researcher may not remove any Information from the premises of Manitoba Archives except her notes and the Copied Information.

3.03 The **Researcher** agrees and acknowledges that **Manitoba** owns all title to and rights and interest in any Information provided by **Manitoba**, including copyright, intellectual property and other proprietary rights.

3.04 The **Researcher** shall pay all reasonable fees and costs, as determined by the Department, with respect to access by the **Researcher** to the Information under this Agreement.

SECTION 4.00 - OBLIGATIONS OF RESEARCHER RESPECTING USE AND DISCLOSURE OF INFORMATION

4.01 The **Researcher** undertakes that:

- (a) the **Researcher** shall keep the Information and any notes taken in strict confidence;
- (b) only the **Researcher** may access the Information shall be used only by **Researcher** and shall be used by the **Researcher** personally;
- (c) the **Researcher** shall use the Information solely for the research purpose described in subsection 2.01 of this Agreement and for no other purpose; and
- (d) the **Researcher** shall not permit the Information to be used for any purpose other than the research purpose as described in subsection 2.01 of this Agreement.

- 4.02 The **Researcher** shall ensure that no Personal Information or other information will be used, disclosed, published or made available in any manner, form or medium (including, without limitation, in any research results, research paper or publication respecting the research and in any related presentation) in a manner which could reasonably be expected to identify any individual. Without limiting the foregoing, the **Researcher** shall ensure that the results of the research described in subsection 2.01 of this Agreement and any related paper, publication or presentation does not include any information, including Personal Information, which either by itself or when combined with other information could reasonably be expected to identify any individual.
- 4.03 The **Researcher** agrees to provide a copy of the results of the research described in subsection 2.01 of this Agreement or any related research paper to the Department upon completion of the research but prior to publication of any results of the research or any research paper and shall comply with any request of the Department to remove from the results or paper any information which, in the reasonable opinion of the Department could identify any individual. The **Researcher** shall clearly state in the research results or research paper that the views, opinions and conclusions contained therein are the **Researcher's** own and have not been endorsed or approved by the Government of Manitoba.
- 4.04 The **Researcher** agrees to provide to the Department a copy of the final version of the results of the research or any related research paper on publication and agree that the Department may freely use and reproduce the results and any related research paper for non-commercial purposes.
- 4.05 The **Researcher** shall not:
- (a) make copies or reproductions of the Information, in whole or in part, in any manner, form or medium;
 - (b) use the Information received from the Department, or any part of it, to develop, establish, expand, modify or maintain a database or other collection of information in machine-readable form or any other form;
 - (c) contact, directly or indirectly, any individual, corporation, business, agency, organization or entity the Information is about;
 - (d) use the Information to sell goods or services to any individual, corporation, business, agency, organization or entity the Information is about;

- (e) sell or disclose the Information, or any part of the Information, for consideration, or exchange the Information for any goods, services or benefit; or
- (f) give the Information to any individual, corporation, business, agency, organization or entity for any purpose, including (but not limited to) for solicitation for charitable or other purposes;

and shall not permit any of these activities to take place by any other person.

SECTION 5.00 - PROTECTION OF INFORMATION AND SECURITY ARRANGEMENTS

- 5.01 The **Researcher** represents and warrants that the **Researcher** shall put in place reasonable security arrangements, including administrative, technical and physical safeguards that ensure the confidentiality and security of the Information and protect the Information against such risks as use, access and disclosure which are not authorized under this Agreement. These security arrangements shall take into account the sensitivity of the Information and the medium in which the Information is stored, handled, transmitted or transferred.
- 5.02 Without limiting subsection 5.01 of this Agreement, the security arrangements which the **Researcher** shall put in place shall, as a minimum, include the security arrangements described in Schedule B to this Agreement.
- 5.03 In addition to complying with the requirements and obligations in this Agreement, the **Researcher** shall comply with any additional reasonable requirements established by **Manitoba** from time to time to protect the Information and shall provide such information and confirmation respecting security arrangements as may be requested by **Manitoba** from time to time.

SECTION 6.00 - DESTRUCTION OF INFORMATION

- 6.01 As directed by the Department, the **Researcher** shall destroy the Information (and all copies of the Information in whatever form or medium):
- (a) immediately upon completion of the research purpose described in subsection 2.01 of this Agreement; or
 - (b) in any event, and notwithstanding any other provision of this Agreement, no later than October 1, 2007.

- 6.02 Where the **Researcher** is directed or required to destroy the Information, or a copy of it, destruction shall be carried out in a manner which adequately protects the confidentiality of the Information and which is appropriate to the medium in which the Information is recorded.
- 6.03 The **Researcher** shall provide certification in writing to **Manitoba**, in the form attached as Schedule "C", of destruction of the Information in accordance with subsections 6.01 and 6.02 of this Agreement.

SECTION 7.00 - REPORTS, MONITORING AND ENFORCEMENT

- 7.01 The **Researcher** shall, immediately upon becoming aware of any of the following, notify **Manitoba** in writing of:
- (a) any use of, access to or disclosure of the Information which is not authorized by this Agreement; and
 - (b) any breach of any term or condition of this Agreement by the **Researcher**;

with full details of the unauthorized use, access or disclosure or of the breach. The **Researcher** shall immediately take all reasonable steps to prevent the recurrence of any unauthorized use, access or disclosure of the Information, or to remedy the breach, and shall notify **Manitoba** in writing of the steps taken.

- 7.02 **Manitoba** and its representatives may carry out such inspections or investigations respecting the use and handling of the Information by the **Researcher** and respecting the **Researcher's** security arrangements as **Manitoba** considers necessary to ensure that the **Researcher** is complying with the terms and conditions of this Agreement and that the Information is adequately protected. The **Researcher** shall cooperate fully in any such inspection or investigation. If any inspection or investigation identifies deficiencies in the information practices or security arrangements of the **Researcher**, the **Researcher** shall take steps to correct the deficiencies immediately to the satisfaction of **Manitoba**.

7.03 Where

- (a) **Manitoba** is reasonably of the opinion that the **Researcher**:
 - (i) has used, permitted access to or disclosed the Information in a manner which is not authorized under this Agreement, or is about to do so,
 - (ii) has not adequately protected the Information from risks such as unauthorized use, access or disclosure, or

- (iii) has failed to comply with, or is about to fail to comply with, any of its obligations or undertakings under this Agreement; or
- (b) **Manitoba** is reasonably of the opinion that there is a conflict between any term or provision of this Agreement and a recommendation of the Ombudsman of Manitoba or a decision or order of any court or tribunal, under any statute, regulation or other legislation, affecting access to information, protection of privacy or this Agreement;

Manitoba may terminate this Agreement at any time by written notice, effective immediately or as of the date set out in the notice.

7.04 On termination of this Agreement for any reason, the **Researcher** shall immediately:

- (a) refrain from any further use of, access to, disclosure of and activities and transactions involving the Information; and
- (b) as directed by **Manitoba**, return or destroy all Information which has been received from **Manitoba** (including, without limitation, all copies in any form or medium). Where the Information is required to be destroyed, destruction shall be in accordance with subsection 6.02 of this Agreement and the **Researcher** shall provide certification in writing of destruction, in the form attached as Schedule "C".

7.05 In addition to its rights under subsection 7.03 of this Agreement or any other rights **Manitoba** may have under this Agreement or otherwise, if **Manitoba** is of the opinion that the **Researcher** has used, permitted access to or disclosed any Information in a manner which is not authorized under this Agreement, or is about to do so, **Manitoba** may report these activities to any one or more of the following for appropriate action:

- (a) the Education/Nursing Research Ethics Board which approved the research;
- (b) any body or bodies sponsoring or funding the research;
- (c) any professional association or disciplinary or other body with jurisdiction to discipline, supervise or regulate the **Researcher**;
- (d) thesis advisor Dr. D. Hlynka of the Department of Education of the University of Manitoba.

SECTION 8.00 - GENERAL

- 8.01 While this Agreement is in effect, and at all times thereafter, the **Researcher** shall be solely responsible for and shall save harmless and indemnify the Department and Manitoba, and their ministers, officers, employees and agents, from and against all claims, liabilities and demands of any kind with respect to any injury to persons (including, without limitation, death), damage to or loss of property, economic loss or incidental or consequential damages or infringement of rights (including, without limitation, privacy rights) caused by, or arising directly or indirectly from:
- (a) the provision of any Information by **Manitoba** to the **Researcher**;
 - (b) the breach of any term or condition of this Agreement by the **Researcher**, or an employee or agent of the **Researcher**; and
 - (c) any omission or wrongful or negligent act of the **Researcher**, or an employee or agent of the **Researcher**.
- 8.02 This Agreement is subject to any restrictions or limitation in, or provisions of, any statute, regulation or other legislation enacted or amended by the Province of Manitoba or the Government of Canada and in effect from time to time which may affect any term or provision of this Agreement.
- 8.03 The obligations and undertakings of the **Researcher** under this Agreement shall survive the completion or termination of the research purpose.
- 8.04 The **Researcher** shall not assign or transfer this Agreement or any of the rights or obligations under this Agreement.
- 8.05 The **Researcher** shall not enter into any contract, sub-contract or arrangement with a third party involving use of or access to, or disclosure of, the Information for any purpose except as specifically provided in this Agreement.
- 8.06 This Agreement shall be interpreted, performed and enforced in accordance with the laws of the Province of Manitoba.
- 8.07 Any notice or other communication given or required under this Agreement shall be in writing and shall be delivered personally or sent by registered mail, postage prepaid, or by way of facsimile transmission, as follows:

To **Manitoba**:
 Barb Devlin
 Manitoba Health

To the **Researcher**:
 Beverley Hicks

Appendix C

Consent Letter and Consent Form

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information. I will answer any questions you have and take as much time as you need to understand.

