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PEER REVIEW AND ACCOUNTABILITY

I'm quite sure the reviewer did not read my paper. The comments raised concerns which I had addressed at some length in the paper.

I don't know what to do, the reviewer refuses to return the copy of my paper to the editor and will not review it either. He has been asked several times.

My paper has been at the review stage for 18 months. If it ever gets through, it will be published and, by then, it will be out of date.

I feel devastated by the reviewer's comments. There were two pages of sarcasm and denigrating remarks. I may never write again.

These reports, made to me by both well published nurse authors and novices, prompted me to request editorial space to comment on the role one assumes when one accepts the task of reviewing manuscripts for nursing journals, including this one.

Being asked to act in a peer review capacity is an honour that is a recognition of one's expertise. The role is critically important, for a reviewer contributes to at least seven functions: supporting our nursing journals; providing constructive feedback to peers; assisting career development; allowing for the dissemination of nursing knowledge and opinion; improving the utilization of research findings or raising further questions; demonstrating to those who fund our work that scholarly writing is occurring; and, encouraging debate on issues that are of concern to the discipline and to health care. It may be that all of these functions matter not one whit with the simultaneous arrival of a manuscript and the recognition that you have work to do!

Over the past few years, my experience as a reviewer has led me to establish several maxims that may be helpful to others.

1. Manuscripts always arrive at a "bad" time. This is because those who have the expertise for reviewing have many other commitments also. Personally, I usually groan when I catch sight of a suspiciously thick package, and the letterhead of the editor makes my stomach contract. In recognition of my adverse reaction, I have set up a system that I follow determinedly - I review the manuscript within five days of receipt by me. I have found that if I delay a review, the delay seems to extend itself mysteriously. The message to myself is that I am dealing with a manuscript expeditiously and hope that manuscripts I submit are dealt with in the same manner.

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2. Concentrate on the task at hand and your remarks will reflect your thorough reading and understanding. Over the past eight years, I have had nursing authors show me comments that smacked of ignorance, impatience and possibly illiteracy. The comments ranged from changing one's style of writing to suit the reviewer, to an inappropriate use of humour, to items that were not related to the content in any way. The reviewer has the advantages of expertise, of invitation and of anonymity; these should be exercised fairly and judiciously. Most journal review forms now have a space for the reviewer to make separate comments to the editor and these are not seen by the author. Vent your feelings in this space, but make sure your remarks to the author are always fair, relevant and helpful.

3. Either do the task of reviewing or return the manuscript promptly. Legally, reviewers have contracted with the editor to accomplish a task within a specific time frame and under certain conditions (guidelines for reviewing); they have agreed to return or destroy the manuscript and understand that they may not use or discuss the ideas in the manuscript until the paper is published and can be referenced. Ethically, when you have accepted to be a reviewer but find yourself for some reason in the awkward position of not being able to do a review, the best action is to return the manuscript promptly with a note of apology. At this point it is worth mentioning that you should alert the editor to plans for sabbatical relocations, extended holiday or sick leave.

4. Follow the review guidelines sent to you. This helps you to balance a review (for few manuscripts are total disasters) and address the aspects of the paper that the editor feels are important. It is always a good idea to give more than one line of feedback, unless the paper is brilliant in concept and presentation.

5. Review yourself. After reviewing four or five manuscripts, re-read your written reviews and check these points: What was your tone? Were you helpful and constructive? Was the review complete and did it highlight strengths as well as weaknesses? Was it relevant? Was the review returned in a timely manner? If you aren't satisfied with your reviewing, it is time to speak with the editor.

6. Remember to end your appointment as reviewer to create opportunity for those who are coming up behind you. The editor may decide to utilize your talents for reviews in which first reviewers have disagreed with one another.

Of course, the editors have a crucial role to play in reviewing and ensuring that authors receive fair treatment. They have to hold us accountable, must speak firmly with errant reviewers and, at times, remove reviewers who consistently demonstrate that they aren't accountable.

Accepting the role of reviewer means prestige is being conferred on you, but responsibility is a prerequisite.

Leslie K. Hardy
Memorial University

ÉVALUATION CONFRATERNELLE ET REDDITION DE COMPTES

Je suis certain que l'examinateur n'a pas lu mon manuscrit. Ses remarques traitent des questions que j'aborde en long et en large dans mon article.

Je ne sais pas quoi faire, l'examinateur refuse de renvoyer la copie de mon article au rédacteur et il refuse de le lire. Or, cela fait plusieurs fois qu'on le rappelle à l'ordre.

Cela fait 18 mois que mon article en est au stade de l'évaluation. S'il arrive à franchir ce stade, il faudra une autre année avant de le publier et il sera alors périmé.

Je suis catastrophé par les remarques de l'évaluateur. Deux pages de sarcasmes et de propos désobligeants. J'y repenserai à deux fois avant d'écrire à nouveau.

Ces commentaires, formulés devant moi par des infirmières aguerries et des profanes, m'ont incité à écrire un éditorial sur le rôle qu'on assume en acceptant la tâche d'examiner des manuscrits soumis à des revues de sciences infirmières, dont celle-ci.

Lorsqu'on vous demande une évaluation confraternelle, c'est un honneur qui témoigne de vos compétences. Le rôle est d'autant plus important qu'un examinateur remplit au moins sept fonctions : il épaule les revues de sciences infirmières; il fournit des réactions constructives à ses collègues; il contribue au développement de carrière; il favorise la diffusion de connaissances et d'opinions en sciences infirmières; il dynamise l'utilisation des résultats de recherche ou il soulève d'autres questions; il apporte la preuve à ceux qui financent nos recherches que nous faisons bel et bien des travaux d'érudition; et il encourage le débat sur les questions qui intéressent la discipline et les soins de la santé. Il se peut que cela vous soit profondément égal lorsque vous voyez atterrir un manuscrit sur votre bureau et que vous savez que vous avez du pain sur la planche!

Depuis quelques années, mon expérience d'examinateur m'a conduit à édifier plusieurs maximes qui pourront être utiles à d'autres :

1. Les manuscrits arrivent toujours au "mauvais" moment. Cela est dû au fait que ceux qui ont les compétences voulues pour les examiner ont également maints autres engagements. Personnellement, je pousse un gémissement lorsque j'aperçois un colis anormalement épais et j'ai de véritables convulsions d'estomac lorsque je vois l'en-tête de l'éditeur. Compte tenu de cette réaction fâcheuse, j'ai conçu un système auquel je me tiens résolument: je lis le manuscrit dans les cinq jours qui suivent sa réception. J'ai en effet découvert que si je retarde cet examen, le délai se prolonge mystérieusement et indéfiniment. Le message est que je m'occupe d'un manuscrit avec autant de rapidité que j'aimerais que l'on traite mes propres manuscrits.

2. Se concentrer sur la tâche à accomplir pour que vos remarques démontrent que vous avez lu attentivement le manuscrit et que vous l'avez compris. Depuis huit ans, combien de fois ai-je vu des auteurs me montrer des observations qui sentaient l'ignorance, l'impatience et parfois même une méconnaissance totale du sujet. Ces remarques pouvaient traduire la volonté de modifier le style d'un auteur pour qu'il cadre mieux avec celui de l'examinateur, elles pouvaient faire preuve d'un humour douteux ou n'avoir carrément aucun rapport avec le fond de l'article. L'examinateur a les pouvoirs d'un juge et d'un auteur anonyme, mais il doit s'en servir de manière juste et judicieuse. La plupart des formulaires d'examen contiennent aujourd'hui de l'espace pour que l'examinateur formule des remarques distinctes à l'égard du rédacteur en chef, lesquelles ne sont pas vues par l'auteur. Laissez libre cours à vos sentiments dans cet espace car il arrive qu'un manuscrit soit mal écrit et mérite carrément d'être rejeté. Cependant, les remarques formulées à l'intention de l'auteur doivent toujours être justes, utiles et avoir un rapport avec le sujet.

3. Vous devez décider tout de suite d'examiner le manuscrit ou de le retourner à l'éditeur. Sur le plan juridique, les examinateurs ont un contrat

tacite avec le rédacteur d'accomplir leur tâche dans un délai prescrit et selon certaines conditions (directives d'examen); ils ont convenu de renvoyer ou de détruire le manuscrit et se sont engagés à ne pas se servir ou à ne pas débattre des idées contenues dans le manuscrit jusqu'à la publication de l'article qui peut alors servir de référence. Sur le plan moral, étant donné que vous avez accepté d'assumer le rôle d'examinateur mais que vous vous trouvez dans la situation étrange de ne pas pouvoir procéder à cet examen, la meilleure solution est de renvoyer le manuscrit le plus rapidement possible avec une note d'excuse. ê ce stade, il est bon que vous parliez au rédacteur de vos plans de congé sabbatique, de congé prolongé ou de congé de maladie.

4. Conformez-vous aux directives qui vous ont été adressées. Cela vous aidera à équilibrer votre critique (il est rare qu'un manuscrit soit une catastrophe complète) et à vous concentrer sur les éléments de l'article qui revêtent de l'importance aux yeux du rédacteur. Il est toujours bon d'écrire plus d'une phrase de remarques, sauf si l'article brille autant par sa conception que par sa présentation.

5. Faites votre propre examen. Après avoir fait la critique de quatre ou cinq manuscrits, relisez vos critiques et vérifiez les points suivants: quel en était le ton? Vos remarques étaient-elles utiles et constructives? La critique était-elle exhaustive et soulignait-elle les points forts et les faiblesses? Était-elle à-propos? L'avez-vous renvoyée dans les délais prescrits? Si vous n'êtes pas satisfait(e) de vos antécédents en la matière, il est peut-être temps que vous parliez au rédacteur.

6. N'oubliez pas de mettre un terme officiel à vos fonctions d'examinateur pour donner la chance à ceux qui viennent derrière vous. Il se peut qu'un rédacteur décide de faire appel à vos talents pour l'examen d'un manuscrit qui a suscité bien des polémiques chez les premiers examinateurs.

Bien sûr, les rédacteurs ont un rôle crucial à jouer dans le processus d'examen pour s'assurer que les auteurs sont traités avec équité. Ils doivent nous tenir responsables, doivent faire preuve de fermeté avec les examinateurs qui manquent de sérieux et parfois se débarrasser des examinateurs qui ont apporté la preuve qu'ils n'avaient aucun sens de leurs responsabilités.

Le rôle de l'examinateur est assorti d'un certain prestige mais également de responsabilités à la hauteur desquelles il faut savoir se tenir.

Leslie K. Hardy
Memorial University

ERRATUM

In the Editorial of the last edition (Volume 23, Number 1), entitled "Family Nursing Thriving" by Nancy Feeley, it was reported that the Third International Family Nursing Conference will be held in Montreal in May, 1993. The conference will take place in *May, 1994*.

LETTER TO THE EDITOR

I was shocked and dismayed to read the editorial "Playing It Shrewd, Not Shrill" (*Canadian Journal of Nursing Research*, 22(4), 1-3). While concerned about the paucity of research funding for nursing research, Dr. Pringle implies we should be nice about this and bide our time. Apparently, when our home-grown doctoral students mature, research funding will conveniently appear.

With all due respect, Dr. Pringle's position does not consider the needs of an already strong cadre of nurse researchers in Canada. Many of these nurse researchers conduct research as an integral part of their academic appointments; some are employed full-time by health care institutions, and a few conduct research as career scientists and scholars. All require funding.

No one can deny that nurses are well prepared to do research. No one can deny that nursing research could make a significant and vital contribution to health care. No one can deny that nursing research is disproportionately underfunded.

Without adequate funding, nursing research becomes a laborious task, with the principal investigator filling multiple roles - research assistant, secretary and gopher. Without adequate funding, "feasibility" is defined by the dollar, rather than the research question, with the research design, sample size, number of variables, or type of analysis downscaled. Feasibility becomes a question of fitting research to financial constraints, such as available equipment and space (neither of which we have). Some research is simply out of the question, such as prospective studies or ethology, which are too costly or require special equipment, or research requiring a wet lab. And as our research is downscaled, nursing research loses credence with the scientific community. Nursing research is considered trivial enough to be ignored.

It is time to become advocates for ourselves, for the quality of our practice, for the development of our profession, and for the health of all Canadians. It is time to take responsibility for this inequity. It is time to speak forcefully and articulately on this issue. It is time to let our government know that this situation cannot continue.

It is not shrewd to be silent; we must be shrill.

Janice M. Morse, R.N., Ph.D. (Anthro), Ph.D.(Nurs)
Professor & MRC/NHRDP Research Scholar
The University of Alberta

COMING EVENTS

The American Nurses Association
Council of Nurse Researchers

1991 International Nursing Research Conference

October 22-25, 1991
Los Angeles Airport Hilton and Towers, Los Angeles, California

Call for Abstracts

First International Conference on
Community Health Nursing Research
Edmonton Convention Centre

Fields of Interest: Health promotion; Illness & injury prevention
Deadline for receipt of abstracts: 15 September, 1992
Contact: Ms. Karen Mills, ICCHNR, Edmonton Board of Health, #500 10216 124 Street, Edmonton, AB, T5N 4A3, (403) 482 1965

European Nursing Conference 1992
Amsterdam, October 11-14

Reassessing Nursing Nursing Care:
A challenge for nurses in the 21st century

Koningslaan 52, 1075 AE Amsterdam telephone: +31-(0)20-793411

THE USE OF AN AUTOBIOGRAPHICAL LETTER IN THE NURSING ADMISSIONS PROCESS: INITIAL RELIABILITY AND VALIDITY

Barbara Brown, Barbara Carpio and Jacqueline Roberts

Nursing education has a two-fold accountability. First it must provide nursing students with a quality education and second it must provide society with professional nurses capable of providing quality health care (Rothman & Rothman, 1977). To ensure this accountability, nursing programmes use a variety of admissions criteria and processes to identify students who will perform well academically and professionally. Yet the reliability and validity of admission criteria and the selection processes continues to be a recurrent and unresolved issue.