This is a graduate research project approved by the University of Manitoba, Faculty of Education.

1. The purpose of this research project is to explain how psychiatric nursing became a legislated profession in Manitoba in 1960, what role men played in this event, who the important people were and their contribution to establishing the profession, how the psychiatric nurses were trained, and how it came to establish a professional place in Manitoba. You have been especially invited to participate because of your particular knowledge of the events of the time.
2. You will not be expected to reveal any information you are uncomfortable with and you may conclude the interview at any time.

We can meet at any place convenient for you where we can be comfortable and have privacy. For example we could meet at your home if that is acceptable to you.

The interviews will be between 45 minutes to an hour but we can stop when you wish. We can also meet on more than one occasion if you wish. We can take as long as you like for you to tell me what you see as important.

3. I would like to use your name as your contribution was significant. Some people do not wish to have their name used but are willing to have their titles used even though this may identify them. Are you comfortable in having your name used? If you do not wish your name to be used can I state your role e.g. Director of Nursing or President of RPNAM? Your decision about whether or not I can use your name or your title will be part of the consent form you sign.
4. I would like to use a tape recorder as I do not want to lose any of the important things you have to say. I will have the tapes transcribed and then use the material from the tape in the dissertation.
5. You will have the opportunity to decide if the chosen quotations can be used in the dissertation.
6. I will give you the opportunity to decide what to do with the tapes. I can return them to you or they could be put into an archival collection for future use. You can decide this. Likewise the transcripts of the tapes can be kept or destroyed depending on your wishes. Your decision will be included as part of the consent form you will sign.
7. When the dissertation is complete you may have an executive summary of the research if you wish. If you would like a summary I will note that and send you one when the study is complete.
8. If you wish to contact me at any time you may do so by calling

9. There will be no monetary compensation for this interview.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate. In no way does this waive your legal rights nor release the researcher from her legal and professional responsibility. You are free to withdraw at any time or refuse to answer any questions without prejudice. Your participation should be as informed as your consent, so please feel free to ask for clarification throughout the interview.

This research has been approved by the Education and Nursing Ethics Research committee. If you have any concerns or complaints you may contact my supervisor, Dr. Denis Hlynka at 474 8907 or the Human Ethics Secretariat at 474-7122 or e-mail margaret_bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records.

Consent Form

There are a number of parts to this consent and I will ask you to circle each part.

1. Do you agree to meet with me to discuss your participation in the development of psychiatric nursing in Manitoba as is outlined in the description of the study? Y N
2. May I use your name in the study? Y N
3. If you do not wish your name used can I use your title? Y N
4. Do you wish to read the transcript before it is included in the dissertation? Y N
5. Do you wish to have the tapes and transcripts returned to you? Y N
6. If you do not wish to have the tapes returned can I put them in the McKee Archives at Brandon University? Y N
7. Do you want an executive summary of the research? Y N
8. Are you clear about the things you have agreed to in this in this consent form? Y N

Participant's signature _____ date _____

Researcher's signature _____ date _____

Appendix D

Tentative Interview Guide

This is an open ended interview guide. Other questions may emerge as the interview proceeds.

- Hello my name is Beverley Hicks and I am a graduate student at the University of Manitoba doing research into psychiatric nursing education in Manitoba and the evolution of the profession of psychiatric nursing. The particular time frame I am interested in ranges from the middle 1950s to 1980. I know you were involved during those years and I am sure you have memories that will help us to understand the events that were important to psychiatric nursing.
- Can you tell me at which mental hospital you were trained?
- What years were you there?
- What can you tell me about the kind of tasks you performed in the hospital?
- What can you tell me about the training you received to carry out these tasks?
- What can you tell me about your experiences as a nurse/attendant in the mental hospital?
- What can you tell me about the kinds of relationships you had with patients?
- What were you taught about mental illness and psychiatric nursing?
- Can you recall the names of any psychiatric nursing leaders you learned about?
- What would you say about the philosophy of psychiatric nursing at the time you worked at the hospital.

- Do you remember the names of the textbooks you used?
- Is there anything from the textbooks that stands out for you?
- What is the most notable thing you recall about those days?

Additional questions for male participants

- As a male nurse how did you perceive your role?
- Do you recall if there were any differences in the way male and female nursing staff were trained and treated?
- At one time the training of men and women was different, what do you recall of the time when the education process was changed and men and women began attending classes together.
- Did you care for female as well as male patients?
- Is there anything else that you remember that you think was important?

Additional questions for nursing instructors

- You were involved in the training of psychiatric nurses. What hospital were you at and when were you there?
- What can you tell me about the training of psychiatric nurses?
- Were the male and female nurses trained the same way?
- What would you say was the philosophy of psychiatric nursing education?
- How did you go about choosing material for the curriculum?
- Were there any other influences you recall on the training programme?
- What other ways do you think learning took place?
- What nursing journals were in the library?
- What else can you tell me that you think is important?

Appendix E

1952 - 1957 3 1/2 Year Program

Combined Psychiatric Nursing with Registered Nursing

1st Year - Brandon Mental Hospital

Theory		Clinical Experience	
Anatomy and Physiology	95 hours	Pre-clinical	16 weeks
Materia Medica	30 hours	Admission	4 weeks
Ethics	8 hours	Active Treatment	4 weeks
History of Nursing	14 hours	Convalescent	2 weeks
Health Education	16 hours	Insulin Therapy	6 weeks
Nutrition	24 hours	Occupational Therapy	1 week
Nursing Arts	200 hours	Child Guidance	1 week
Psychology	26 hours	Infirmery	6 weeks
Psychiatry	75 hours	Continued Service	<u>6 weeks</u>
			46 weeks
Psychiatric Nursing	50 hours		
Conferences	12 hours		
Occupational Therapy	8 hours		
Pharmacology	<u>32 hours</u>		
	590 hours		

2nd Year - Brandon General Hospital

Communicable Diseases	24 hours	Medicine	12 weeks
Diet Therapy	15 hours	Surgery	12 weeks
Medicine	14 hours	O.R.	10 weeks
Medical Nursing	16 hours	Orthopedics	6 weeks
O.R.	7 hours	E.E.N.T.	7 weeks
Anaesthesia	4 hours	Diet Kitchen	<u>4 weeks</u>
Eye, Ear, Nose, Throat	12 hours		51 weeks
Eye, Ear, Nose, Throat N.	8 hours		
Surgery	21 hours		
Surgical Nursing	21 hours		
Orthopedics	6 hours		
Orthopedic Nursing	10 hours		
Community Health	<u>20 hours</u>		
	178 hours		

**3rd Year
Grace Hospital**

Theory		Clinical Experience	
Obstetrics	30 hours	Obstetrics	4 weeks
Gynecology	<u>18 hours</u>	Case Room	4 weeks
	48 hours	Nursery	4 weeks
		Gynecology	<u>4 weeks</u>
			16 weeks

Children's Hospital

Pediatrics	30 hours	Infants	3 weeks
Clinics	<u>12 hours</u>	Milk Laboratory	1 week
	42 hours	Observation	2 weeks
		Kenny Treatment	<u>6 weeks</u>
			12 weeks

Ninette Sanatorium

Tuberculosis	<u>34 hours</u>	T.B.	7 weeks
		Surgery	<u>1 week</u>
			8 weeks

4th Year - Brandon Mental Hospital

First Aid	14 hours	O.R.	4 weeks
Neurology	12 hours	Administration	4 weeks
Neurology Nursing	4 hours	Teaching	4 weeks
Seminar	15 hours	Lobotomy	6 weeks
Trends	10 hours	Psychiatry	<u>18 weeks</u>
Principles of Teaching	10 hours		36 weeks
Principles of Supervision	10 hours		
Communicable Diseases	15 hours		
Community Health	<u>25 hours</u>		
	115 hours		

Total in Theory	1007 hours	Total in Clinical	169 weeks
-----------------	------------	-------------------	-----------

Appendix F

Psychiatric Nursing Diploma (Male Nurse) 1958-1961

Psychiatry	45
Psychiatric Nursing	38
Neurology	N/A
Remotivation	N/A
Occupational Therapy	9
Psychology	N/A
Sociology	N/A
Anatomy & Physiology	60
Microbiology	N/A
Nursing Arts	90
Drugs	15
Nutrition	N/A
Personal Hygiene	N/A
Community Health	N/A
First Aid	35
Medical & Surgical Nursing	60
Ethics	6
Mental Retardation	N/A
Seminars	N/A
Total	358 hours

Clinical Experience (Minimum)

Service Oriented Until 1960

Admission	12 weeks
Insulin Therapy	6 weeks
Continuing Service	6 weeks
Infirmery	6 weeks
Geriatric	6 weeks
Occupational Therapy	1 week
Total	38 weeks

Appendix G

Psychiatric Nursing Course Curriculum 1961-1963

Minimum Hours

Psychology	24 hours
Psychiatry	40 hours
Psychiatric Nursing	70 hours
Occupational and Recreational Therapy	15 hours
Basic Nursing	160 hours
Microbiology	15 hours
Drugs and Solutions	50 hours
Anatomy and Physiology	50 hours
Personal and Community Health	16 hours
Nutrition	15 hours
Medical and Surgical Nursing	50 hours
Personal and Vocational Relationships	20 hours
Sociology	25 hours
Remotivation	24 hours
Seminars	40 hours
Mother and Infant Care	50 hours - only LPN
Nutrition Laboratory	30 hours - only LPN
Total	614 + LPN

Appendix H

Approved Two-Year Curriculum for Psychiatric Nursing Training 1968

Clinical Experience

Psychiatric: Admission, Active Treatment & Continued Treatment	16 weeks
Medical & Surgical Nursing (including Geriatrics, O.R. and Treatment Room)	12 weeks
Social Service	1 week
Social and Rehabilitative Techniques	4 weeks
Mental Retardation	6 weeks
General Hospital	10 weeks
Specialty Nursing	21 weeks
Holidays (accumulative Statutory Holidays)	2 weeks
	72 weeks

Theoretical Instruction

Psychology	50 hours
Mental Retardation	40 hours
Psychiatric Nursing (including 50 hours of Psychiatry)	200 hours
Motivational Therapies	50 hours
Basic Nursing	100 hours
Microbiology	15 hours
Pharmacology	60 hours
Anatomy & Physiology (including Neurology)	90 hours
Introduction to Healthful Living	16 hours
Nutrition (Theory)	20 hours
Medical & Surgical Nursing	160 hours
Professional Adjustments I & II	40 hours
Sociology	40 hours
Seminars & Clinics	100 hours
 Total Hours of Theory	 981 hours

Appendix I

Curriculum Suggestions - Community Psychiatric Nursing

1. Formal Training in Interview Techniques-Both theory and practice. This could include group methods-T-groups or sensitivity for self awareness and role playing.
2. Theory and Techniques of Counselling-This should include ability to interpret what patient says, relationships which can form and ones that should evolve between nurse and patient and goals of counselling.
3. Formal Training in Social Services Area-To provide basic skills in:
 - a) Planning and writing social nursing histories.
 - b) Handling social nursing problems.
 - c) Family relations, therapy and marriage counselling-criteria to determine when such services are necessary and when referrals should be made.
4. Mental Health Act-Greater emphasis on those parts of the Act which relate to the different types of admissions, discharge procedures and transfers. Closely related to this is criteria for the placement of patients.
5. Planning Total Patient Care and Individual Therapy.
6. Preventative Psychiatry-More detail and greater emphasis than is now placed on this area of study.
7. Techniques in Psychotherapy-Individual group and ventilating.
8. Techniques in Supportive Therapy.
9. Crisis Intervention - Basic theory and procedures in handling such occurrences.
10. Interpersonal Relationships - A review of the different types of relationships and their effects.
11. Clinical Symptoms - More emphasis on observing same and doing psychiatric nursing assessments.
12. Community Agencies - The detailed role, policies and procedures for referrals to other agencies and where the nurse fits in, in relation to the agencies. The dynamics of the procedures involved between patient, nurse and community agency.

13. Communications - Formal training in public speaking and public relations.
14. Psychiatric Regions - A breakdown of the different areas, their functions, policies, procedures and differences.
15. Pharmacology - Psychotropic drugs, reactions and side effects.
16. Child Psychiatry.
17. Sociology - Understanding the community.
18. Legal Responsibilities in Community Psychiatric Nursing.

Appendix J

Recommendations of the P.N.A.C. Education Committee

The Committee recommends that the following philosophy of education be adopted by P.N.A.C.

We believe that education denotes the deliberate methods of training and direction used by a society to include its ideals of life and culture in its maturing individual members and thus to perpetuate itself.

We believe that education in psychiatric nursing is to prepare the psychiatric nursing student for full participation as a professional person in the promotion of mental health.

We believe that nursing contains two broad and easily definable areas: the technical clinical approach - bedside nursing care; and the psychological social approach of the individual's understand of his problems, presenting him as a person with a difficult life style - psychiatric nursing care.

We believe that both areas contain their own areas of specialization - medical specialty and psychiatric nursing - therefore it is necessary to prepare nurses to specialize at the diploma level in both areas.

The Committee recommends the following objectives of education be adopted by P.N.A.C.

1. To promote and maintain an enlightened and progressive standard of psychiatric nursing throughout Canada.
2. To encourage the uniformity of the educational program at the highest possible standard for the purpose of providing well qualified registered psychiatric nurses.
3. To promote better understanding throughout the nation of the work and the important of the psychiatric nurse.
4. To work in co-operation with other approved bodies having similar interests and objectives in the promotion of mental health in Canada.
5. To promote the upholding of our professional code of ethics in order to render high standards of professional services to the public.
6. To foster the formation of educational programs and of psychiatric nurses' associations across Canada.

The Committee recommends that 70 per cent of classroom instruction time should be spent on PSYCHIATRIC NURSING and RELATED SOCIAL SCIENCES. This should include such things as:

1. Psychiatric Nursing, which should include:
 - Psycho-Geriatric Nursing
 - Community and Preventative Psychiatric Nursing
 - Crisis Intervention
 - Drug Dependence
 - Child, Adolescent, and Adult Psychiatric Nursing
 - Psycho-Pharmacology
2. Rehabilitation Techniques
3. Mental Retardation
4. Sociology
 - introductory
5. Psychology
 - introductory
 - developmental
 - abnormal
6. Management Techniques
7. Personal and Vocational Relationships

The Committee recommends that approximately 30 per cent of the classroom instruction is to be in PHYSICAL or BIOLOGICAL and RELATED SCIENCES. This should include such things as:

Nursing Arts
 Medical and Surgical Nursing
 Microbiology and Infectious Diseases
 Basic Pharmacology
 Anatomy and Physiology or Biology
 Nutrition

The Committee recommends no more than 30 per cent of the time allotted for clinical instruction should be spent on the physical aspects, and no less than 70 per cent on psychiatric nursing

They recommend that physical nursing experience should include affiliation in a general hospital setting.

They also recommend that the 70 per cent in psychiatric nursing settings should include experience in:

Acute Psychiatric Services
Mental Retardation
Psycho-Geriatrics
Community Settings

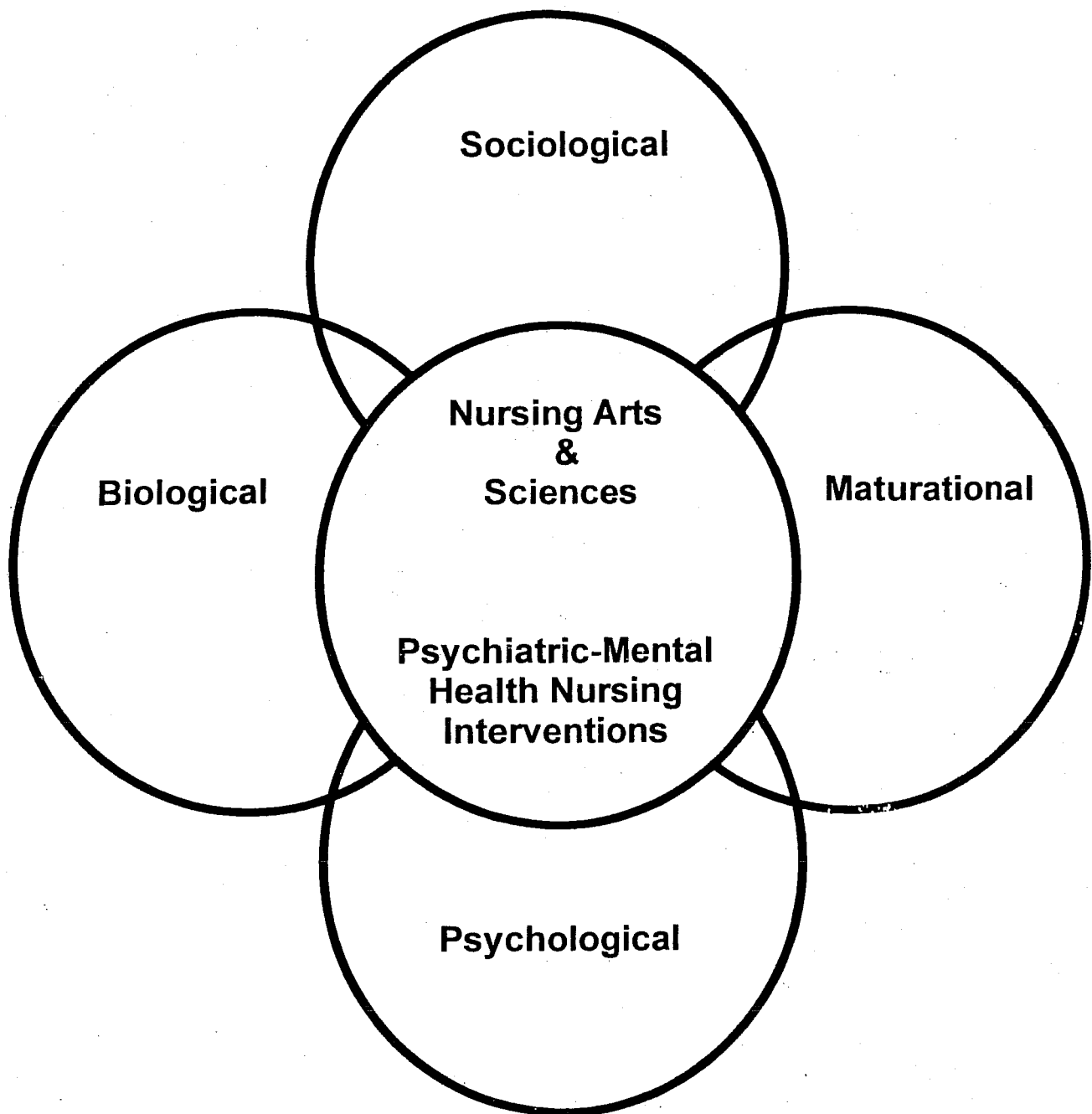
The Committee recommends that the question of uniformity of final examinations be tabled pending provincial response to the other proposals of the Committee.