The admission process is an extremely complex issue, affected by a number of interacting factors (RNAO, 1981). Student-related factors include limited enrolments that necessitate the identification of the most suitable candidates, unidentified factors that motivate applicants to seek nursing education, recruitment activities of the nursing programmes, characteristics of success both in the nursing programme and in nursing practice, and reasons behind the attrition rates. Other factors include varying philosophies of education; curriculum models and teaching methods that may require particular unique student and faculty qualities and abilities; availability of resources in both the educational and clinical facilities; and, the changing expectations and demands with respect to the competence of nurses and to employment opportunities. Finally, there is a dearth of research activities that would result in increased reliability and validity of the admission criteria and processes.

Literature Review

A perusal of the literature addressing the issue of student selection reveals a diversity of admission practices and a continued search for valid predictors of achievement. Most of the literature focuses either on identifying factors that predict success and attrition in the nursing programme or on examining

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the predictability of success in professional certification. Measures of academic and non-academic attributes of students have provided the base for admission criteria and selection of nursing students. Previous academic performance, including the high school grade point average and standardized academic tests, are used most frequently to predict pre-professional academic achievement and the potential for successful completion of the nursing programme (Grant, 1986; Higgs, 1984). Non-academic attributes considered important in nursing include motivation, interest in nursing, problem-solving ability and personality characteristics (Bauwens & Gerhard, 1987; Berger, 1984; Burgess, 1980; George & Owen, 1983; Loos, 1983; Zagar, 1982). These are often assessed by standardized personality and interest tests, a pre-admission interview, questionnaires and biographical essays and a variety of demographic factors.

McMaster University School of Nursing is no exception in facing the challenge to develop reliable and valid admission criteria and procedures in order to select, from a large pool of applicants, those students most likely to succeed in a curriculum that portends to the small group, self-directed and problem-based learning style. To this end, an autobiographical letter is used as one component of the admission process. Literature addressing the autobiographical letter as a selection device is scarce. Interestingly, as far back as 1959, Beyerl suggested, as one of many selection options, that the applicant's written reasons for entering nursing be assessed to determine her or his interest. In two more recent papers, the Registered Nurses' Association of Ontario (1981) and Weinstein and colleagues (1979) suggested that the merits of the autobiographical essay or questionnaire should be explored, in terms of their effectiveness for collecting data on the interests, language skills and background of the applicants. Walden (1979) discusses the autobiographical letter:

> Applicants can be asked to write personal essays by which they can be evaluated more comprehensively with regard to such qualities as motivation, values, degree of open-mindedness, coping strength, or whatever. The objective would be to translate into written form what one might hope to gain from a direct interview with an applicant. Admission raters could then be trained to examine these statements for the qualities desired. A probable result would be greater consistency and greater standardization among raters. [101:56].

Walden (1979) also identifies several disadvantages to the autobiographical letter. The organized, articulate writer is likely to fare better than one who has difficulty putting thoughts to paper. Also, there is no assurance that the applicant wrote the personal statement.

In examining the validity of grades versus interview in predicting academic performance in a nursing programme, Stronck (1979) mentions briefly the

use of an autobiographical letter. A small proportion of points in the admission score were awarded on the basis of a short essay composed by the applicant. Results indicated that narrative skills of the applicants correlated with academic performance in the nursing college. The investigators recommended that applicants identify their professional goals and attitudes in writing.

The selection of medical students at McMaster University follows a similar admission format to that of the School of Nursing. Hamilton (1972) compared those applicants selected for interview, on the basis of autobiographical letter ratings, with 30 students selected at random. Even though the academic profiles of the two groups were similar, the randomly-selected group received poor interview ratings when compared to those selected on the basis of letter scores. There was also a weak positive association between the assessment given to the letters and the interviews of the same candidate. Three readers were asked to rate each letter. There was a total agreement in 42% random association. The question of whether the letter reflected the literary style or background experience of the applicants rather than their potential and concerns about "faking" the letter were also raised. No relation was noted between the letter assessment and the applicant's type of academic background or the applicant's age or verbal scores on the Medical College Admissions Test. It was acknowledged that there is no assurance that the letter is actually written by the applicant. However as far as they could judge, the applicants were honest and had taken "great pains" in writing the letter. It was expected that the interview would reveal those applicants who had been dishonest.

More recently, Heale, Blumberg, Wakefield and McAuley (1987) explored the reliability and validity of the autobiographical letter and of the interview used to select applicants to the Family Medicine residency programme over a three-year period. Significant correlations were reported between readers ($r = 0.49$), between interviewers ($r = 0.45$), as well as between the letter score and the interview score ($r = 0.32$). There was a significant correlation between the interview score and the number of exceptional ratings a resident received from clinical supervisors ($r = 0.40$). There were no differences in selection letter scores, or in overall selection rankings between "exceptional" ratings and "major problem" ratings. The investigators concluded that, although both the letter and the interview are reliable, the letter is not recommended for the selection of family residents; it does not discriminate between those residents who are exceptional and those residents who are having major problems in their residency.

In conclusion, the autobiographical letter has been suggested as an admissions selection procedure, and our counterparts in the medical school have deemed it as an acceptable component of the admissions process. The

RNAO (1981) position paper recommended that each nursing programme engage in systematic evaluation of its own admission process in order to determine reliability and cost-effectiveness as predictors of programme success. Therefore, the purpose of this research was to explore initial reliability and validity of the autobiographical letter, which is used as one component in the nursing admissions process. This study was conducted during the 1988 admission cycle.

Methods

Applicants to the four-year basic baccalaureate stream who are not admitted directly from high school and registered nurses who apply to the degree completion stream are asked to write an autobiographical letter. This focuses on three criteria: their personal qualities, their reasons for applying to the programme and their ability to function within its aims and objectives. The letter is to be typed and is limited to two pages in length. The applicants are informed that this letter is used to screen and select applicants for an interview.

The letters are assessed by a three-member reader team which includes a faculty member, a community representative and a third- or fourth-year nursing student or local nursing alumnus. There are two sets of reader teams; one set for the applicants to the basic stream and one set for the post RN degree completion applicants. Following an orientation session, each reader receives a package of approximately 10-15 letters. They score the letters independently, using a standardized Likert rating scale in which the scores range from unacceptable (1) to outstanding (7) suitability to the programme. A work sheet listing a series of questions is also provided to the readers in order to guide their assessment and rating of the three criteria that are expected to be discussed in the letter. Although there is not a specific score for each of the criteria, the three criteria are viewed as contributing equally to the score.

Once the reader has assessed the letter, the score out of seven is recorded on the standardized rating scale. The letter scores assigned by the faculty, community and student or alumnus reader teams are then totalled to produce a composite team score out of a possible 21 for each autobiographical letter. Those applicants whose letters receive a high rating are then invited to a team interview. In turn, files of all interviewed applicants are brought to collation and applicants are selected for acceptance into the programme.

To explore the reliability and validity of the autobiographical letter, the reader teams were sent their regular package of letters, and four control letters were included in each package (Time 1). Readers were blind to this maneuver and scored all letters in the package. To establish inter-rater reliability of the four control letters, a sample of 20 letters was randomly

selected from both the basic and post-RN stream applications. Three faculty members with experience in letter reading, (including two members of the admissions committee), read and scored these letters, using the standardized rating scale. Those letters that were scored consistently by all three raters were then identified. Of those, one letter from each of the standardized rating scale categories: unacceptable/reservations (≤3.9), acceptable (4-4.9), good (5-5.9) and very good to outstanding (6-7) was selected as a control letter.

To determine inter-team reliability, team reader scores for all four pre-rated letters were analyzed using analysis of variance and intra-class correlations. These four control letters were then sent to the same readers to score three months later (Time 2). Using repeated measures analysis of variance, the scores between teams were compared and reliability coefficients for teams were calculated. To determine intra-team reliability, team scores were initially to be compared between Time 1 and Time 2. However, the total return response rate for all categories of readers at Time 2 was low (Basic 67%; post RN 58%) and very few complete teams were represented at Time 2. Thus, intra-team realiability could not be compared between Time 1 and Time 2. Numbers did permit measurement of intra-status (faculty, community, student or alumnus) reliability.

Face validity was established through a variety of methods. The autobiographical letter has been used for several years and both the instructions to the applicant and the marking scheme to the readers have been designed, developed and revised to reflect the aims and objectives of the nursing programme. Letter readers attend an orientation session during which the aims and objectives of the program are reviewed, the three criteria are discussed in the context of the questions on the work sheet and the standardized rating scale and the scoring of two letters is practised. To improve face validity, reader packages included an evaluation form, and readers are encouraged to submit comments and suggestions as to how the process can be made more efficient and effective.

Concurrent validity was assessed by comparing the team reader letter scores with the four pre-rated letter scores using analysis of variance and Q Kappa. In addition, letter scores were correlated with interview scores for the post-RN degree applicants. The basic applicant pool was considerably larger; thus, only the highest scoring applicants (a combination of academic reference and letter scores) were invited to an interview. Consequently a comparison between basic applicants' letters and interviews was not done, as there were no applicants with low letter scores that were invited to be interviewed.

Results

The results of the reliability testing of basic degree applicants and post-RN degree completion applicants are presented separately. For the basic degree applicants, 12 reader teams read, on average, 10 basic applicant autobiographical letters, including the four pre-rated control letters. Using analysis of variance there was no statistical significant difference (ANOVA $F = 2.1$, $p = NS$) between the 12 teams. The team mean scores for the basic control letters are displayed in Figure 1. The intra-class correlation was .80, indicating good reliability for the teams at Time 1. Combined letter reliability estimates for Time 1 and Time 2 for each status of reader were also consistently good (Quadratic Kappa .72 (faculty); .77 (community); .71 (student).

Turning to the post-RN applicant results, there were also 12 teams that read from 7-10 letters including the four control letters. There was no statistically-significant difference (ANOVA $F = 1.3$, $p = NS$) between the teams. The team mean scores for the post-RN control letters are displayed in Figure 1. Reliability of the team scores at Time 1 was satisfactory (ICC = .43). Time 1 and Time 2 combined letter reliability estimates, for all four letters, varied according to status of reader (Quadratic Kappa .67 (faculty); .65 (student); .38 (community).

Face validity was examined through reader feedback and 56 out of 72, or 78%, of readers completed the reader evaluation forms. Of the 56 responses, 40 (71%) were from readers who had attended the orientation. The majority found the session very useful and reported that the opportunity to practise and review scoring two letters increased their confidence in their ability to evaluate fairly. The rating forms reportedly facilitated the scoring; were concise, yet addressed the three criteria; and promoted consistency in the ratings. Comments ranged from "time consuming but necessary", "the middle range letters were the most difficult to score" and "would be helpful to have a resource person available". Many readers commented on the value of the process and found it enjoyable and challenging. The time to read and score the questionnaires ranged from 1.5 to 12 hours with the majority taking 4-6 hours. Times reported by first time readers were longer than those by experienced readers.

In terms of concurrent validity, there was a statistically-significant difference between the mean scores of the four control letters of the 12 reader teams (Basic: $F=50.13$, $p <.001$; Post-RN: $F=9.5$, $p <.001$ - see Figure 2). The agreement between the team reader scores and the pre-rated letter scores was acceptable for the basic applicants (Kappa = .63) and somewhat less so for the post-RN applicants (Kappa = .54). The team reader scores, did not correlate well with the interview scores ($r = .18$) and agreement above and beyond chance was low (Kappa = .11).