The Committee recommends the following guidelines for the education of psychiatric nurses:

1. Psychiatric nurses' education programs must be maintained as a unique health manpower category, to come under the authority of the department of education in each province.
2. The present educational system in this country could accommodate marginal changes qualitatively and quantitatively, namely more extensive preparation in the community mental health, the behavioural aspect of education, and psycho-geriatrics.
3. The program for psychiatric nursing education should be administered as a distinct program with its own program head who must be an active member of the respective Psychiatric Nurses Association in Canada.
4. The exploratory discussion be at once undertaken by the provincial associations in each province to determine the feasibility and acceptability of offering courses in social sciences content. Credit for these courses should be acknowledged by the Psychiatric Nurses' advisory committee as the fulfillment of its requirements.
5. The curricula for psychiatric nursing programs be so constructed as to facilitate the interlocking of courses of instruction between the home school and the university.

Appendix K

CURRICULUM MODEL



Explanation of 1979 Curriculum Model

Each of the outer circles represents a grouping of related subject areas.

<u>Biological Sciences</u>	Anatomy and Physiology
	Basic Sciences
<u>Sociological Sciences</u>	Introduction to Sociology
	Social Systems
<u>Growth and Development</u>	Maturation
<u>Psychological Systems</u>	Introductory Psychology
	Behavior Modification

The inner circle contains nursing arts and science and psychiatric-mental health nursing interventions. The following are identified as the content in each area.

<u>Nursing Arts and Sciences</u>	Communication
	Fundamentals of Nursing
	Basic Nursing Skills
	Nursing of Physical States

Psychiatric–Mental Health Nursing

The content of this division represents behavioural patterns which are commonly linked to medical psychiatric diagnoses. Psychiatric nursing care is designed to help individuals with the following behaviour patterns.

Psychiatric-Mental Health Nursing Interventions to Assist Individuals and Groups (Children to Aging) In institutions and the Community cope with:

Anxiety and Stress

Withdrawal and Projective Patterns of Behavior

Depression and Elation

Social Problems

Undergoing Various Therapeutic Interventions

Children and Adolescents Experiencing Emotional Problems

Aging Manifestation Requiring Nursing Assistance

Individuals and Groups in the Community requiring Psychiatric Nursing Assistance.

Two further subjects completed the curriculum.

Developmental Habilitation. This is the care of individuals with developmental disorders.

Integrated Practicum. An integrated practicum experience which was the the culmination of the course.

Appendix L

'WORKING PAPER ON STANDARDS OF PRACTICE FOR THE REGISTERED PSYCHIATRIC NURSE'

This publication sets forth standards of Psychiatric Nursing Practice as developed by the Psychiatric Nurses Association of Canada and the Standards Committee of the Provincial Associations of Alberta, British Columbia, Manitoba, Nova Scotia, Ontario and Saskatchewan.

Permission has been granted by the American Nurses' Association for the use and reproduction of 'Standards: Psychiatric-Mental Health Nursing Practice, 1973'.

PREAMBLE

A preamble presently being developed will include statements of belief about Man, Society, Health, Nursing, Psychiatric Nursing and Education (Teaching and Learning).

INTRODUCTION

In accordance with a resolution approved in October, 1975 by the plenary session at the annual meeting of the Psychiatric Nurses Association of Canada, a committee was appointed to develop standards of practice for Psychiatric Nursing in Canada. Concomitantly the Registered Psychiatric Nurses' Association of Manitoba, Saskatchewan Psychiatric Nurses' Association, Psychiatric Nurses' Association of Alberta, Registered Psychiatric Nurses' Association of British Columbia and Psychiatric Nurses' Association of Nova Scotia appointed provincial committee to develop standards of practice. The "Working Paper" was and is being reviewed by the Psychiatric Nurses Association of Ontario.

STANDARD I

Collects data through pertinent clinical observations based on a knowledge of nursing and the behavioral and physical sciences.

Rationale:

Organized clinical observation is a pre-requisite to realistic assessment of an individual's needs and for the formulation of appropriate nursing intervention.

Knowledge acquired in the study of the nursing, behavioral and physical sciences fosters acuity of perception and alerts the registered psychiatric nurse to physical, psychological, cultural, social, spiritual and other relevant data.

STANDARD II

Involves the individual, family and appropriate others in the assessment, planning, implementation and evaluation of the individual's nursing care program.

Rationale:

Since the problem-solving process is a learning experience, the individual should be encouraged to participate as actively as possible in his program. The ability to participate in such a process will vary from person to person and even within the same person. The family unit is one of the most influential group in society. Therefore, the most effective and individualized program may be developed when the family and other relevant others are included.

STANDARD III

Uses problem-solving in developing a psychiatric nursing care plan.

Rationale:

Problem-solving is a systematic, step-by-step approach to the resolution of an identified problem. Based on pertinent theories of human behavior the psychiatric nursing care plan is systematized by the problem-solving method, individualized by the characteristics and capabilities of the individual and his environment, and is used to maximize the effectiveness of the program for the individual.

STANDARD IV

Promotes the realization of optimal health in individuals through health teaching.

Rationale:

Health teaching is an essential part of a psychiatric nurses' role. Every interaction can be utilized as a teaching-learning situation. Formal and informal teaching methods can be used in working with individuals. Emphasis is on understanding mental health problems as well as on developing ways of coping with them thus promoting optimum health.

STANDARD V

Uses activities of daily living in a goal directed way when interacting with individuals.

Rationale:

Activities of daily living include the individual's personal and social living patterns. An individual's developmental and intellectual level, emotional state and physical status are reflected in and influenced by these activities. Therefore, the registered psychiatric nurse is in a unique position to assess and intervene in these processes in order to encourage constructive changes in the individual's behavior so that each may realize his full potential.

STANDARD VI

Uses knowledge of somatic therapies and related clinical skills while working with individuals.

Rationale:

Various treatment modalities may be needed by individuals. Clinical observations and judgments are made concerning the effects of drugs and other treatments used in the therapeutic program.

STANDARD VII

Modifies the environment to establish and maintain a therapeutic milieu.

Rationale:

Any environment is composed of both human and non-human resources which may work for or against the individual's well being. The registered psychiatric nurse works with people in a variety of setting. The milieu is structured and/or altered so that it serves the individual's best interests as an inherent part of the overall therapeutic plan.

STANDARD VIII

Participates with members of the multi-disciplinary team in assessing, planning, implementing and evaluating selected programs for the individual.

Rationale:

Because services to the individual are provided by a variety of professional and non-professional personnel in addition to the registered psychiatric nurse, it is essential that their contributions be co-ordinated to integrate the individual's total program.

STANDARD IX

Uses psychotherapeutic interventions to assist the individual in achieving optimal health.

Rationale:

In order to help the individual achieve better adaption and improved health, the registered psychiatric nurse assists the individual to explore and identify his mode of living and relating, and possible alternatives.

STANDARD X

Practices as an accountable health professional in providing psychiatric nursing care.

Rationale:

The registered psychiatric nurse in accepting responsibility for his professional behavior enters into agreement with the individual. This agreement defines the expectations of the individual and the registered psychiatric nurse.

STANDARD XI

Participates with members of the multi-disciplinary team in community mental health planning.

Rationale:

There is a need for the registered psychiatric nurse to participate in programs that strengthen the existing health potential of all members of society. Concepts such as prevention, early intervention, and continuity of care are essential in planning to meet the community's mental health needs. The psychiatric nurse uses his psychiatric nursing expertise, organizational, educational, consultative skills and works in co-operation and collaboration with other community agencies to facilitate the development and implementation of mental health services.

STANDARD XII

Shares responsibility for a leadership role including the supervision and teaching of ancillary and other personnel in meeting the psychiatric nursing care needs of the individual.

Rationale:

As a member of the nursing team contributes to the leadership of personnel in the provision of psychiatric nursing care. The focus is on the continuing development of each member of the team.

STANDARD XIII

Assumes responsibility for personal and professional development and contributes to the professional growth of others.

Rationale:

In order to function effectively and to enhance professional competence in a world of rapid cultural, social and technological changes, the registered psychiatric nurse must assume responsibility for his own continuing development. Multi-disciplinary team functioning necessitates that the registered psychiatric nurse supports others in their development.

STANDARD XIV

Contributes to the development of psychiatric nursing.

Rationale:

Psychiatric nursing uses a pragmatic and eclectic approach to the resolution of nursing problems. The registered psychiatric nurse has responsibility for continuing development and refinement of knowledge in the mental health field.

STANDARD XV

Practices psychiatric nursing based on the Psychiatric Nurses' Association of Canada's Code of Ethics.

Rationale:

Inherent in the ethical standards of psychiatric nursing is respect for the life, dignity and the rights of man which are unrestricted by considerations of nationality, race, creed, colour, age, sex, religion, politics or social status.

STANDARD XVI

Understands the provincially and federally sponsored legal limitations, statutes and acts covering his actions as a registered psychiatric nurse functioning in current health systems in Canada.

Rationale:

The registered psychiatric nurse must be thoroughly aware of the legal ramifications affecting self and others in order to make sound independent judgments concerning the individual's needs and rights.

Appendix M

Psychiatric Nurses Association of Canada Code of Ethics

1. The fundamental responsibility of the Registered Psychiatric Nurse is to promote Mental Health.
2. The Registered Psychiatric Nurse must be prepared to practice and maintain professional competencies.
3. The Registered Psychiatric Nurse must be responsible for his own growth and development in the field of Psychiatric Nursing through continuing education.
4. The Registered Psychiatric Nurses must be prepared to practise and maintain professional competency in order to provide professional nursing service to those entrusted to his care.
5. The Registered Psychiatric Nurse must respect and accept an individual's uniqueness and integrity, regardless of colour, race, creed, gender or religion.
6. The Registered Psychiatric Nurse will hold in confidence all personal information entrusted to him except where there is evidence of immediate danger to the individual and/or others.
7. The Registered Psychiatric Nurse shall accept full responsibility for his psychiatric nursing actions and decisions.
8. The Registered Psychiatric Nurse is obligated to give and carry out orders intelligently, to avoid misunderstandings or inaccuracies by verification, and to refuse to participate in any procedure contrary to established practise as defined within the Code of Ethics.
9. The Registered Psychiatric Nurse sustains confidence in all members of the health team; incompetency or unethical conduct of associates in the health professions should be exposed to the proper authority.
10. The Registered Psychiatric Nurse has an obligation to give conscientious service and in return is entitled to just remuneration. A professional worker does not accept gratuities or bribes.
11. The Registered Psychiatric Nurse does not permit his name to be used in connection with testimonials or in the advertisement or products.
12. The Registered Psychiatric Nurse understands and adheres to those laws which affect the practice of Psychiatric Nursing.
13. The Registered Psychiatric Nurse shall participate and share responsibility with other citizens and health professionals in promoting efforts to meet the Mental Health needs of the public.
14. The Registered Psychiatric Nurse shall, in co-operation with other members of the health team, as early as possible, make the individual aware of the kind of treatment procedure contemplated, medications involved, financial responsibilities, and the anticipated outcomes and possible concomitant reactions and consequences.
15. The Registered Psychiatric Nurse shall have personal concern for the individual he is working with. He will always maintain his personal concern within the bounds of his professional responsibilities, so as to safeguard the welfare of the individual both during and after treatment.

Appendix N***The Psychiatric Nurses' Pledge***

I Do Hereby Pledge my wholehearted service to those entrusted to my care . . .
.endeavoring at all times to understand the patient's individual emotional and physical
needs and differencesTo that end, I will strive for skill in the fulfillment of my
duty, holding sacred and inviolate all confidences entrusted to me

I Promise to respect the personal rights and privileges of my patient, and to do all in
my power to prevent or alleviate physical or psychological discomfort.

I Will always be kind, tolerant and just . . . I will endeavour to cultivate a keen sense
of observation and an understanding attitude

I Acknowledge the dignity of my profession and accept the obligation it implies . . . I
will faithfully perform my duties, and will give the utmost in cooperation to those
persons with whom I associate in ministering to the mentally ill.

All Of Which I Pledge on My Sacred Honor

Canadian Journal of Psychiatric Nursing.

Cover Vol. XX July August, 1979.

Appendix O

The Song of the Psychiatric Nurse

I never get mad, I get hostile,
I never feel sad, I'm depressed;
If I sew or I knit and enjoy it a bit,
I'm not handy...I'm merely obsessed.

I never regret, I feel guilty;
And if I should vacuum the hall,
Wash the woodwork and such, and not mind
it too much,
Am I tidy? Compulsive is all.

If I can't choose a hat, I have conflicts,
With ambivalent feelings towards net.
I never get worried, or nervous or harried;
Anxiety...that's what I get.

If I'm happy, I must be euphoric;
If I go to the Stork Club or Ritz
And have a good time making puns or a rhyme,
I'm manic, or maybe a schiz.

If I tell you you're right, I'm submissive,
Representing aggressiveness too,
And when I disagree, I'm defensive you see,
And projecting my symptoms on you.

I love you but that's just transference,
My Oedipus rearing its head;
My breathing asthmatic is psychosomatic...
A fear of exclaiming, "Drop dead!"

I'm not lonely, I'm simply dependent;
My dog has no fleas, just a tick...
So, if I'm a cad, never mind, just be glad
That I'm not a stinker...I'm sick!.

BIBLIOGRAPHY**Archives**

Provincial Archives of Manitoba

GR 157

H-14-21-B
H-14-21-1B
H-14-21-1G
H-16-19-1
H-16-19-1A
S-14-21-1B

GR 459

1-1-8C
8-3-74-1-3
H-14-21-1
H-14-21-A
N-4
N-5
N-6
N-7
File Psychiatric Nurses Act 1959-1968
W-4

GR 1554

Minutes of Medical Superintendents Meetings 1963-1972

GR 1555

Records of Advisory Committee
1280-1
1280-2
1280-3
1280-4

GR 2124

1104-3

GR 5331 and GR 6852

Minutes of University Grants Commission

GR 6224

Brandon Mental Health Centre Collection

P 4562

Minutes of Licensed Practical Nurses Advisory Council
Meetings

Private Archives and Museums

Alberta Psychiatric Nurses Association Archives, Edmonton, Alberta.

Brandon Mental Health Centre Museum, Brandon, Manitoba.

British Columbia Registered Psychiatric Nurses Association Archives, Burnaby, British Columbia.

Canadian Council of Psychiatric Nurses Archives, Regina, Saskatchewan.

Canadian Nurses Association Archives, Ottawa, Ontario.

College of Registered Nurses of Manitoba Archives, Winnipeg, Manitoba.

College of Registered Psychiatric Nurses of Manitoba Archives, Winnipeg, Manitoba.

McKee Archives, Brandon University, Brandon, Manitoba.

Manitoba Developmental Centre Museum, Portage la Prairie, Manitoba.

Saskatchewan Registered Psychiatric Nurses Association Archives, Regina, Saskatchewan.

Manitoba Government Statutes

Statutes of Manitoba, 1960. Chapter 108. An Act respecting the Psychiatric Nurses Association of Manitoba.

Statutes of Manitoba, 1960. Chapter 54. An Act to provide for the Education of Psychiatric Nurses.

Statutes of Manitoba, 1980. Chapter 46. The Registered Psychiatric Nurses Act.

Legislative Documents

Debates and Proceedings of the Provincial Legislature of Manitoba, February 17, 1960, February 24, 1960, March 4, 1960, March 26, 1960, May 2, 1963, July 15, 1980, July 29, 1980.

Journal of the Legislative Assembly of Manitoba, 1960.

Standing Committee on Private Bills, July 16, 17, 18, 1980.

Reports

Annual Reports

PAM GR 6224
Hospital Copies
1947
1952
1957
1958
1962
1963

Manitoba Legislative Library

Annual Report of the Manitoba Department of Health and Public Welfare, Provincial Mental Hospitals, 1930.

Annual Report of the Manitoba Department of Health and Public Welfare, Manitoba School for Mentally Defective Persons, 1951.

Annual Report of the Manitoba Department of Health and Public Welfare, Provincial Mental Hospitals, 1953.

Annual Report of the Manitoba Department of Health and Public Welfare, Mental Hospitals, 1956.

Government of Canada Reports

Royal Commission on Health Services (Hall Report) 1964.
Nursing Education in Canada (Mussallem) 1965.

Manitoba Government Reports

Report of the Minister of Health's Committee on the Supply of Nurses, November 1966.

The Clarkson Report. Mental Health and Retardation Services in Manitoba: A Report to the Minister of Health and Social Development Province of Manitoba 1973.

The Task Force. Report of the Joint Ministerial Task Force on Nursing Education in Manitoba, Province of Manitoba, December 1977.

Private Reports

Breen, Lawrence J. and Associates. The Perceived Role of the Registered Psychiatric Nurse in the Mental Health Delivery System of the Province of Manitoba A Report submitted to the Registered Psychiatric Nurses Association of Manitoba, March 1, 1976. *The Breen Report*.

Canadian Nurses Association Report. The Preparation of Nursing Personnel for the Care the Mentally Ill. 1954.

Evans, Joan, and Cameron, Paula. *Final Report: Contradictions and Tensions in the Lives of Men: Exploring masculinities in numerically female-dominated professions of nursing and elementary school teaching*. Dalhousie University, Social Sciences and Humanities Research Council of Canada, June 10, 2007.

Manitoba Association of Registered Nurses, April 1976. *Challenge and Change*.

Interviews Conducted by Beverley Hicks

Myrtle Barnett	March 12, 2002
Remi Beaudette	November 27, 2006
Marlene Brichon	October 22, 2006
Jack Holleman	March 9, 2006
	February 1, 2007
	February 7, 2007
John Martyniw	July 13, 2005
Annette Osted	May 22, 2007
Shirley Jo-Paine	April 23, 2007
Gerald Pronyk	July 12, 2007
Janissa Read	October 6, 2007
Elinor Samels	August 2, 2005
	February 14, 2006

Tom Street

May 14, 2007

Walter Tetzlaff

February 1, 2007

Books

Alexander, F. G. and S. T. Selesnick. *The History of Psychiatry: An Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present*. New York: Harper & Row, 1966.

Author Unknown, *Dear Bill, Let's Start and Association. . . A Tribute to the Psychiatric Nurses Association of Canada on the Occasion of Its 25th Anniversary*. British Columbia: Registered Psychiatric Nurses Association, 1976.

Barker, F., P. Hulme, and M. Iversen, eds. *Uses of History: Marxism, Postmodernism and the Renaissance*. Manchester, England: Manchester University Press, 1991.

Baumgart, Alice J. and Jenniece Larsen, eds. *Canadian Nursing Faces the Future: Development and Change*. St. Louis, MO: C. V. Mosby, 1988.

Bloom, Benjamin S., ed. *Taxonomy of Educational Objectives: The Classification of Educational Goals: Handbook 1: Cognitive Domain*. New York: David McKay, 1956.

Brown, Amy Frances. *Curriculum Development*. Philadelphia: W. B. Saunders, 1960.

Burke, Peter, ed. *New Perspectives of Historical Writing*. University Park, Pennsylvania: The Pennsylvania State Press, 1992.

Cheek, Julianne. *Postmodern and Poststructural Approaches to Nursing Research*. Thousand Oaks, CA: Sage Publications, 1993.

Connelly, M. and D. J. Clandinin. *Teachers as Curriculum Planners: Narratives of Experience*. New York: Teachers College Press, 1988.