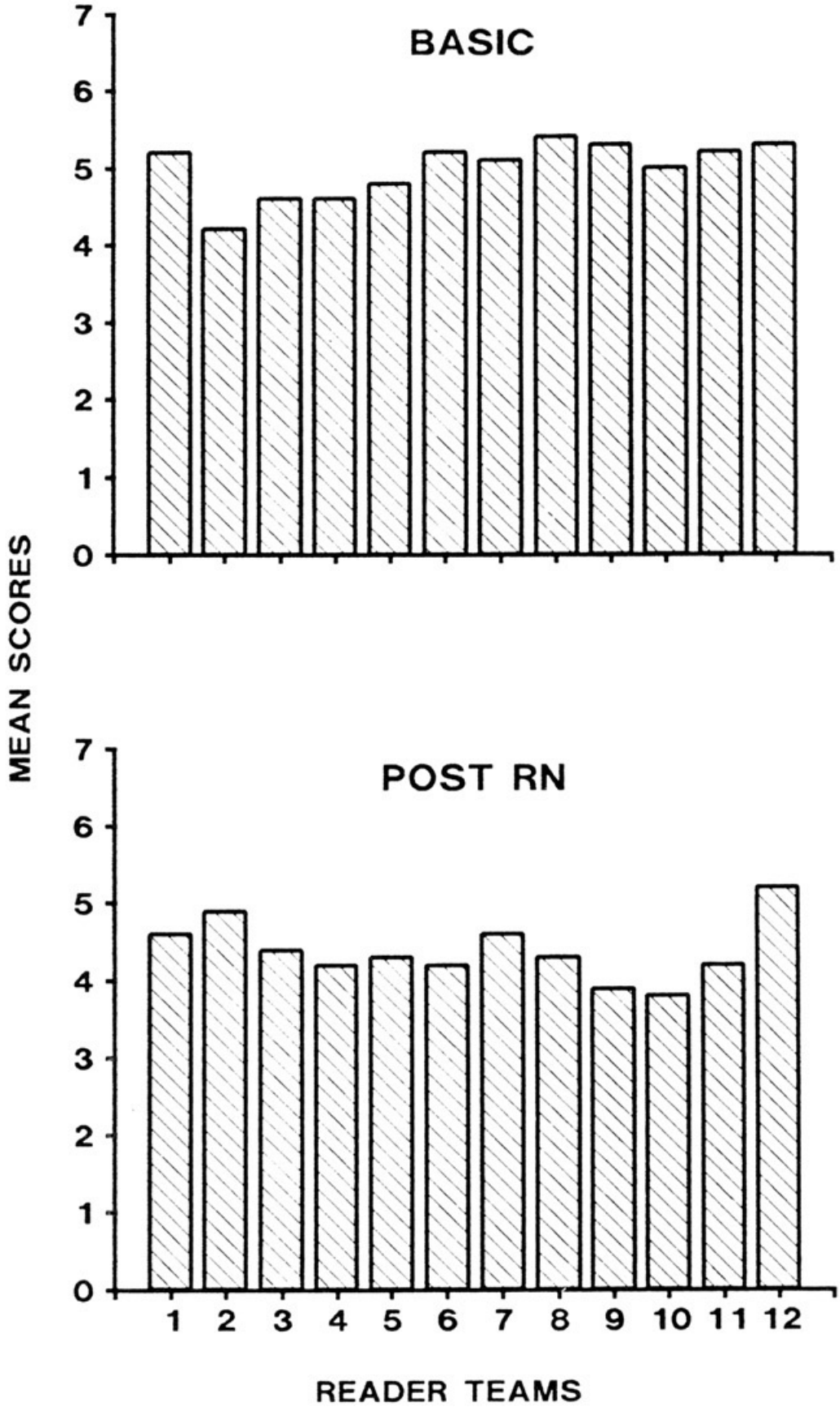

Figure 1
Team Scores for the Control Letters

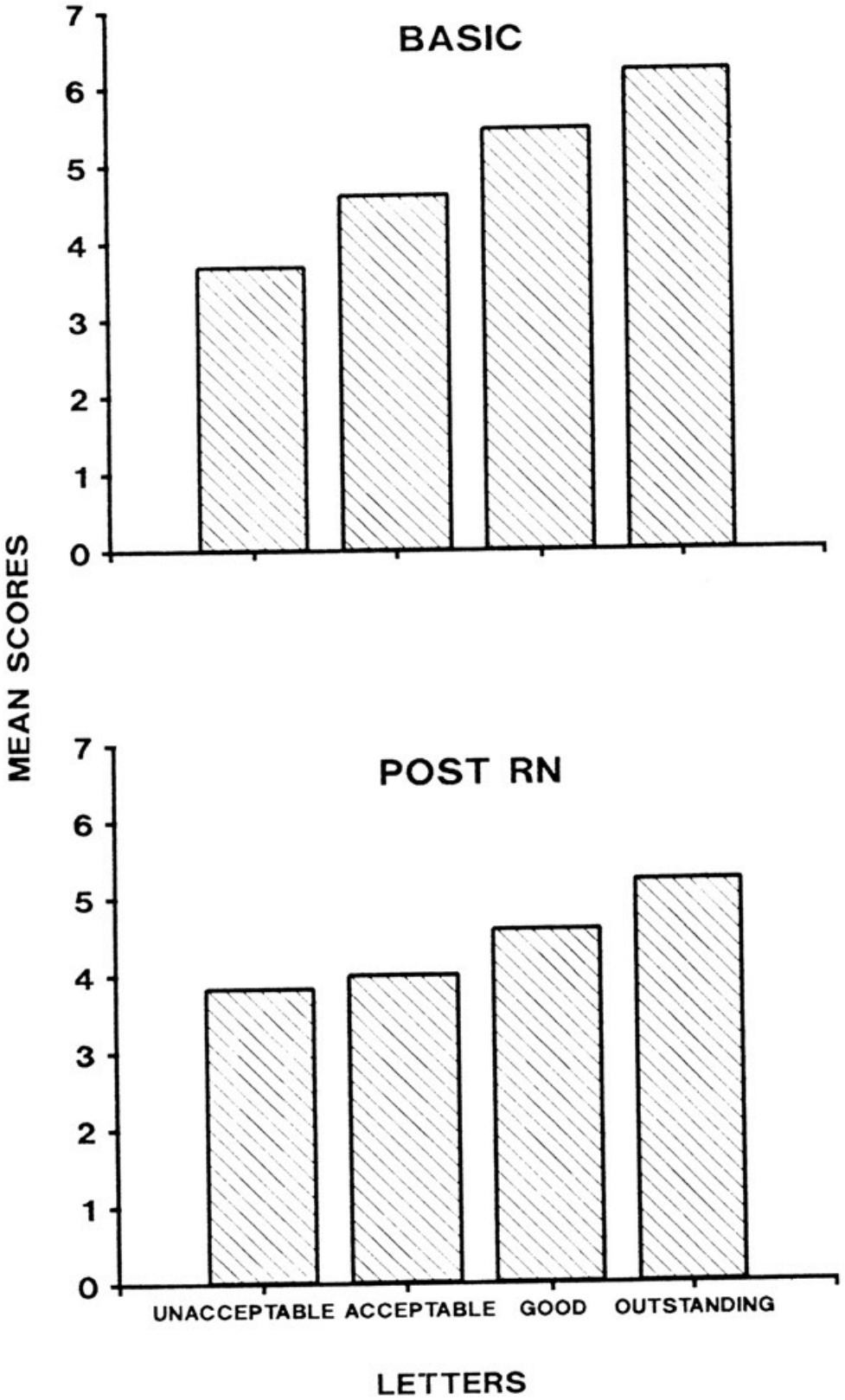

Figure 2
Control Letter Mean Scores

Discussion and Conclusions

The intent of this study was to explore the initial reliability and validity of the autobiographical letter that is used as one component of the nursing admissions process. With regard to reliability, the results are favourable. For both applicant pools, reader team reliability was acceptable, indicating the reader teams score consistently. When comparing Time 1 and Time 2 for each status of team members for the basic applicants, the reliability estimates were consistently good and did not vary according to category of the reader. For the post-RN applicants the reliability estimates varied with the community readers demonstrating the lowest reliability over time.

This result could be attributed to the somewhat more diverse nature of this group of readers, in contrast to the nursing faculty and students, thus raising the possibility that their criteria for rating may not be as objective. For example, letter readers included a Dean of Health Sciences and a Health Science librarian, as well as hospital and community directors of nursing and several clinical nurse specialists. An explanation for the discrepancy between the high reliability score of .77 for the basic community raters and the low reliability score for the post-RN community raters is less apparent. Perhaps the post-RN community readers are open to subjectivity bias between Time 1 and Time 2 in that they have some pre-conceived expectations of what they are looking for when scoring the letters of applicants who are already nurses, versus the basic applicants who are expected to know little about nursing.

In reflecting on the concurrent validity results, the reader teams were also able to rate letters consistently and discriminate as to applicant suitability to the programme, in keeping with the pre-rated predictions of the four control letters. The team letter scores for post-RN applicants were not significantly correlated with the team interview scores. Rather than viewing this result as indicative of poor validity for the autobiographical letter, the results may suggest that the letter and the interview are two different approaches that measure distinct applicant qualities.

In conclusion, we plan to continue to use the concept of the autobiographical letter as part of our admissions process. However, in terms of on-going improvement, and increasing reliability and validity, the applicant is now given three specific questions to address rather than three broad headings. For example, "comment on your personal qualities" has been changed to "describe a situation which reflects your personal strengths and limitations". The scoring system has been devised to reflect the expectations of each question as well as a global score. This admissions component is now referred to as the autobiographical questionnaire rather than letter.

A more in-depth orientation to questionnaire reading is warranted particularly for the community readers. In addition to practising scoring several letters, the orientation session should include a more in-depth discussion of the nursing programme itself. A resource person for readers may also be warranted. On the other hand, including only nurses as community readers may also improve the reliability of this group of readers; however, this would be at the cost of narrowing the perspective and pool of readers.

The School of Nursing strongly endorses this admissions process as necessary to select candidates who will not only perform well academically and professionally in nursing but also will succeed in a curriculum that is based on small group, self-directed and problem-based learning. Needless to say, this type of admissions process is resource intensive from both School of Nursing and bureaucratic perspectives. Consequently, we should continue to evaluate and to monitor our admissions process.

Future research directions will examine the reliability of the more structured autobiographical questionnaire approach. Also, to explore predictive validity, the students accepted into the program will be followed to graduation and their autobiographical letter and interview scores will be compared with their grades.

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RÉSUMÉ

Le rôle de la lettre autobiographique dans les modalités d'admission à un programme de sciences infirmières: fiabilité et validité initiales

Les tenants de la lettre autobiographique maintiennent que les raisons invoquées par un candidat à l'appui de sa demande d'admission à un programme de sciences infirmières devraient pouvoir servir à évaluer ses attitudes, ses valeurs et ses motifs et éventuellement à identifier les étudiants qui ont le plus de chances de réussir. Le dossier de candidature au programme de sciences infirmières de l'Université McMaster doit comporter une lettre dans laquelle l'étudiant décrit ses qualités personnelles, les motifs de sa demande et ses chances d'atteindre les objectifs du programme. Les lettres sont évaluées par un jury de trois membres formés d'un professeur, d'un représentant de la communauté et d'un étudiant. Les candidats retenus sont invités à passer une entrevue. La présente étude a pour objet de déterminer la fiabilité et la validité initiales de l'évaluation de la lettre autobiographique par le jury. Les lettres témoins de 4 candidats détenteurs d'un diplôme et de 4 candidats au programme ordinaire ont été évaluées pour déterminer si elles reflétaient le profil des candidats inadmissibles, admissibles, acceptables ou idéaux et ont été incluses dans la trousse remise aux équipes de lecteurs. Chaque lettre a été lue et notée indépendamment selon une échelle normalisée. Les équipes qui ont noté les lettres des candidats détenant un diplôme et les équipes qui ont jugé les lettres des candidats au programme régulier ont fait état d'une différence dans les moyennes des lettres ($F=9,5$, $p<0.001$; $F=50.13$, $p<0,001$ respectivement), en revanche, aucune différence n'a été notée au niveau des moyennes des équipes ($F=1,3$, $p=NS$; $F=2,09$, $p=NS$ respectivement). On n'a pas établi de corrélation positive entre les scores des lettres des candidats détenteurs d'un diplôme ($r=0,18$) et les scores de l'entrevue. Les observations corroborent cette composante des modalités d'admission et il y a lieu de poursuivre les tests de validité.

VALIDATION INITIALE D'UNE NOUVELLE ECHELLE DE BESOINS: L'INVENTAIRE DES BESOINS DES FAMILLES (IBF)

Ginette Coutu-Wakulczyk et Louise Chartier

Depuis les années soixante-dix, le nombre d'écrits se rapportant aux besoins des familles dont un membre est hospitalisé dans une unité de soins intensifs n'a cessé de croître. Cette situation s'explique d'une part, par la généralisation de telles unités au sein des centres hospitaliers et, d'autre part, par une conscientisation du personnel soignant a l'égard de la place de la famille dans l'approche holistique des soins dispensés au malade. Dans la pratique actuelle, l'intervention infirmière vise surtout à répondre au besoin d'information de la famille, tel que perçu par les soignants. Aussi, le contenu des programmes d'enseignement portent davantage sur le problème de santé du malade, les traitements en cours et sur les appareils entourant le malade.

Cependant, dans le domaine de la recherche portant sur les soins aux familles, l'infirmière est confrontée à la pénurie d'instruments spécifiques qui soient à la fois valides et fidèles. A cet effet, dans une revue exhaustive des écrits pertinents, Simpson (1989) constatait que l'échelle de Molter (1979) demeurait encore aujourd'hui, la plus utilisée. Pourtant, lors de l'analyse critique, Simpson a également démontré les lacunes psychométriques importantes de cette échelle au niveau de la recherche et dans l'application des résultats à la pratique des soins infirmiers. D'ailleurs, des problèmes métrologiques ont aussi été rapporté dans l'étude de validation de la traduction française (Coutu-Wakulczyk et Chartier, 1990) de la dernière version du "Critical Care Family Needs Inventory" (CCFNI) par Molter & Leske (1983).

Or, l'infirmière francophone pour planifier et dispenser des soins au malade tout en tenant compte de la famille, doit relever un double défi. Premièrement, le manque d'échelles en langue française possédant des qualités psychométriques adéquates rend la recherche difficile à réaliser, et deuxièmement, cette situation implique des difficultés dans la pratique au niveau de l'évaluation des besoins des familles vivant une situation de maladie.

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Aussi, le but poursuivi dans cet article est de présenter un outil: l'Inventaire des besoins des familles (IBF) de Chartier et Coutu-Wakulczyk (1988) applicable en recherche et en clinique. Cet article se compose d'une brève revue des connaissances pertinentes, de la description de l'IBF, du cadre théorique sous-jacent et des résultats psychométriques préliminaires calculés sur les données d'un échantillon de familles québécoises.