Davies, Celia, ed. *Re-Writing Nursing History*. London, England: Croom Helm, 1980.

Dickinson, Harley D. *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984*. University of Regina, Regina: Saskatchewan: Canadian Plains Research Centre, 1989.

Digby, Anne. *Madness, Mortality and Medicine: A Study of the York Retreat, 1796-1914*. Cambridge, London: Cambridge University Press, 1985.

- Dwyer, Ellen. *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums*. New Brunswick, NJ: Rutgers University Press, 1987.
- Etzioni, Amitai, ed. *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers*. London: Collier-Macmillan, 1969.
- Fitzpatrick, M. Louise, ed. *Historical Studies in Nursing: Papers Presented at the 15th Annual Stewart Conference on Research in Nursing March 1977*. New York: Teachers College Press, 1978.
- Foucault, Michel. *Madness and Civilization: A History of Insanity in the Age of Reason*. Translated by Richard Howard. New York: Random House, 1965.
- Gibbon John Murray and Mary Mathewson. *Three Centuries of Canadian Nursing*. Toronto: Macmillan, 1947.
- Goffman, Erving. *Asylums*. Garden City, NY: Anchor Books, 1961.
- Grob, Gerald N. *The State and the Mentally Ill: A History of Worcester State Hospital in Massachussets, 1830-1920*. The University of North Carolina Press: Chapel Hall, 1996.
- Gutting, Gary. *The Cambridge Companion to Foucault*. Cambridge, England: Cambridge University Press, 1994.
- Huey, Florence L. *Psychiatric Nursing 1946 to 1974: A Report on the State of the Art*. New York: The American Journal of Nursing Co., 1975.
- Jenkins, Keith. *Re-thinking History*. London: Routledge, 1991.
- Jones, Maxwell. *The Therapeutic Community: A New Treatment Method in Psychiatry*. New York: Basic Books, 1953.
- Kahan, F. H. *A Different Drummer (The History of the Saskatchewan Psychiatric Nurses' Association 1948-1973)*. The Saskatchewan Psychiatric Nurses' Association, 1973.
- Karnosh, Louis J. with the collaboration of Dorothy Mereness. *Psychiatry for Nurses* (4th ed.). St. Louis: C.V.Mosby, 1953.
- Krathwohl, David R. *Taxonomy of Educational Objectives: The Classification of Educational Goals: Handbook 11: Affective Domain*. New York: David McKay, 1956.
- Laing, R. D. *The Divided Self*. Harmondsworth, Middlesex: Penguin Books, 1965.

- LaJeunesse, Ronald A. *Political Asylums*. Edmonton, Alberta: The Muttart Foundation, 2002.
- Lynn, Kenneth S., ed. and the Editors of Daedalus. *The Professions in America*. Boston: Houghton Mifflin, 1965.
- Maggs, Christopher J., ed. *Nursing History: The State of the Art*. London: Croom Helm, 1987.
- McIntyre, Marjorie and Elizabeth Thomlinson. *Realities of Canadian Nursing: Professional, Practice, and Power Issues*. Philadelphia: Lippincott Williams & Wilkins, 2003.
- McPherson, Kathryn. *Beside Matters: The Transformation of Canadian Nursing, 1900-1990*. Toronto: Oxford University Press, 1996.
- Medico-Psychological Association, *Handbook for Mental Nurses*. London: Bailliere, Tindall and Cox. First publication 1885.
- Meleis, Afaf Ibrahim. *Theoretical Nursing Development and Progress* (2nd ed.). Philadelphia: J. B. Lippincott, 1991.
- Melosh, Barbara. *The Physicians Hand: Work Culture and Conflicts in American Nursing*. Philadelphia: Temple University Press, 1982.
- Micale, Mark S. and Roy Porter, eds. *Discovering the History of Psychiatry*. New York: Oxford University Press, 1994.
- Nehring, Wendy M. *A History of Nursing in the Field of Mental Retardation and Developmental Disabilities*. Edited by Gary Siperstein. Washington, D.C.: American Association on Mental Retardation, 1999.
- Nolan, Peter. *A History of Mental Health Nursing*. London: Chapman & Hall, 1993.
- Peplau, Hildegard E. *Interpersonal Relations in Nursing*. New York: G. P. Putnam & Sons, 1952.
- Pinar, William F., William M. Reynolds, Patrick Slattery and Peter M. Taubman. *Understanding Curriculum: An Introduction to the Study of Historical and Contemporary Curriculum Discourses*. New York: Peter Lang, 1995.
- Prado, C. G. *Starting with Foucault: An Introduction to Genealogy*. Boulder, CO: Westview Press/New England, 1995.
- Rabinow, Paul. *The Foucault Reader*. New York: Pantheon Books, 1984.

- Rafferty, Anne Marie. *The Politics of Nursing Knowledge*. London: Routledge, 1996.
- Refvik, Kurtland I. *History of the Brandon Mental Health Centre*. Brandon Manitoba, Canada: BMHC Historical Museum, 1991.
- Reverby, Susan. *Ordered to Care: The Dilemma of American Nursing 1850-1945*. New York: Cambridge University Press, 1987.
- Rosenau, Pauline M. *Postmodernism and the Social Sciences: Insights, Inroads, and Intrusions*. Princeton, NJ: Princeton University Press, 1992.
- Rothman, D. J. *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, revised 2nd ed. Boston: Little Brown, 1990.
- Schubert, William H. *Curriculum: Perspective, Paradigm, and Possibility*. New York: Macmillan, 1986.
- Schwartz, Morris S. and Emmy Lanning Shockley. *The Nurse and the Mental Patient: A Study in Interpersonal Relations*. New York: Russell Sage Foundation, 1956.
- Schwirian, P. *Professionalization of nursing: Current issues and trends* (2nd ed.). Philadelphia: J. B. Lippincott, 1998.
- Scull, Andrew T. *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England*. New York: St. Martin's Press, 1979.
- Shorter, Edward, ed. *TPH: History and Memories of the Toronto Psychiatric Hospital, 1925-1966*. Toronto, Ontario: Wall & Emerson, 1996.
- Shorter, Edward. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York: John Wiley & Sons, 1997.
- Shortt, Samuel Edward Dole. *Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry*. Cambridge: Cambridge University Press, 1986.
- Smith, Doug, Bates, Jock, and Jones, Esylit. *Lives in the Public Service: A History of the Manitoba Government Employees' Union*. Co-published by the Manitoba Government Employees' Union, 1993.
- Stark, Joan. S. and Lisa. R. Lattuca. *Shaping the College Curriculum: Academic Plans in Action*. Boston: Allyn and Bacon, 1997.
- Steele, Katharine McL. and Marguerite L. Manfreda. *Psychiatric Nursing* (4th ed.). Philadelphia: F. A. Davis, 1953.

- Szasz, Thomas. *The Myth of Mental Illness*. New York: Harper and Row, 1961.
- Tomes, Nancy. *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1850-1883*. Cambridge: Cambridge University Press, 1984.
- Torres, Gertrude and Helen Yura. *Today's Conceptual Today's Framework: Its Relationship to the Curriculum Development Process*. New York: National League for Nursing, 1974.
- Tyler, Ralph W. *Basic Principles of Curriculum and Instruction*. Chicago: The University of Chicago Press, 1949.
- Vollmer, Howard M. and Mills, Donald L. *Professionalization*. Englewood Cliffs, New Jersey: Prentice Hall, 1966.
- Warsh, Cheryl Krasnick. *Moments of Unreason: The Practice of Psychiatry and the Homewood Retreat, 1883-1923*. Montreal and Kingston: McGill-Queen's University Press, 1989.
- Zilboorg, G. *A History of Medical Psychology*. New York: W. W. Norton, 1941.

Articles and Chapters in Books

- Bem, Sandra L. "Probing the Promise of Androgyny." In *Beyond Sex-Role Stereotypes: Readings Toward a Psychology of Androgyny*. Edited by Alexandra G. Kaplan and Joan P. Beam. Boston: Little Brown and Company, 1976.
- Carpenter, M. "Asylum Nursing Before 1914: A Chapter in the History of Labour." In *Re-Writing Nursing History*. Edited by C. Davies. London: Croom Helm, 1980.
- Coburn, Judy. "I See and Am Silent: A Short History of Nursing in Ontario." In *Women at Work in Ontario, 1850-1930*. Toronto, Ontario: Canadian Women's Educational Press, 1974.
- Davies, Celia. "Professionalizing Strategies as Time and Culture Bound: American and British Nursing Circa 1893." In *Nursing History: New Perspectives, New Possibilities*. Edited by Lagemann and Ellen Condliffe. New York: Teachers College, Columbia University, 1983.
- Di Censo, Alba, Donna Ciliska, and Gordon Guyatt. "Introduction to Evidence-Based Nursing." In *Evidence Based Nursing: A Guide to Clinical Practice*. St Louis: Elsevier Mosby, 2005.