Connaissances Pertinentes

La littérature se rapportant aux besoins des familles fournit des informations sur une gamme de besoins, présentés sous forme de fréquences relatives basés sur le CCFNI de Molter (1979) et de Molter et Leske (1983). La plupart des items du CCFNI ont été relevés à partir de connaissances empiriques et énoncés de façon à suggérer des moyens par lesquels l'infirmière peut apporter un soutien aux membres des familles. Cependant, la majorité des études citées portaient sur de petits échantillons variant entre 7 et 71 sujets, tirés de populations composées de membres de familles, d'infirmières et de malades (Simpson 1989). Ces données jettent un doute sur la possibilité de généralisation des résultats.

Dans un contexte de recherche, les besoins ont été regroupés par ordre prioritaire selon les catégories d'interventions suivantes: information, soutien émotionnel, empathie, qualité de la relation famille-personnel soignant et ressources disponibles (Rogers, 1983; Norris, O'Neil et Grove, 1986; Bouman, 1984; Leske, 1986). Toutefois, d'autres auteurs, dont Dockter et al. (1988), Bedsworth et Molen (1982), Dhooper (1983), Gillis (1983), se sont plutôt penchés sur l'identification globale des préoccupations vécues par les familles au moment de l'hospitalisation.

Une autre lacune selon Simpson (1989), se situe au niveau de l'absence de cadre théorique. En effet, le cadre théorique du CCFNI (Molter et Leske, 1983) n'étant pas spécifié, l'interprétation des résultats portait selon les études, sur des concepts de crise, de perte et de deuil, du soi ou sur l'évaluation cognitive. De plus, le CCFNI dans sa forme originale ne permet pas de distinguer entre l'étendue et l'intensité des besoins, limitant ainsi son utilité au moment de l'application et du transfert des résultats à l'intervention clinique.

En outre, la valeur psychométrique du CCFNI (Molter et Leske, 1983) a montré des faiblesses et des redondances au niveau de l'analyse de contenu et de l'analyse d'items lors de l'étude de validation de l'adaptation française du CCFNI (Coutu-Wakulczyk et Chartier, 1990). Récemment, Simpson (1989) et Lynn-McHale et Bellinger (1988) soulignaient également l'importance d'orienter la recherche vers des outils permettant de différencier les besoins spécifiques, des besoins généraux selon l'intensité et le nombre de besoins en utilisant des cotes quantitatives.

Dans cette perspective, l'Inventaire des besoins des familles (IBF) de Chartier et Coutu-Wakulczyk (1988) répond aux attentes exprimées tant pour son utilité au plan de la recherche qu'à celui de la planification des interventions de soins infirmiers. L'IBF a été validé dans la langue française et anglaise à partir de la méta-analyse de trois études, portant sur des échantillons de familles dont un membre était hospitalisé aux soins intensifs (Chartier et Coutu-Wakulczyk, 1989a; Rukholm et al., 1989, Chartier et al., 1990). Des analyses ont été effectuées sur les données de ces trois populations afin de vérifier l'effet potentiel de la culture et de la langue et les résultats sont publiés dans le IBF: Manuel d'utilisation-I (Chartier et Coutu-Wakulczyk, 1990).

Description de l'IBF

Le précurseur de l'Inventaire des Besoins des Familles (IBF) est le CCFNI de Molter et Leske (1983). A partir des 46 items du CCFNI, 33 énoncés de formulation perceptuelle ont été adaptés au contexte québécois pour fin de l'étude initiale de validation. Cet instrument est auto-administré et chacun des items réfère à un besoin que la personne peut acquiescer avoir et simultanément en indiquer l'intensité ou, au contraire, en réfuter l'importance pour elle-même. L'IBF utilise une échelle de type Likert en 4 points d'importance, variant entre 0 pour "pas important" et 3 pour "très important".

L'IBF fournit trois cotes qui renseignent sur différents aspects de besoins tels que perçus: 1) le Score Global des Besoins (SGB); 2) l'Indice d'Intensité des Besoins (IIB); et 3) le Nombre Total de Besoins (NTB).

Le SGB (Score global des besoins) représente le meilleur indicateur du niveau ou de l'importance des besoins et peut être retenu comme seul score, si un score unique est désiré. Le SGB fournit l'information combinée du nombre et de l'intensité des besoins perçus.

L'IIB (Indice d'intensité des besoins) est uniquement une mesure de l'intensité des besoins, c'est-à-dire que le score est corrigé pour le nombre de besoins. Cet indice fonctionne de façon à mesurer l'effet du style de réponse dans la manière qu'utilise l'individu pour communiquer l'importance de ses besoins, soit en l'augmentant, soit en le diminuant.

Le NTB (Nombre Total de besoins) représente le décompte du nombre de besoins que l'individu rapporte être positifs ou ressentis, indépendamment de l'intensité. Cette cote, utilisé en même temps que le SGB, fournit une mesure du style de réponses d'après le nombre de besoins positifs.

En ce qui a trait à la pratique, ces trois scores offrent des balises pour la planification d'interventions de soins. En effet, les interventions seront

différentes en présence d'un grand nombre de besoins exprimés comme étant peu importants, des actions à poser en fonction d'un nombre restreint de besoins mais de grande importance dans une dimension donnée.

Cadre théorique de l'IBF

L'Inventaire des besoins des familles (IBF) se base sur un cadre théorique de la perception de soi selon l'approche perceptuelle ou phénoménologique. Le concept de besoin dans une situation déterminée est étudié selon l'angle de la perception de la personne. La notion de besoin et son intensité est fonction de la perception qu'un individu a de lui-même, de l'auto-évaluation d'un événement et de son environnement matériel et humain tels que perçus.

Combs et Snygg (1959) ont été les premiers à démontrer le caractère prioritaire, déterminant, de la signification des choses, telles que perçues par l'individu, dans l'organisation de son comportement. C'est le parallèle entre l'approche objective (Stimulus --> Réponse) et l'approche subjective (Stimulus --> Perception <==> Réponse) qui différencie le plus ces deux approches.

Par l'approche objective, le comportement en termes de besoins d'une personne est évalué du point de vue de l'observateur extérieur à la situation. En l'occurence, l'infirmière décrit les besoins des membres des familles en fonction de l'événement et des stimuli environnementaux présents à l'unité de soins qui lui apparaissent influençant et produisant le comportement de l'individu. C'est la primauté du stimulus sur le comportement.

Dans l'approche perceptuelle ou phénoménale, ce qui prévaut, c'est la compréhension du comportement et des besoins de l'individu à partir de son propre point de vue. En d'autres termes, c'est la façon dont le membre de la famille perçoit les choses "dont lui-même" qui est la "réalité" sur laquelle l'infirmière peut et doit intervenir.

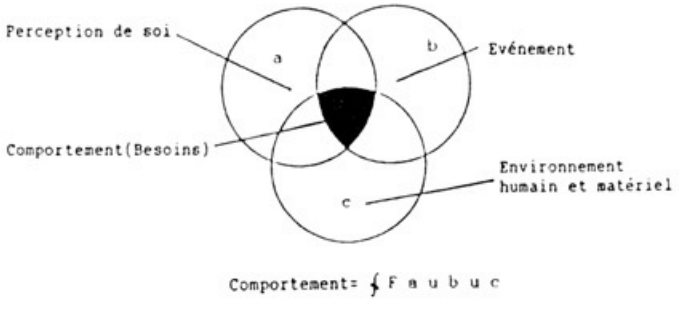

Figure 1
Représentation schématique du comportement et des besoins en fonction de la perception de soi, de l'événement et de l'environnement

Source: Coutu-Wakulczyk, Montgomery et O'Brien (1989)

La Figure 1 représente schématiquement la relation d'influence réciproque entre le comportement (besoins), l'événement de maladie et l'environnement. Ainsi, les besoins sont en fonction, non de l'événement externe et de l'environnement, mais de la perception qu'en a l'individu.

La théorie phénoménologique ou perceptuelle est formée des trois composantes organisationnelles suivantes: le soi phénoménal, le champ perceptuel et le champ phénoménal. Le soi phénoménal constitue la portion la plus différenciée et une grande partie du champ perceptuel; il a aussi trait à l'ensemble des perceptions que l'individu a de lui-même (Combs et Snygg, 1959; Combs et al. 1976). Le champ perceptuel se rapporte à l'ensemble des perceptions de l'univers entier, incluant la personne elle-même, tel qu'expériencié par l'individu, alors que le champ phénoménal est constitué par la totalité des expériences qui s'offrent à l'individu.

De plus, le champ perceptuel présente, selon Combs et al. (1976), les quatre caractéristiques suivantes: 1) la stabilité: réfère à la capacité par laquelle un individu sélectionne et organise ses perceptions de façon relativement stable; sans une certaine stabilité, l'individu ressent de l'anxiété; 2) la fluidité: c'est par cette propriété que l'individu peut changer son comportement et se permettre l'adaptation nécessaire à la satisfaction de ses besoins; 3) la direction: signifie que la satisfaction des besoins tels que perçus influence le sens opératoire de l'action dans l'organisation du comportement; et 4) l'intensité: se rapporte à la force avec laquelle les événements du champ phénoménal sont expérienciés, et cette caractéristique est en fonction du degré de différenciation (awareness) de l'individu.

Toutefois, même si le champ perceptuel inclut la totalité de l'univers tel qu'expériencié, la différenciation de cet univers ne se fait pas dans toutes ses parties avec le même niveau de clarté (Coutu, 1982). En effet, au sein même du champ perceptuel qui embrasse la totalité de l'univers tel qu'expériencié par la personne au moment de l'action, une part importante, centrale (Allport, 1955) et consistante (Lecky, 1945) constitue la perception de soi (Combs et Snygg, 1959), c'est-à-dire toutes les représentations qu'une personne peut avoir d'elle-même, alors que le champ phénoménal par contre, qui comprend la totalité des expériences, varie continuellement (Carrier, 1975; Hamachek, 1978).

De plus, les ramifications des attentes culturelles, tant au point de vue social, psychologique que physiologique, résultent des différentes perceptions de chaque individu. Etant donné que le corps est l'aspect le plus constant des expériences vécues, les perceptions qui s'y rapportent, jouent une part importante dans la définition du soi phénoménal. En d'autres mots, le soi phénoménal s'étend pour inclure la vaste perception des interactions de l'environnement et des événements.

Ainsi, basé sur ce cadre perceptuel, les interventions infirmières efficaces s'adressent à la "personne" et s'orientent vers la perception: perception de la personne (famille) elle-même, la perception qu'elle a de l'événement et la perception de son environnement humain et matériel. Dans ce contexte, un moyen d'auto-évaluation des besoins spécifiques des membres des familles est essentiel pour quiconque tente d'assister ces derniers dans leur cheminement. Ce point de vue est d'autant plus plausible qu'il serait utopique pour l'infirmière de croire qu'elle a le pouvoir d'agir directement sur l'événement lui-même, ou sur l'environnement humain et matériel de la famille.

Le cadre perceptuel, permet également au niveau clinique, de tenir compte de l'âge, de l'affiliation des acquis cognitifs antérieurs des membres de la famille et tout le processus par lequel l'être humain sélectionne, organise et interprète les stimulations sensorielles de son monde environnant, en images significatives et cohérantes. Dans le contexte de la recherche infirmière, l'utilisation d'une échelle valide et fidèle, permet de mettre en évidence les connaissances nécessaires à la planification, la mise en application et l'évaluation d'interventions destinées à répondre adéquatement aux besoins des familles.

Méthode de L'étude

Les données utilisées pour cette validation initiale du IBF ont été recueillies dans une unité de soins intensifs chirurgicaux du Centre Hospitalier Universitaire de Sherbrooke (CHUS). L'échantillon de convenance formé de 207 sujets adultes provenait de la famille immédiate de malades admis à l'unité. Ces visiteurs représentaient une moyenne de 2.3 sujets par malade. Les 91 patients adultes visités par les sujets représentaient 55.1% du total de la population de l'unité des soins intensifs chirurgicaux admis durant les 10 semaines de l'étude (Chartier, Coutu-Wakulczyk, 1989 b).

La collecte des données a été réalisée par des infirmières normalement affectées au service à l'unité mais retirées de leur horaire régulier durant les jours assignés à l'étude. L'IBF était auto-administré, en présence de l'interviewer dans une pièce adjacente à l'unité, sitôt après la collecte des données socio-démographiques.

Résultats

Données socio-démographiques

L'échantillon était composé de 155 (74.9%) femmes et de 52 (25.1%) hommes. L'âge moyen des sujets se situait à 45.4 ans (+/- 15.2) et l'étendue variait entre 18 et 91 ans. L'affiliation des sujets au malade visité se répartissait comme suit: conjoint, parent, fils/fille, fratrie, soit belle-famille tel que

montré au Tableau 1. La scolarité des sujets était similaire à celui de la population générale du Québec. En raison du caractère régional du CHUS, 32% des répondants demeuraient à une distance de 100 km ou plus de l'hôpital.