- Foucault, Michel. "Neitzsche, Genealogy, History." In *The Foucault Reader*. Edited by Paul Rabinow. Translated by D. R. Bouchard and S. Simon. New York: Pantheon Books, 1984. Original work published in 1971.
- Francis, Daniel. "The Development of the Lunatic Asylum in the Maritime Provinces." In *Medicine in Canadian Society: Historical Perspectives*. Edited by S. E. D. Shortt. Montreal, Quebec: McGill-Queen's University Press, 1981.
- Friedson, Eliot. "The Futures of Professionalisation." In *Health & The Division of Labour*. Edited by Margaret Stacey. London: Croom Helm, 1977.
- Greenland, Cyril. "Origins of the Toronto Psychiatric Hospital." In *TPH: History and Memories of the Toronto Psychiatric Hospital, 1925-1966*. Edited by Edward Shorter. Toronto, Ontario: Wall & Emerson, 1996.
- Hlynka, Denis. "Postmodern and Poststructural Theory." In *Handbook of Research for Educational Communications and Technology*. Edited by D. H. Jonassen. New York: Simon & Schuster Macmillan, 1996.
- Hodder, Ian. "The Interpretation of Documents and Material Culture." In *Handbook of Qualitative Research*, 2nd ed. Edited by Norman K. Denzin and Yvonna S. Lincoln. Thousand Oaks: CA. Sage Publications, 2000.
- Kelley, Jean. "The Conceptual Framework in Nursing Education." In *Faculty-Curriculum Development Part VI*. New York: National League for Nursing, 1975.
- Lego, Suzanne. "The One-to-One Nurse Patient Relationship." In *Psychiatric Nursing 1946 to 1974: A Report on the State of the Art*. Compiled by Florence L. Huey. New York: The American Journal of Nursing Company, 1975.
- Lyotard, Jean Francois. "The Postmodern Condition: A Report on Knowledge." In *Theory and History of Literature* Vol. 10. Edited by W. Godzich and J. Schulte. Translated by G. Bennington * B. Massumi. Minneapolis: University of Minnesota Press, 1984. Original work published in 1979.
- Schwab, Joseph J. "The Teaching of Science as Enquiry." In *The Teaching of Science*. Cambridge, MA: Harvard University Press, 1966.
- Schwab, Joseph J. "The Practical: Translation into Curriculum." In *Science, Curriculum, and Liberal Education: Selected Essays*. Chapter 12. Edited by Ian Westbury and Neil Wilkof. Chicago: The University of Chicago Press, 1978.

Sills, Grayce. "Use of Milieu Therapy." In *Psychiatric Nursing 1946 to 1974: A Report on the State of the Art*. Compiled by Florence L. Huey. New York: The American Journal of Nursing Company, 1975.

Journal Articles

- Adams, F. R. "From Association to Union: Professional Organization of Asylum Attendants, 1869-1919." *British Journal of Sociology* XX (1) (1969): 11-25.
- Atkinson, H. S. "The Registered Nurse-A Specialist: Psychiatric Institutions Need Them." *The Canadian Nurse* 51 (7) (July, 1955): 544-546.
- Author Unknown. "The History and Future of Psychiatric Nursing." *Canadian Journal of Psychiatric Nursing* XXIV (4) (October, November, December 1983): 6-10.
- Author Unknown. "Officers of the Canadian Association of Psychiatric Nurses Visit Manitoba." *The Bison* X (2) July 1957: 14.
- Author Unknown. Caption under photo of Alf Barnett *The Bison* XII (1) March 1959: 8.
- Author Unknown. "A Century of Psychiatric Nursing." *Canadian Journal of Psychiatric Nursing* XX (July-August 1979): 5-7.
- Author Unknown. "Psychiatric Nurses Association of Canada." *Prism* (July 1980): 7-16.
- Bixler, Genevieve Knight and Roy White Bixler. "The Professional Status of Nursing." *The Canadian Nurse* 42 (1) (January 1946): 35-43.
- Boschma, Geertje, Olive Yonge, and Lorraine Mychajlunow. "Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75." *Nursing Inquiry* 12 (4) (2005): 243-255.
- Boschma, Geertje. "The Gender Specific Role of Male Nurses in Dutch Asylums: 1890-1910." *Nursing History* 4 (3) (Summer 1999): 13-19.
- Bramadat, Ina, Guest Editorial. "Focus: History of Nursing, Nursing History: Some Issues and Insights." *Canadian Journal of Nursing Research* 27 (3) (1995): 3-14.
- Brown, Thomas E. "Foucault Plus Twenty: On Writing the History of Canadian Psychiatry in the 1980s." *Canadian Bulletin of Medical History* 2 (1985): 23-49.

- Brown, Thomas. "Dance of the Dialectic? Some Reflections (Polemic and Otherwise) on the Present State of Nineteenth-Century Asylum Studies." *Canadian Bulletin of Medical History* 11 (1994): 267-296.
- Burt, Katrina. "Issues Update: Male Nurses Still Face Bias." *American Journal of Nursing* 98 (9) (September 1988): 64-65.
- Care, Dean, David Gregory, John English and Peri Venkatesh. "A Struggle for Equality: Resistance to Commissioning of Male Nurses in the Canadian Military, 1952-1967." *Canadian Journal of Nursing Research* 28 (1) (1996): 103-117.
- Christy, Teresa E. "The Methodology of Historical Research: A Brief Introduction." *Nursing Research* 24 (3) (1975): 189-192.
- Church, Olga. "From Custody to Community in Psychiatric Nursing." *Nursing Research* 36 (1987): 48-55.
- Connor, Patrick J. "Neither Courage nor Perseverance Enough: Attendants at the Asylum for the Insane, Kingston, 1877-1905." *Ontario History* 88 (4) (1996): 251-272.
- Dooley, Christopher. "'They Gave Their Care, But We Gave Loving Care': Defining and Defending Boundaries of Skill and Craft in the Nursing Service of a Manitoba Mental Hospital during the Great Depression." *Canadian Bulletin of Medical History* 21 (2) (2004): 229-251.
- Duncan, Susan M., Beverley D. Leipert and Judy E. Mill. "Nurses as Health Evangelists: The Evolution of Public Health Nursing in Canada, 1918-1939." *Advances in Nursing Science* 22 (1) (1999): 40-51.
- Dzurec, Laura Cox. "Poststructuralist Musings on the Mind/Body Question in Health Care." *Advances in Nursing Science* 26 (1) (2003): 63-76.
- Edginton, Barry. "Moral Treatment to Monolith: The Institutional Treatment of the Insane in Manitoba, 1871-1919." *Canadian Bulletin of Medical History* 5 (1988): 167-188.
- Egeland, James W. and Julia S. Brown. "Sex Role Stereotyping and Role Strain of Male Registered Nurses." *Research in Nursing & Health* 11 (1988): 257-267.
- Evans, Joan. "Men in Nursing: Issues of Gender Segregation and Hidden Advantage." *Journal of Advanced Nursing* 26 (1997): 226-231.
- Fitzsimmons, Laura. "Mental Hygiene and Hospital Nursing." *The Canadian Nurse* 41 (7) (July, 1945): 523-526.

- Gortner, Susan R. "The History and Philosophy of Nursing Science and Research." *Advances in Nursing Science* 5 (2) (January 1983): 287-292.
- Griffin, John D. M. "An Historic Oversight." *Canadian Psychiatric Association Bulletin* 26 (2) (April, 1994), 5.
- Hartig, Elisabeth. "Developing a Psychiatric Nursing Curriculum Incorporating the Standards of Practice for the Registered Psychiatric Nurse." *The Canadian Journal of Psychiatric Nursing* XIX (1) (January-February 1978): 6-7.
- Holmes, C. A. "Alternatives to Natural Science Foundations for Nursing." *International Journal of Nursing Studies* 27 (3) (1990): 187-198.
- Horsfall, J. "Psychiatric Nursing: Epistemological Contradictions." *Advances in Nursing Science* 20 (1) (1997): 56-65.
- Hughes, John S. "Country Boys Make the Best Nurses: Nursing the Insane in Alabama, 1861-1910." *Journal of the History of Medicine and Allied Sciences, Inc.* 49 (1994): 79-106.
- Johnson, Dorothy E. "A Philosophy of Nursing." *Nursing Outlook* 7 (4) (April 1959): 198-200.
- Kellie, John. "Letter to the Editor." *The Canadian Nurse* (December 1967): 4.
- Kelly, Norma R, Mary Shoemaker and Tim Steele. "The Experience of Being a Male Student Nurse." *Journal of Nursing Education* 35 (4) (April 1996): 170-174.
- Krausz, Moshe, Peri Kedem, Ziona Tal and Yehuda Amir. "Sex Role Orientation and Work Adaptation of Male Nurses." *Research in Nursing & Health* 15 (1992): 391.
- Mackintosh, Caroline. "A Historical Study of Men in Nursing." *Journal of Advanced Nursing* 26 (1997): 232-236.
- MacLennan, David. "Beyond the Asylum: Professionalization and the Mental Health Hygiene Movement in Canada, 1914-1938*." *Canadian Bulletin of Medical History* 4 (1987): 7-23.
- Mansell, Diana. "Designers Corner, Sources in Nursing Historical Research: A Thorny Methodological Problem." *Canadian Journal of Nursing Research* 27 (3) (1995): 83-86.
- Martyniw, John. "Letter to the Editor." *The Canadian Nurse* (December 1967): 4-5.