Tableau 1

Répartition des sujets selon l'âge, le sexe, l'affiliation et la scolarité

Caractéristiques	N	%	
Age			
18 - 30 ans	39	18.8	
31 - 43 ans	59	28.5	
44 - 56 ans	53	26.6	X = 45.4 ans
57 - 69 ans	45	21.8	s.d. = 15.2
70 et + ans	11	5.3	
Total	207	100.0	
Sexe			
Féminin	155	74.9	
Masculin	52	25.1	
Total	207	100.0	
Affiliation			
Conjoint	51	24.6	
Mère/père	19	9.2	
Enfant	64	30.9	
Fratrie	25	12.1	
Belle-famille	32	15.5	
Autre	16	7.7	
Total	207	100.0	
Scolarité			
Primaire	54	26.1	
Secondaire	89	43.0	
Collège	34	16.4	
Université	29	14.4	
Sans réponse	1	0.1	
Total	207	100.0	

Profil des scores

Les scores ont été calculés à partir de l'échelle de type Lickert en quatre (4) points (0 à 3) et le score global pouvaient varier entre 0 et 99. Le Tableau 2 présente les moyennes, les écart-types et l'étendue des trois scores fournis par l'IBF: l'SGB (Score Global des Besoins), l'IIB (Indice d'intensité des besoins et l'NTB (Nombre total des besoins).

Tableau 2

Moyenne, écart-type et étendue des scores des répondants

Scores	X	e.t.	Etendue
Score global des besoins (SGB)	71.7	15.0	74.0
Indice d'Intensité des besoins (IIB)	2.2	0.45	2.2
Nombre total des besoins (NTB)	29.5	4.2	23.0

Analyses de fidélité et de validité

Les aspects psychométriques calculés ont porté sur l'analyse d'items, la consistance interne, la fidélité moitié-moitié (homogénéité), la validité de contenu et la validité des concepts opérationnels.

L'analyse des items constitue un premier pas vers la validité d'un instrument (Engelsmann, 1982). Ainsi, cette première étape permet de vérifier la contribution de chacun à la valeur psychométrique de l'outil. Les items de l'IBF ont ainsi été calculés selon la proportion de réponses à chacun des 4 points de l'échelle. Le Tableau 3 montre la répartition des réponses en fréquences relatives selon le besoin et l'importance accordée à l'item.

La fidélité d'un instrument se reflète par la consistance interne dont la mesure par excellence est le coefficient Alpha de Cronback. Les autres mesures de fidélité calculées étaient la fidélité moitié-moitié selon les procédés de Spearman-Brown et de Guttman. Ces résultats renseignent sur l'homogénéité entre les items pairs/impairs et 1re moitié/2e moitié respectivement. Les résultats des diverses analyses de fidélité sont présentées au Tableau 4.

Tableau 3
Répartition des fréquences relatives de l'IBF selon chacun des items et l'échelle en 4 points d'importance

Item	Importance 0 %	1 %	2 %	3 %
Inf. sur environnement	11.5	11.5	13.0	64.0
Parler au M.D.	2.4	10.1	22.2	65.3
Savoir à qui téléphoner	3.4	4.9	12.6	79.1
Parler de mes sentiments	11.6	22.2	37.2	29.0
Accès service d'alimentation	8.7	9.7	22.2	59.4
Avoir directives	2.4	6.8	16.4	74.4
Présence d'amis	8.7	12.1	31.9	47.3
Justification des soins	0.0	3.9	18.0	78.1
Type de personnel soignant	4.4	3.4	23.3	68.9
Endroit pour être seul	18.8	20.8	36.2	24.2
Information sur traitements	0.5	4.8	16.9	77.8
Confort	3.4	15.9	36.2	44.5
Aide avec problèmes financiers	41.1	23.6	16.9	18.4
Téléphone disponible	2.9	10.1	28.5	58.5
Visite aumonier	14.5	14.0	25.6	45.9
Parler de la mort	15.0	12.0	30.0	42.0
Etre accompagné	20.3	13.5	32.4	33.8
Famille prise en charge	7.7	11.1	37.2	44.0
Pouvoir quitter	4.8	7.7	28.5	59.0
Parler à l'infirmière	3.4	3.9	23.7	69.0
Pleurer	31.4	29.5	25.1	14.0
Disponibilité autres ressources	14.5	17.4	30.4	37.7
Accès salle toilette	4.8	10.1	24.2	60.9
Etre seul ad lib	23.7	31.4	30.4	14.5
Aide avec problèmes familiaux	27.5	23.7	29.0	19.8
Information sur service aumonier	14.5	14.5	35.7	35.3
Aider aux soins	5.3	11.6	22.2	60.9
Salle d'attente	1.0	5.3	17.4	76.3
Info. équipement	4.3	6.3	21.7	67.7
Utiliser langue maternelle	3.4	3.4	14.0	79.2
Visite préalable de l'unité	18.4	15.9	36.2	29.5
1ère visite avec infirmière	13.0	15.0	30.4	41.6
Demeurer au chevet	1.9	4.3	25.1	68.7

Tableau 4
Coefficients de fidélité selon la méthode d'analyse

Méthode d'analyse	Coefficient
Correlation entre items	.76
Spearman-Brown (pair-impair)	.86
Guttman (consistance interne)	.86
Cronback Alpha	.90

L'analyse de contenu réfère à l'échantillon d'items en termes de représentation des comportements spécifiques utilisés pour mesurer une caractéristique ou un trait. Ainsi, à cette étape de validation, l'analyse des items et la consistance interne fournissent les informations de base à cet effet. A l'étape suivante dans le processus de validation de l'IBF il faut se pencher sur l'analyse factorielle en composante principale afin de vérifier la structure interne de l'instrument. En d'autres termes, l'analyse factorielle a permis de ressortir le nombre de dimensions non correllés entre eux (technique orthogonale) impliqués dans la variation des résultats. Ce processus représente une étape essentielle à l'établissement de la validité des concepts opérationnels et de la structure interne de l'IBF.

L'analyse en composante principale a fourni 5 facteurs indépendants qui expliquent 80.3% de la variation de l'IBF. Les résultats de l'analyse en composante principale sont présentés au Tableau 5. Une première analyse des différents facteurs suggère la présence de 5 dimensions relativement indépendantes se rapportant aux besoins environnementaux (humain et matériel), besoins face à l'événement, besoins face à soi, besoins physiques et au comportement ou actions. Trois items supplémentaires sont ajoutés aux 5 dimensions dont deux réfèrent aux besoins spirituels et un à la possibilité de mort.

Tableau 5

Analyse factorielle en composante principale

Facteurs	IBF	
	Valeur Eigen	Cum %
1	2.13	13.1
2	6.47	53.1
3	1.70	63.6
4	1.57	73.3
5	1.13	80.3
6	0.98	86.3
7	0.94	92.1
8	0.75	96.8
9	0.52	100.00

Discussion et Conclusion

Les résultats générés par cette étude préléminaire de validation démontrent que l'Inventaire des besoins des familles (IBF) répond suffisamment au critère de consistance interne, avec un coefficient Alpha de Cronback de l'ordre de 0.91 pour justifier son utilisation en recherche. L'homogénéité de cette nouvelle échelle a également été démontrée par des coefficients supérieurs à 0,80 aux deux procédés d'analyses d'items soit le Spearman-Brown et le Guttman.

L'analyse des items présente quelques faiblesses métrologiques pour certains items. Cependant, cette constatation pourrait bien être attribuable aux caractéristiques spécifiques de l'échantillon et du milieu ou l'étude s'est déroulée. En effet, dans l'étude de validation transculturelle, ces items ont démontré une valeur de discrimination auprès d'échantillons d'allophones et de francophones hors-Québec.

En regard de la validité de l'IBF, quoique plusieurs étapes restent à franchir à partir de recherches ultérieures, cette échelle présente une structure dimensionnelle suffisamment homogène pour permettre de ressortir la ou les dimensions des besoins où une intervention s'avère nécéssaire. L'utilisation de cette échelle d'auto-évaluation des besoins des familles peut fournir au personnel infirmier dans la pratique clinique, des indices importants pour la planification d'interventions auprès des familles.

De plus, le cadre phénoménologique de l'IBF permet de tenir compte des besoins tels qu'expériencés par la famille. Dans l'étude de validation initiale, la durée du séjour en soins intensifs et les connaissances antérieures n'ont pas démontré d'effet significatif sur les besoins vécus par les familles tels que mesurés par l'IBF.

En conclusion, l'état actuel des travaux suggèrent d'entreprendre des études subséquentes auprès de différentes populations de familles touchées par diverses situations de maladie. De telles études permettront de poursuivre la validation de l'IBF et d'élargir le cadre de son utilisation dans la pratique clinique. Plus spécifiquement, la planification et l'évaluation d'interventions infirmières adéquates et mesurables auprès des familles, repose sur des résultats de recherches rigoureuses.

Aussi, des études sont en cours, auprès de populations de familles face à une chirurgie générale comparativement aux familles confrontées aux services de soins intensifs, afin de dégager des besoins spécifiques rattachés à différents milieux de soins.

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ABSTRACT

Validation of a New Scale for Needs: The inventory of family needs

This article presents the initial validation study results of a new scale to measure family needs: l'Inventaire des besoins des familles (IBF) (Chartier & Coutu-Wakulczyk, 1988). The scale is available in both French and English. Based on the perceptual theory, the IBF is a self-report scale composed of 33 items. It also offers three (3) different sub-scores of the importance of needs: the Global Score of Needs (GSN), the Intensity Need Index (INN) and the Total Number of Needs (TNN).

The IBF was first validated on a sample of 207 subjects drawn from the adult population of immediate family members visiting a patient in a surgical intensive care unit in the CHUS in Sherbrooke. The reliability yielded a 0.91 Cronback Alpha coefficient and the homogeneity coefficient for Spearman-Brown and Guttman procedures were 0.89 and 0.86 respectively. The principal component factor analysis and factorial matrices lead to examine the conceptual structure of five independent factors.

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THE DEVELOPMENT OF A SCALE TO MEASURE CHILDBIRTH EXPECTATIONS

Annette Gupton, Janet Beaton, Jeff Sloan and Ina Bramadat

The hypothesized link between women's childbirth expectations and their subsequent psychological response to the experience has not been widely explored. The few studies done in this area have focused on the negative consequences of unmet expectations. Women whose expectations for childbirth are not confirmed by the actual experience evaluate themselves and the experience negatively (Kearney & Cronenwett, 1989; Leifer, 1980; Levy & McGee, 1975; Lumley & Astbury, 1980). In the postpartum period, such women experience feelings of failure, anger, guilt and grief (Grace, 1978; Lipson & Tilden, 1980; Marut, 1978). Mercer (1985) and Gottlieb and Barrett (1986) linked problems with mother-infant interaction to a negative or unanticipated birth experience.

In a recent prospective study of 825 women, the assumption that women with overly high expectations are likely to be disappointed and hence dissatisfied because of unmet expectations, was questioned (Green, Coupland, & Kitzinger, 1990). It was found that high expectations do not necessarily lead to dissatisfaction. Women who had their negative expectations realized were more likely to experience poor outcomes. Without further study, the relationship between what women expect of childbirth and how they evaluate their experiences is unclear. A necessary initial step in the exploration of this relationship is the development of a reliable and valid instrument to measure childbirth expectations.

Literature Review

Few empirical studies have directly investigated maternal childbirth expectations. Roberts (1983) discussed in general terms the need for women

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to develop realistic expectations about pain during labour and Grace (1978) described the resulting grief and personal sense of loss when childbirth expectations are not met. Leifer (1980), in a study of the psychology of the first pregnancy, found that women who romanticized labour had the most difficulty in childbirth and reacted to it as a negative experience.

The impact of unmet childbirth expectations has been investigated in relation to the experience of women who have undergone an unanticipated cesarean section (Cranley, Hedahl & Pegg, 1983; Marut & Mercer, 1979), in studies of factors associated with the experience of severe labour pain (Astbury, 1980; Fridh, Kopare, Gaston-Johansson & Norvell, 1988) and most recently in a study of the correlates of satisfaction with the delivery experience (Seguin, Therrien, Champagne & Larouche, 1989). In general, these studies have found that, when there is a lack of congruence between maternal expectations and the actual childbirth experience, the labour and delivery experience is perceived negatively and often associated with a higher degree of pain.

Clark (1975) conducted one of the first studies to investigate maternal childbirth expectations directly. She explored the relationship between birth expectations and perceptions of the childbirth experience by means of a semi-structured interview administered in the last month of pregnancy and on the first day post delivery. Results indicated that there was a relationship between birth expectations and the amount of distress women experienced in labour. Women who rated their labour as positive had accurately anticipated the amount of discomfort they would experience. Women who reported their labour as negative had underestimated the severity of the discomfort they would feel.

In a study designed to investigate the relationship between expectation and the subjective outcome of childbirth, Levy and McGee (1975) found that women who rated their deliveries as favourable indicated the experience was better than expected, while those women with negative impressions reported childbirth to be worse than expected. They contend that these results are congruent with Janis's theory that exaggerated anticipation of danger leads to a negative outcome following stress impact.

More recently, Scott-Heyes (1982) attempted to clarify the relationship between birth expectations and women's postnatal evaluations of their labour experience. Anticipated and actual evaluations were found to be significantly correlated, suggesting that women's expectations for childbirth do influence their actual experience. The relationship between birth expectations and the actual experience was also examined by Stolte (1987) who found, not surprisingly, that significantly more primiparas than multiparas rated their labour and delivery as "not like" what they had expected.

While these studies have made an important contribution to our understanding of the impact of childbirth expectations on the birth experience, many have been limited in scope and have addressed only the global question of whether expectations were met. Information about expectations for specific aspects of labour usually has not been obtained and, as a result, relatively little is known about which expectations may be important determinants of childbirth satisfaction.

The purpose of this article is to describe the first steps in the development of a tool to assess childbirth expectations. The ultimate goal is to use this instrument in subsequent research studies to explore the relationship between childbirth expectations and associated outcome variables. The following sections describe the initial phases in the development of the *Childbirth Expectations Questionnaire* (CEQ), the refinement and testing of scale items and the psychometric techniques used to establish the reliability and validity of the instrument.

Phase 1--Initial Development

Phase 1 involved the construction of scale items for the CEQ. Using a semi-structured interview guide, in-depth interviews were conducted with eleven women in their third trimester of pregnancy recruited from prenatal classes. A sample size of eleven women was deemed sufficient for the purpose of generating expectation statements, when content analysis of the data revealed no new categories of expectations were emerging. Each interview required a minimum of one hour to complete. Questions focused on their general thoughts and concerns regarding childbirth and their expectations for the experience (Beaton & Gupton, 1990). Analysis of these data, together with a review of the childbirth expectation literature, yielded over 100 expectation statements. These statements were analyzed for thematic content and sorted into five major categories which formed the basis for the initial conceptualization of the CEQ subscales. These categories were as follows.

1. *Pain*: the woman's assessment of how painful her labour would be: e.g. "I will experience the worst pain I have ever had."
2. *Self-efficacy*: the woman's assessment of how well she would be able to cope with labour: e.g. "I will be afraid of panicking."
3. *Intervention*: the woman's assessment of technological interventions that might be used during her labour: e.g. "Lots of medical equipment and machinery will be used."
4. *Significant Other*: the woman's assessment of how helpful her husband or partner would be to her during labour: e.g. "My husband/partner will be a source of support to me."
5. *Environment*: the woman's assessment of how supportive the childbirth environment would be: e.g. "I will feel reassured by the nurse's presence."

A panel of four experts in maternal-infant nursing were asked to review the 100 scale items for relevance and clarity of wording and to sort them into one of the five categories. All items judged to be ambiguous in meaning were discarded. Similarly, with respect to categorization, items for which there was less than 75% agreement were deleted. As a result of this process, the CEQ was reduced to 58 items. To avoid response set, wording of these remaining items was reviewed to ensure that approximately half were worded negatively and half were worded positively. All negatively-worded items were reverse scored so that a higher score would represent more positive childbirth expectations. A five-choice Likert scale format was chosen. Lissitz & Green (1975) indicated that this format gives scale reliability equal to if not better than alternative scoring methods. The items were then randomly ordered to form Draft 1 of the Childbirth Expectations Questionnaire.

Phase II--Refinement of Scale Items

Draft 1 of the CEQ was administered to a sample of 202 women in their third trimester of pregnancy attending prenatal classes in a large midwestern Canadian city. Ninety-four percent of the sample were married and 79% were expecting their first child. Approximately half of the sample (n=106) completed the questionnaire on two separate occasions: at the end of one prenatal class and, one week later, at the beginning of the next class. This approach to test-retest reliability was chosen to reduce the possibility that differences in women's responses at the two test times might represent true change rather than lack of instrument stability. The determination of instrument stability is particularly problematic when measuring phenomena such as childbirth expectations which may change over time. The question of instrument stability over time must be balanced against the issue of the instrument's sensitivity to a true change in respondents' attitudes.

As women completed the CEQ, they were asked to comment on the clarity of items, note omissions and add their general observations about the instrument. The most common comment concerned the difficulty women said they experienced making predictions about what would happen to them during childbirth. For example, in response to the item "I will feel intense pain", several women wrote, "Who knows?". To acknowledge these feelings, instructions for completion of the CEQ were rewritten to include the following statement: "While no one can know for sure what will happen to them in labor, we are interested in knowing what you anticipate or expect the childbirth experience will be like for you." A second area of concern related to lack of reference to the labour coach in such items as "My husband/partner will be a source of support to me". As a result of these comments, for each item in which the term "husband/partner" appeared, the term "partner/coach" was substituted.

Standard procedures for item analysis described by Nunnally (1978) were used to identify questionable items. The correlation of each item with the CEQ total score and with the item subscale were compared. Any item that did not correlate well (< 0.30) or that appeared redundant was flagged for further investigation and subsequently either deleted or reworded. On the basis of this analysis 22 items were identified as problematic and were removed.

Internal consistency was tested using Cronbach's alpha. The alpha coefficient for the total scale (58 items) was 0.85 and for the five subscales ranged from 0.79 for self-efficacy to 0.72 for intervention. Scale reliability also was assessed using only the 36 items retained after item analysis. Cronbach's alpha was 0.80 for the total scale. For the five subscales, coefficient alpha was: self-efficacy 0.76, significant other, 0.76, supportive birth environment 0.69, pain 0.68 and intervention 0.68. Coefficient alpha is influenced by the number of scale items; as such, the drop in alpha levels is to be expected. Following Nunnally (1978), this level of reliability was judged sufficient to justify further development of the CEQ.

The Kendall Tau B correlation coefficient was 0.67 for test-retest reliability. Thirty-three of the 106 women who completed the CEQ a second time indicated that their expectations for childbirth had changed since the first administration of the instrument. The reasons most frequently given for changes in expectations were thinking over the content of prenatal classes during the intervening week and developing complications of pregnancy. On the basis of this information, the CEQ was judged to have acceptable stability.

To validate the constructs represented by the five subscales, a factor analysis of the remaining 36 items was performed. Following the guidelines set out by Stevens (1986), the principal components method with an orthogonal varimax rotation was employed. Four factors with eigenvalues greater than one emerged from the analysis. This, together with an analysis of how individual scale items loaded on the four factors, resulted in substantial rethinking of the conceptual underpinnings of the CEQ. First, items from both the "pain" and "self-efficacy" subscales loaded heavily on the first factor suggesting that these items were all related to the same concept. The items loading highest on this factor were: " I will be afraid of panicking" (.67) and " I will worry about the severity of labour pain" (.66). Further analysis of the other items loading on Factor 1 revealed that the concept was related to a woman's expectation for her ability to cope with the pain of childbirth. A second source of concern was that items in the "environment" subscale loaded on several factors. In particular, items related to physician support and the physical environment did not load on the same factor (III) as the nurse support items. The scale items loading highest on this factor were:

"The nurses will spend little time with me" (.69) and, "The nurses will be present to offer me encouragement" (.67). We were specifically interested in women's expectations for nursing support and, because all nursing support items were highly correlated with each other, these items were retained, while those items dealing with physician support and the physical environment were flagged for possible deletion. Nine items related to support by significant other loaded heavily on Factor II. The item loading highest on this factor was "I will feel comforted by my husband/partner's presence" (.66). Six items concerning expectations for the use of medical intervention loaded on Factor IV. The scale item "Lots of medical equipment and machinery will be used" loaded highest on this item (.56).

As a final step in the analysis, all items flagged for removal were again re-examined as a group. The purpose of this procedure was to determine whether any additional or unrecognized construct(s) might be present. A possible theme of "personal control" emerged from this re-examination. As a result, all items relating to personal control, including control over the environment, interventions, or other aspects of the birth experience were retained and used to develop a new "control" subscale. Draft Two of the CEQ consisted of 50 items and five subscales: pain/coping, significant other, intervention, nursing support and control.

Phase III -- Further Refinement

Draft 2 of the CEQ was tested on a sample of 104 pregnant women attending a series of prenatal classes identical to those utilized by women who participated in the testing of Draft 1. Ninety percent of the sample were married, 78% were expecting their first child and 93% had completed high school. Exploratory factor analysis failed to confirm the existence of a "control" construct and all items related to this subscale were deleted. Additional items were removed on the basis of low item-total and item-subscale correlations. Subsequent analyses were performed on the remaining 36 items. The alpha coefficient of reliability was 0.81 for the total CEQ; for the four remaining subscales it was: pain/coping 0.82, support by significant other 0.77, nursing support 0.75 and intervention 0.67.

Refactoring of the 36 items verified the existence of the four subscales while examination of scree plots indicated that the differences between factors could be clearly distinguished. Nine items related to coping with pain loaded significantly (0.40 or higher) on Factor I. The highest loading was 0.77 for the item "I will be afraid of panicking". Six items related to support by significant other loaded on Factor II. The item loading highest was "my partner/coach will tell me what is going on" (0.78). Seven items indicating expectations for nursing support loaded on Factor III. The highest loading (0.76) was obtained for the item "The nurses will spend little time with me".

Six items concerned with expectations for medical intervention loaded on Factor IV. The item with the highest loading was "There is little chance I will end up having a cesarean section" (0.61). The clarity of the factor structure was such that all 36 items were retained, after minor changes in wording, to produce Draft III of the CEQ.

Phase IV

Draft 3 of the CEQ was used as a pre-labour measure in a longitudinal study comparing the expectations, perceptions and satisfaction of women experiencing different types of labour (Bramadat, 1990). Subjects (n=100) in their third trimester of pregnancy were recruited from the same population of prenatal class attenders as subjects who participated in Phase III. Comparison of Phase IV sample demographics with those of Phase III using Chi-square tests and Krushal-Wallis/Wilcoxon procedures showed no significant differences between the two samples on any variable. With respect to reliability, analysis of the Phase IV CEQ data set revealed results similar to those obtained in Phase III. Inspection of eigenvalues and rotated factor matrices provided additional confirmation of the high degree of correspondence between the two data sets. On the basis of this evidence, the decision was made to pool the results of Phases III and IV.

The Kaiser-Meyer-Olkin *Measure of Sampling Adequacy* (MSA) was used to establish the degree of confidence which could be placed in subsequent factor solutions, considering the modest observation to variable ratio. The value of the Kaiser-Meyer-Olkin MSA lies in the information it provides about the extent to which a scale represents a unified family of ideas or concepts as well as about how well each scale item is related to that family (Kaiser, 1970; Kaiser, 1981). Kaiser suggests deleting a scale item with an MSA of less than 0.6. The MSA for all scale items was greater than 0.6, except for the intervention item "I will be up walking around for most of my labour" which had an MSA of 0.3. Examination of the correlation matrix indicated that this item correlated with only two other scale items and even these correlations were not particularly strong (<0.3). Inspection of item analysis data indicated that omission of this item would not adversely affect the internal consistency of the CEQ. On the basis of this evidence, the item was deleted from the CEQ so that, for the purpose of further analysis, the CEQ consisted of 35 items.

According to Kaiser (1970, 1981), the overall MSA of an instrument should be approximately 0.8 in order for the results of factor analysis to be seriously regarded as evidence of construct validity and generalizability. Because the overall MSA of the CEQ was 0.78, the decision was made to proceed with factor analysis of the 35-item CEQ using the pooled data set n=204. Analysis of scree plot data (Figure 1) and the varimax rotated factor solution again

confirmed the existence of four distinct factors. Loadings were generally clear and well defined for each factor. (Table 1)

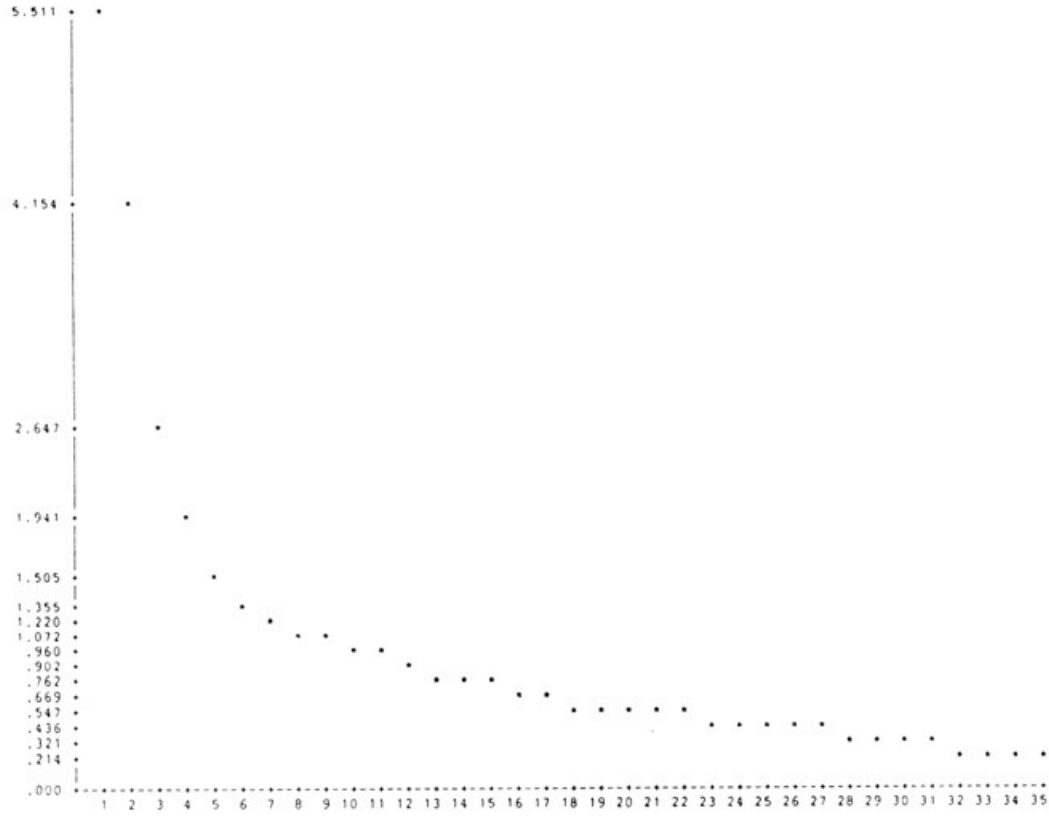

Figure 1
Eigenvalue Plot for the Childbirth Expectations Questionnaire

As the yardstick for identifying significant factor loadings, Stevens (1986) advises using double the critical value for the test of a significant correlation coefficient with a Type I error rate of one percent. For n=204, this means rejecting as spurious any item with a factor loading below 0.45. Using this criterion, 10 of the 11 pain/coping items loaded significantly on Factor I. The entire nursing support subscale loaded on Factor II with eight of the nine items attaining significance. All seven items related to support by partner/coach loaded on Factor III, five with loadings greater than 0.45. Five of the nine intervention items loaded significantly on Factor IV as did one pain item. This item, "I will feel intense pain" also cross-loaded on Factor I. While obviously related to the concept of coping with pain, the item may also be subtly reflective of an expected need to use medical intervention (e.g. analgesics) if pain is severe. Six items failed to load significantly on any factor. However, these items seemed logically oriented to the appropriate subscale and, as a result, were retained for reassessment in future studies.