- Matas, J. "The Story of Psychiatry in Manitoba." *The Manitoba Medical Review* (June-July 1961): 360-364.
- McCrone, S. "The Impact of the Evolution of Biological Psychiatry on Psychiatric Nursing." *Journal of Psychosocial Nursing* 34 (2) (1996): 38-46.
- McPherson, Kathryn and Meryn Stuart, Guest Editors. "Writing Nursing History in Canada: Issues and Approaches." *Canadian Bulletin of Medical History* 11 (2) (1994): 3-22.
- Mericle, Bruce P. "The Male as Psychiatric Nurse." *Journal of Psychosocial Nursing* 21 (11) (1983): 28-34.
- Moran, James E. "Keepers of the Insane: The Role of Attendants at the Toronto Provincial Asylum, 1875-1905." *Social History* XXVII (55) (May 1995): 51-75.
- Newton, Mildred. "The Case for Historical Research." *Nursing Research* 14 (1) (Winter 1965): 20-26.
- Nolan, Peter W. "The Founding of Psychiatric Nurse Training and its Aftermath." *British Journal of Psychiatry* 159 (1991): 46-52.
- Okrainec, Gary D. "Perceptions of Nursing Education Held by Male Nursing Students." *Western Journal of Nursing Research* 16 (1) (1994): 94-107.
- Osted, Annette. "A Narrow Line - Empathy but Not Involvement." *The Canadian Journal of Psychiatric Nursing* X111 (3) (May-June 1972): 5.
- Osted, Annette. "40th Anniversary Tribute." *Update Registered Psychiatric Nurses Association of Manitoba* (March 2000).
- Paterson, Barbara L., Sharon Tschikota, Marta Crawford, Marian Saydak, Peri Venkatesh and Teri Aronowitz. "Learning to Care: Gender Issues for Male Nursing Students." *Canadian Journal of Nursing Research* 28 (1) (1996): 25-39.
- Pincock, Thomas A. "A Half Century of Psychiatry in Manitoba." *Canada's Mental Health* 14 (May 1970): 4-10.
- PNAC Education Committee. "Recommendations of the P.N.A.C." *Canadian Journal of Psychiatric Nursing* XIII (3) (May-June 1972): 8-9.
- Popkewitz, Thomas S. "A Changing Terrain of Knowledge and Power: A Social Epistemology of Educational Research." *Educational Researcher* 26 (9) (December 1997): 18-29.

- Porter-O'Grady, Tim. "Reverse Discrimination in Nursing Leadership: Hitting the Concrete Ceiling." *Nursing Administration Quarterly* 19 (2) (Winter 1995): 56-62.
- Rafael, Adeline R. Falk. "The Politics of Health Promotion: Influences on Public Health Promoting Nursing Practice in Ontario, Canada from Nightingale to Nineties." *Advances in Nursing Science* 22 (1) (1999): 23-39.
- Ryan, Sandra and Sam Porter. "Men in Nursing: A Cautionary Comparative Critique." *Nursing Outlook* 41 (6) (November-December 1993): 262-267.
- Santos, Elvin H. and Edward Stainbrook. "A History of Psychiatric Nursing in the Nineteenth Century, Part I." *Journal of the History of Medicine* (Winter 1949):48-74.
- Sills, Grayce M. "Research in the Field of Psychiatric Nursing 1952-1977." *Nursing Research* 26 (3) (May-June 1977): 201-207.
- Silva, Mary Cipriano and Daniel Rothbart. "An Analysis of Changing Trends in Philosophies of Science on Nursing Theory Development and Testing." *Advances in Nursing Science* (January 1984): 1-13.
- Sootkoos, Alphonse. "Editorial Introduction." *Journal of Psychiatric Nursing* (January 1963): 3.
- Stevenson, G. H. "The Place of Mental Hygiene and Mental Nursing in this Reconstruction Period." *The Canadian Nurse* 41 (7) (July 1945): 519-522.
- Strong-Boag, Veronica. "Making a Difference: The History of Canada's Nurses." *Canadian Bulletin of Medical History* 8 (1991): 231-248.
- Stuart, Meryn. "Half a Loaf is Better than No Bread: Public Health Nurses and Physicians in Ontario, 1920-1925." *Nursing Research* 41 (1) (1992): 21-27.
- Terbenche, Danielle. "'Curative' and 'Custodial': Benefits of Patient Treatment at the Asylum for the Insane, Kingston, 1878-1906." *The Canadian Historical Review* 86 (1) (March 2005):29-52.
- Tipliski, Veryl Margaret. "Parting at the Crossroads: The Emergence of Education of Psychiatric Nursing in Three Canadian Provinces, 1909-1955." *Canadian Bulletin of Medical History* 21 (2) (2004): 253-279.
- Toman, Cynthia and Meryn Stuart, Guest Editors. "Emerging Scholarship in Nursing History." *Canadian Bulletin of Medical History* 21 (2) (2004): 223-227.

Walk, Alexander. "The History of Mental Nursing." *The Journal of Mental Science* (January 1961): 1-17.

Walkup, James. "The Early Case for Caring for the Insane in General Hospitals." *Hospital and Community Psychiatry* 45 (12) (December 1994): 1224-1228.

Williams, Christine L. "Hidden advantages for men in nursing." *Nursing Administration Quarterly* 19 (2) (Winter 1995): 63-70.

Theses and Dissertations

Bassendowski, Sandra. "Development of the Core Curriculum in Nursing at Wascana Institute of Applied Arts and Sciences." Master's thesis, University of Regina, 1988.

Boschma, Geertje. "Creating Nursing Care for the Mentally Ill: Mental Health Nursing in Dutch Asylums, 1890-1930." Ph.D. diss., University of Pennsylvania, 1997.

Church, Olga. "That Nobel Reform: The Emergence of Psychiatric Nursing in the United States, 1882-1963." Ph.D. diss., University of Illinois, 1982.

Clarke, Ian H. "Public Provisions for the Mentally Ill in Alberta, 1907-1936." Master's thesis, University of Calgary, 1973.

D'Antonio, Patricia O'Brien. "Negotiated Care: A Case Study of Friends Asylum, 1800-1850." Ph. D. diss., University of Pennsylvania, 1992.

Dooley, Christopher. "When Love and Skill Get Together: Worker, Skill and the Occupational Culture of Mental Nurses at the Brandon Hospital for Mental Diseases, 1919-1946." Master's thesis, University of Manitoba, 1998.

Johnson, Cornelia. "A History of Mental Health Care in Manitoba: A Local Manifestation of an International Social Movement." Master's thesis, University of Manitoba, 1980.

Kebicz, Rodney B. "The Art of Caring: Male Nurses Providing Personal and Intimate Care with Female Patients." Master's thesis, University of Manitoba, 2000.

Martin, Angela. "Determinants of Destiny: The Professional Development of Psychiatric Nurses in Saskatchewan." Master's thesis, University of Regina, 2003.

McKay, Marion Lynne Clark. "Saints and Sanitarians: The Role of Women's Voluntary Agencies in the Development of Winnipeg's Public Health System, 1882-1945." Ph. D. diss., University of Manitoba, 2005.

- Mombourquette, Duane John. "A Government and Health Care: The Co-operative Commonwealth Federation in Saskatchewan, 1944-1964." Master's thesis, University of Regina, 1990.
- Nishida, Paul Susumu. "The Establishment of Saskatchewan's Mental Hospitals 1912-1940." Master's thesis, University of Regina, 1988.
- Nolan, Peter. "Psychiatric Nursing, Past and Present: The Nurses Viewpoint." Ph.D. diss., University of Bath, UK, 1989.
- Prebble, Catherine Mary (Kate). "Ordinary Men and Uncommon Women: A History of Psychiatric Nursing in New Zealand Public Mental Hospitals, 1939-1972." Ph.D. diss., University of Auckland, 2007.
- Robinson, J. Renee. "Rural Mental Health Services for People with Severe and Persistent Mental Illness: Organization and Effectiveness." Ph.D. diss., University of Manitoba, 2005.
- Simpson, John H. "An Interpretation of the Concept of Caring by People with Development Challenges." Master's thesis, Brandon University, 1996.
- Tarko, Michel Andre. "A Grounded Theory Study of the Experience of Spirituality Among Persons Living With Schizophrenia." Ph.D.diss., University of British Columbia, 2002.
- Tipliski, Veryl Margaret. "Parting at the Crossroads: The Development of Education for Psychiatric Nursing in Three Canadian Provinces, 1909-1955." Ph.D. diss., University of Manitoba, 2002.
- Wood, Susan T. "Changing Times: A Historical Review of Psychiatric Nursing in the Province of Saskatchewan." Master's thesis, University of Regina, 1998.

Unpublished Papers and Documents

- Author Unknown. *History*. Alberta Registered Psychiatric Nurses Association, Edmonton, Alberta. Circa. 1951.
- Kellie, John. "A History of the School of Nursing: The Manitoba Developmental Centre." Unpublished manuscript, 1988. CRPNM Archives.
- Narfason, Della. "Historical Perspective, School of Psychiatric Nursing, Selkirk." Unpublished manuscript, 1986. CRPNM Archives.
- PNAC Standards Committee on Psychiatric Nursing. "Working Paper on Standards of Practice for the Registered Psychiatric Nurse." Unpublished document

Psychiatric Nurses Association of Canada, Revised May 1977. BMHC Museum.

Stokes, Vera. "Articles of Interest: The Evolution of the Manitoba School for Mental Defectives Portage la Prairie, 1890-1943." Undated article. Museum, Manitoba School, Portage la Prairie, Manitoba.

Strong, Richard. "A Short History of Psychiatric Nursing in B.C." Circa 1951. Office of the Registered Psychiatric Nurses Association of British Columbia, Burnaby, British Columbia.

The Register of Students of Brandon Mental Hospital School of Nursing, 1920-1995.

Papers Presented

Dooley, Christopher. *Needle Nurses or People Persons*. Paper presented at the Canadian Society for the History of Nursing, Saskatoon, Saskatchewan, June 1, 2007.

Scott, Joan Wallach. *After History?* Paper presented at the History and the Limits of Interpretation Symposium, Rice University, March 15-17, 1996. Paper can be accessed at:
http://cohesion.rice.edu/humanities/csc/conferences.cfm?doc_id=371.

Personal Collection

Terry Gibson

Newspapers

The Brandon Sun
 Winnipeg Free Press
 Winnipeg Tribune

E-Mails

Rick MacLowick, July 17, 2003
 Marlene Brichon, August 20, 2006
 Barry Russell, September 8, 2007

Personal Communication and Phone Calls

Terry Gibson, February 6, 2007
 Robin Giles, May 19, 2007
 Ross Stewart, May 30, 2007