Table 1

Loading and Factor Structure of the Childbirth Expectations Questionnaire (N=204)

Factor 1 Pain/Coping	Factor 2 Nursing support	Factor 3 Partner/Coach	Factor 4 Intervention
.77			
.77			
.70			
.61			.29
.59			
.58			-.27
.57		.25	
.53			.38
.52			.30
.51			
	.75		
	.74		
	.68		
	.64		
	.62		
	.60		.31
	.51		-.26
	.45	.33	
	.41		.39
		.72	
		.70	
		.69	
		.61	
		.49	
		.42	
		.38	.35
	.28	.37	.31
		.34	.25
			.57
			.53
			.51
			.49
			.48
			.46
			.36

Underline indicates significant loading, p=<.01

Reliability analysis was conducted on the 35-item CEQ using the pooled data set (n=204). The results are shown in Table 2 and indicate that the CEQ has a reliability acceptable for instruments used in basic research (Nunnally, 1978).

Table 2

Internal Consistency of the Childbirth Expectations Questionnaire

Subscale	Coefficient Alpha
Pain/Coping	.84
Nursing support	.80
Partner/Coach support	.72
Intervention	.65
Total scale	.82

Current Form of the CEQ

In its present form, the CEQ consists of 35 items scored on a Likert-like format ranging from strongly disagree (1) to strongly agree (5). A stem statement, "With regard to my labour and delivery experience, I expect that:", is followed by brief statements descriptive of childbirth expectations. Four subscales reflect major areas of childbirth expectations: coping with pain (eleven items), support by partner/coach (seven items), nursing support (eight items) and intervention (nine items). A score can be calculated for each subscale. As well, a total score can be obtained by summing the four subscale scores. The subscales vary in number of items, but may be readily standardized to produce percentile scores for comparison. A high score on the CEQ indicates positive expectations for the childbirth experience and would incorporate expectations for support from a partner/coach and the nurse, the ability to cope with pain that will not be unbearable, and minimal technological intervention in the labour process.

Discussion

Psychometric research on the CEQ over the course of several studies has been fruitful and indicates that continued developmental work with the instrument is justified. Refinement of the intervention scale in particular is required and efforts to increase the conceptual clarity of the instrument will be a major focus of future studies. Results have been consistent across several studies, although testing with larger samples and use of multiple measures is required to demonstrate the instrument's validity adequately.

To date, the CEQ has been used with low-risk homogeneous samples of pregnant women in their third trimester of pregnancy. The task remains to examine the ability of the CEQ to discriminate among different populations of pregnant women (e.g, distinguish differences in expectations between high and low-risk women). The CEQ was developed using middle-class women and, as such, may reflect a middle-class orientation to childbirth. Samples of women more socially disadvantaged than those used thus far might reveal a different set of expectations and, for some groups, questions related to support by partner or coach might not be relevant. Several studies designed to address these issues are on-going.

For the future, use of the CEQ could contribute to increased understanding of the development and importance of women's childbirth expectations. Longitudinal study of childbirth expectations could reveal whether childbirth expectations change over time, and in what direction such changes might occur. Of particular interest would be examination of the impact of childbirth education on the development of childbirth expectations. Knowledge of the development and nature of women's childbirth expectations and of the variables which influence them would assist childbirth educators in developing teaching strategies to prepare women better for the realities of the childbirth experience.

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RÉSUMÉ

Élaboration d'une échelle de mesure des attentes relatives à l'accouchement

Le but de cette série d'étude était de développer un instrument pour mesurer les attentes des femmes par rapport à l'accouchement. Les phases de développement du questionnaire des attentes à l'accouchement (CEQ) sont décrient ainsi que les téchniques analytiques qui sont utiliseés pour évaluer la sûreté et la validité. Présentement, le CEQ comprend 35 articles de style Likert dans lesquels sont inclus les 4 catégories suivantes: faire face à la douleur de l'accouchement, l'appui du partenaire, l'appui des infirmières, et l'intervention medicale. Dans le futur le CEQ pourrait être utiliser dans des études pour augmenter la connaissance du développement et de la nature des attentes de la femme par rapport à l'accouchement. En comprenant ces attentes des femmes et les facteurs qui les influencent, on pourrait assister aux enseignant des classes d'accouchement à développer des stratégies qui amélioreraient la préparation des femmes aux réalités face à l'accouchement.

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CRITERION-RELATED VALIDITY OF THE ACTIVE LISTENING COMPONENT OF THE BEHAVIOURAL TEST OF INTERPERSONAL SKILLS

Joanne K. Olson, Carroll L. Iwasiw and Brian A. Gerrard

Active listening is a major component of therapeutic communication with clients. Although active listening has received much attention in many disciplines, valid and reliable tools to measure a health professional's active listening skills are lacking. The absence of behavioural measures of empathy limits research in this important dimension of clinical practice.

The purpose of this study was to extend the validity testing of the active listening component of the *Behavioral Test of Interpersonal Skills* (BTIS), a test of communication skills (Gerrard & Buzzell, 1980). Specifically, it was criterion-related validity that was assessed. Validation of this aspect of the BTIS was critical because active listening has been identified as one of the most essential aspects of therapeutic communication.

Review of the Literature

Active listening and empathy

Active listening is defined as "the skill of understanding what your patient is saying and feeling and communicating to your patient in your own words what you think he is saying and feeling" (Gerrard, Boniface & Love, 1980, p. 133). The literature frequently refers to the same type of behaviour as empathy. Active listening can be considered to be the measurable dimension of empathy. Through analysis of a helper's verbal response to a patient it is possible to determine the accuracy of the helper's understanding of the thoughts and feelings expressed by the patient.

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Rogers (1958; 1961) has identified empathy as one of the major elements in establishing a helping relationship. Of all aspects of the therapeutic communication process in nursing, empathy has been cited as one of the most essential and complex (Forsyth, 1980; Gagan, 1983; Kalisch, 1973; La Monica, 1981). In attempting to be supportive, nurses sometimes make statements such as "don't worry" or "don't be upset". These "Don't Feel" statements are antithetical to empathy (Gerrard & Buzzell, 1980, p. 9) because they negate the patient's feelings and deny the right to experience those feelings. Although empathy is essential in a helping relationship, nurses have not always demonstrated high levels of empathy (Hughes & Carver, 1990; Iwasiw & Olson, 1987; Olson & Iwasiw, 1987).

Relationship of health professionals' interpersonal skills to patient outcomes

Health professionals require good interpersonal skills to establish, maintain and terminate effective helping relationships with patients and to establish and maintain collaborative relationships with each other. Poor communication skills on the other hand could anger and threaten patients so that their purpose in seeking health care is defeated (Gerrard et al., 1980).

Various studies, reported mainly in the medical and counselling literature, have examined the behavioural relationship between health professionals' interpersonal skills and patient outcomes. Nursing studies of this nature have been limited in number; however, several have specifically provided evidence that the nurses' use of empathy positively influences client outcomes. Williams (1979) found that the level of nurse empathy was related to changes in self-concept in elderly patients. In a study by La Monica, Wolf, Madea and Oberst (1987), the immediate effects of nurses' empathy, before and after empathy training, were measured on the variables anxiety, depression, hostility and satisfaction with care. There was less anxiety and hostility reported in patients cared for by nurses who had received empathy training. In a 1990 study, Vanderlee reported that nurses' levels of empathy were positively correlated with clients' feelings of being understood, as measured by the empathy subscale of the Barrett-Lennard Relationship Inventory.

Purpose and Hypotheses

The purpose of this study was to test the criterion-related validity of the active listening component of the Behavioural Test of Interpersonal Skills. Actual clinical interactions were the standard against which the BTIS was tested. Previous criterion-related validity testing has been based on supervisor and peer ratings of subjects' communication skills - and not on assessment of actual interactions between health professionals and patients. The interpersonal categories of the Behavioural Test of Interpersonal Skills which this study tested were:

1. *Feeling*: Any relevant general (e.g. upset) or specific (e.g. angry) reference to feeling.

2. *Content*: The reason for the speaker's feeling.

3. *Don't Feel*: Any attempts to suppress or discourage expression of speaker's feelings (Gerrard & Buzzell, 1980, p. 43).

Based on the assumption that nursing personnel would structure interactions such that patients would feel free to disclose Feeling and Content, we hypothesized that there would be positive correlations of at least .50 between:

1. subjects' BTIS percentage scores on the behavioural category Feeling and the percentage of opportunities to which they correctly identify patients' Feelings during clinical interactions.

2. subjects' BTIS percentage scores on the behavioural category Content and the percentage of opportunities to which they correctly identify the Content of patients' statements during clinical interactions.

3. subjects' BTIS percentage scores on the behavioural category Don't Feel and the percentage of opportunities to which they make Don't Feel statements to patients during clinical interactions.

Methods

Design

This study was a descriptive correlational investigation. Nursing personnel were audiotaped while responding to the simulated patients on the BTIS and while interacting with real patients. Subjects' statements of Feeling, Content and Don't Feel, in response to the BTIS patient situations and during patient interactions, were scored. Correlations were computed for each category between BTIS percentage scores and percentage scores in actual subject-patient interactions.

Instrument

The Behavioural Test of Interpersonal Skills (BTIS) is a test that can be used to assess the interpersonal or interviewing skills of any health professional student or practitioner. The tool is useful for comparing the interpersonal skills of different groups, for giving feedback on the effectiveness of interpersonal skills training and for research.

The test consists of two main parts: a videotape that is used to elicit verbal responses (see Figure 1 for an example of one BTIS situation and its content analysis); and, a content-analysis scoring sheet that is used to rate the verbal responses.

Female Patient:

"It's a dull nagging pain. I don't know what else I can tell you. It just goes on and on night and day. I don't think it's ever going to go away."

Content Analysis Category	*Scoring Guidelines*
Feeling	Underlying: hopeless, helpless, scared. Surface: in pain, worried, upset.
Content	"Because ... the pain never stops, you think you won't get better."

Figure 1
Sample BTIS patient situation and content analysis.

There are 26 problem situations on the BTIS videotape to which a subject can respond with active listening. Thirteen are patient situations and 13 are health professional situations. Only the patient situations were used. There are three categories of patient situations: Aggression (verbal attacks and unreasonable requests); Distress (depression/sadness, pain, anxiety and anger); and Positive Emotion (happiness and affection).

Reported use of the BTIS. The BTIS has been used to study the interpersonal skills of practicing professionals (Hills & Knowles, 1983; Iwasiw & Olson, 1985, 1987). Student communication skills have also been assessed with the BTIS (Anderson & Gerrard, 1984; Gerrard, 1982; Olson & Iwasiw, 1987).

Reliability of the BTIS. The non-reactivity of the Active Listening categories (Feeling, Content and Don't Feel) has been demonstrated. There were no significant differences in subjects' initial scores on the BTIS and their scores at 6 and 16 week intervals (Gerrard & Buzzell, 1980).

Validity of the BTIS. Content validity of the BTIS was established through an extensive literature review and input of health professionals in the development of the initial problem situations (Gerrard & Buzzell, 1980). There is moderate support for the construct validity of the active listening component of the BTIS (Anderson & Gerrard, 1984; Gerrard & Buzzell, 1980; Olson & Iwasiw, 1987).

Criterion-related validity of the BTIS categories of Feeling, Content and Don't Feel was demonstrated in a study where peers and supervisors used

semantic differential items to rate a sample of 26 nurses. These ratings were based on supervisors' familiarity with the nurses and not on direct observation of their communication skills. Significant positive correlations ($p<.05$) were found between the semantic differential item "Has Empathy for Others", and the categories of both Feeling and Content. A significant negative correlation ($p<.05$) was found between the category Don't Feel and the item "Has Empathy for Others" (Gerrard & Buzzell, 1980, pp. 22-26).

Study sample and sampling procedures

The population was composed of registered nurses, registered nursing assistants, nursing aides and nursing orderlies (all employed on selected units in two acute care and two chronic care institutions) and registered nurses in two community health agencies. Nursing personnel whose positions required regular interaction with patients were invited to participate. A variety of nursing personnel was included in the expectation of yielding a wide distribution of scores on the study variables.

Eligible staff were identified through the agency personnel offices and a letter was sent inviting them to attend an informational session about the project. Signed consent was obtained from volunteer subjects and appointments were made for data collection. The sample consisted of 41 volunteers. Twenty-five subjects were registered nurses and 16 were non-professional nursing personnel.

Procedures to obtain patient participation

On the day of patient audiotaping the head nurse identified the alert and oriented patients who were assigned to the subject. A research assistant explained the study to these patients, requested their participation and obtained their written consent to be tape-recorded while receiving nursing care. Written information was also provided to these patients. Two or three patients for each subject agreed to participate and none withdrew from the study.

Data collection procedures

There were two parts to the data collection. One part consisted of nurse subjects being audiotaped for 30-60 minutes during their usual interactions with patients. Subjects were also audiotaped while responding to the BTIS. The order of the patient and BTIS taping sequence was varied in an attempt to eliminate the possible effects of one taping situation on the other taping situation.

The research assistant instructed each subject in the use of the tape recorder and informed him or her about the patients who had agreed to participate.

The research assistant then left the unit and returned later to retrieve the recording. Each subject was in control of the taping session and decided precisely when, for how long and with which consenting patients taping would occur. Voice-activated, pocket-sized recorders were used for convenience and to reduce the artificial nature of the taping session. Sixty-minute tapes eliminated the need to change or turn over the tape.

A room on each unit was used for the BTIS taping sessions. Subjects were alone and were audiotaped while responding aloud to the BTIS. This tape was immediately given to the research assistant.

Audiotape analysis

BTIS. Responses to the BTIS were scored by two of the investigators. Active Listening was scored in accordance with the guidelines for the categories of Feeling, Content and Don't Feel, as described in the BTIS User's Manual (Gerrard & Buzzell, 1980). See Figure 1. Intra-rater and inter-rater scoring reliability had previously been established for each behavioural category (Cohen's Kappa Statistic 0.85-1.00). For each behaviour (Feeling, Content, Don't Feel) a score of "one" was obtained when the behaviour was present in the subject's response. The absence of the behaviour resulted in a score of "zero".

Subject-patient. The subject-patient audiotapes were analyzed according to a procedure developed by the investigators. The investigators randomly selected three, five-minute segments of each subject-patient audiotape for analysis. The interactions were first analyzed for the feelings and content expressed and these constituted the number of opportunities to respond with active listening. The interactions were then analyzed to determine the subject's Feeling, Content and Don't Feel responses to the opportunities. Each subject received a final percentage score for these three communication behaviours. This score represented the percentage of opportunities to which the subject gave Feeling, Content and Don't Feel responses. The possible range of scores for each category was 0-100% (See Figure 2 for an example of a subject-patient interaction analysis). Intra- and inter-rating scoring reliability for subject-patient interactions had been established for feelings and content expressed by the patient and therefore, the opportunities for active listening responses and for subjects' responses of Feeling, Content and Don't Feel (Kappa statistics 0.85-0.90).

Subject tapes had been coded by the research assistant in a manner to ensure that the investigators could not link any subject's BTIS and patient interview tapes. This procedure was employed to reduce bias in scoring.

Nurse-Patient Interaction	Opportunities to Respond with Active Listening		Active Listening Responses		
	Feeling	Content	Feeling	Content	Don't Feel
Nurse: I understand that your arthritis has been really bothering you.					
Patient: I've tried to do everything I'm supposed to. I take my the pain pills and I rest and I never overdo it, but still.... the pain is bad.	discouraged, disheartened, disappointed	about the pain			
Nurse: You feel discouraged that the pain is bad, even though you follow the doctor's orders.			✓	✓	
Patient: I try not to let it get me down, even when I have these flare-ups. Sometimes though, it's hard to keep smiling. I do try to be pleasant.	wants likes determined, down, depressed, discouraged	to be pleasant during flare-ups			
Nurse: Don't be discouraged. You've made a lot of progress since you came into hospital.					✓
Patient: Yeah, I guess so.					
Total	3	3	1	1	1
Subject's Score			1/3 = 33-1/3%	1/3 = 33-1/3%	1/3 = 33-1/3%

Figure 2.
Sample nurse-patient interaction and content analysis.

Results and Discussion

Hypothesis testing

BTIS percentage scores and interview percentage scores were analyzed using Pearson product-moment correlations for each of the three categories (Feeling, Content, Don't Feel).

Hypothesis 1, that there would be a positive correlation between Feeling responses to the BTIS and to real patients, was not supported ($r = .12$; $K = .07$; $p>.05$). There was no significant correlation between BTIS percentage

scores on the behavioural category Feeling and the percentage of Feeling responses in clinical interactions.

Hypothesis 2 was not supported ($r = -.10$; $K = -.7$; $p>.05$). There was no significant correlation between BTIS percentage scores on the behavioural category Content and the percentage of Content responses in clinical interactions.

Hypothesis 3 was not supported ($r = .24$, $p>.05$). There was no significant correlation between BTIS percentage scores on the behavioural category Don't Feel and the percentage of Don't Feel responses in clinical interactions.

Post-hoc content validation of the BTIS. To ensure that similar situations were being presented to the subjects on the BTIS and during actual clinical interactions, each patient statement was labelled according to the BTIS categories of patient situations. The clinical interviews gave the subjects opportunities to respond to situations of Distress (pain, depression/sadness, anxiety and anger) and Positive Emotions. There were no situations of Aggression (verbal attacks and unreasonable requests) in the interviews. See Table 1 for a comparison of the percentages of the types of patient situations presented to subjects on the BTIS and during actual client interviews. The BTIS presented an approximately equal percentage of all types of patient situations, whereas situations of pain predominated with real patients.

Table 1

Percentage of Types of Patient Situations Presented to Subjects

	BTIS	Interview
Distress		
Pain	15.38	38.57
Depression	15.38	12.69
Anxiety	15.38	21.31
Anger	15.38	13.19
Positive Emotion	7.69	14.21
Aggression		
Verbal attack	15.38	0
Unreasonable request	15.38	0

Additional discussion

Study results may be interpreted in two ways. The active listening component of the BTIS may indeed lack concurrent criterion-related validity. It is also possible that the BTIS does have criterion-related validity but that method problems interfered with the demonstration of the validity.

One such problem was in the scoring procedures. Four subjects received a score of 0% when there were no opportunities to respond with Feeling. For 22 subjects, 0% meant a failure to identify the Feeling stated by the patient, no matter how many opportunities were present. A score of 100% meant, in some instances, simply that the subject had responded accurately only once to one opportunity. Therefore, a final score of 0% or 100% may not have represented a large quantitative difference in Feeling responses.

Clinical interaction is the ultimate external criterion for assessing tests of health professional communication. Nonetheless, the Hawthorne effect may have operated so that subjects may not have responded in their usual manner during data collection. It is also possible that only subjects who felt confident about their communication skills and comfortable with audiovisual equipment volunteered. Another issue is whether interaction with only one or two patients truly represented the subject's usual patterns of interaction with many patients.

This study was premised on the assumption that nursing personnel would structure interactions so that patients would feel free to disclose Feeling and Content. This assumption was inaccurate. In the 15-minute analyzed segments, there were 20 of the 41 subjects who were given only two or fewer opportunities to respond with Feeling. The patient's lack of disclosure seemed to result from the nurses' monopolization of the interaction (often with a focus on self), or directing of the interaction to superficial or social topics (e.g., the weather). Although social communication is appropriate at times, the predominance of this type of interaction fails patients who need encouragement to describe their situation and perspective.

Conclusions and Implications

Concurrent criterion-related validity of the active listening component of the *Behavioral Test of Interpersonal Skills* was not demonstrated in this study. Clinical active listening skills cannot be predicted from individual scores on the BTIS. Therefore, critical decisions about students' or practitioners' communication skills should not be based on BTIS scores. However, because the BTIS situations have content validity, they continue to be useful for teaching purposes.

This study has added to the literature in three ways. A method was developed to identify and score the opportunities for active listening given by the patient to the health care provider. This method of content analysis has potential for use in many types of communication studies. Content analysis of patient statements has provided support for the categories of patient situations on the BTIS and thus, further evidence for the content validity of the instrument. The major strength of this investigation has been the development of a method to validate communication tools during actual clinical practice. Few instruments have been subjected to such rigorous testing.

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RÉSUMÉ

L'écoute attentive Validité du volet écoute active du test comportemental du sens des relations humaines

L'objet de cette étude était d'appliquer le test de validité du volet écoute active du test comportemntal du sens des relations humaines (BTIS). Ce test comportemental est une vidéocassette de scénarios simulés entre un patient et un co-travailleur. Par écoute active, on entend la compréhension de ce qu'une autre personne dit et ressent et le renvoi de cette compréhension à cette personne. Les sujet soumis à cette étude corrélationnelle descriptive étaient 41 infirmiers/infirmières travaillant dans des établissement de soins aigus, de soins prolongés et de santé communautaire. Les sujets ont été filmés tandis qu'ils réagissaient aux patients simulés dans le cadre du test et alors qu'ils interagissaient avec des patients réels. On a analysé les bandes audio au niveau de l'écoute active. Les corrélations établies entre les résultats obtenus au BTIS et les interactions infirmière-patient n'ont pas atteint le seuil d'importance statistique,sans doute en raison de l'échelle restreinte des résultats. On n'a pas non plus réussi à démontrer la validité du volet écoute active, même s'il faut tenir compte dans cette constatation des difficultés inhérentes aux méthodes d'étude. Cette étude est venue s'ajouter à la littérature sur les méthodes qui permettent de mesurer les interactions cliniques et d'évaluer la validité simultanée des instruments.

WIDOWHOOD GRIEF: A CULTURAL PERSPECTIVE

Janet N. Rosenbaum

Grieving widows are at risk for health problems and mortality (Rigdon, Clayton & Dimond, 1987), and are of special interest to nurses who could provide culturally relevant care. The death of a spouse, even when expected, leads to distress (Glick, Weiss & Parkes, 1974; Lopata, 1979). While self-help groups for widows are available (Silverman, 1975, 1986), clinical observations demonstrate that many widows avoid these groups as well as professional assistance. Could it be that such help is inconsistent with their cultural values, beliefs and lifeways, and therefore is viewed as irrelevant?

The purpose of this transcultural nursing study, which was part of a larger study that also investigated cultural care and health (Rosenbaum, 1990a), was to describe and explain the grief meanings and experiences of older Greek-Canadian widows, within their world view and social structure dimensions.

The 1986 census data indicated there were 36,435 people in Ontario whose "home language" was Greek (Statistics Canada, 1986). However, the actual size of the Greek community was much larger because census figures did not account for thousands of Greek-Canadians who identified with the culture but did not speak Greek.

Research questions

The research questions that guided this portion of the investigation were as follows.

1. What are the meanings and experiences of grief phenomena of older Greek-Canadian widows?

2. What are the meanings and experiences of the transition from wife to widow for older Greek-Canadian women?

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Definitions

Greek-Canadians are persons who were born in Canada or who immigrated to Canada, who identify themselves as Greek-Canadians.

Grief phenomena are those culturally-based beliefs, practices, emotional expressions and sorrow following the death of a significant person. Within this definition, the concepts of grief and mourning were as follows.

> *Grief* refers to the sorrow expressions and their meanings following the death of a significant person.
> *Mourning* is the culturally-based practices which are performed following the death of a significant person.

Conceptual Framework

Leininger's theory of *Cultural Care Diversity and Universality* (1988) and van Gennep's (1960) analysis of rites of passage provided the conceptual framework for this investigation.

Care is necessary for growth, well-being and human survival (Leininger, 1988). Care, the essence of nursing, is universally expressed in all cultures, but has diverse meanings and expressions. Leininger posited three modes of nursing actions for health maintenance and illness recovery: cultural care preservation that perpetuates the client's cultural practices, cultural care accommodation that adapts the client's or nurse's practices and cultural care repatterning that restructures the client's or nurse's practices.

All cultures were found by van Gennep (1960) to have ceremonies or rituals, called rites of passage, that assisted individuals to pass from one life cycle stage, such as birth, marriage and death, to another stage. The rites of passage included three phases: rites of separation detach the individual from the previous social situation or stage; transition rites assist the individual to shift to a new stage; and, rites of incorporation integrate the individual into the new stage.

Review of the Literature

The literature on widowhood grief phenomena is reviewed from the perspectives of nursing, psychiatry, sociology, social work and anthropology.

In the nursing literature there have been a few studies that have explored grief phenomena among widows and widowers, but no nursing studies were found that were specific to cultures. In a qualitative study of widows whose husbands, younger than 50 years of age, died of a variety of causes, the con-

cept of "uncoupled identity" was developed (Saunders, 1981). The study described the experience of transition from being a member of a married couple to being a single person without exploring cultural factors.

Factors necessary for adjustment to a single lifestyle were investigated in a correlation survey (Brock, 1984). Change post-marriage, life change, education, social participation and life-style accounted for 15% of the variance of psychological well-being. Although culture was not explored, the limits to generalizability of the study (differences such as age, race, class and cultural groups) were acknowledged.

Several studies on widowhood were conducted in Canada. In one study, it was found that the progression along a pathway of adaptation took much longer than the literature described (Vachon, Lyall, Rogers, Freedman-Letofsky & Freeman, 1980). These authors did not report cultural beliefs and practices. However, Vachon (personal communication) said Italian, Greek and Maltese widows had difficulty adapting to widowhood because of inadequate support from their social networks and delegation of low status as a family babysitter.

A model for grieving among the elderly was developed by Dimond (1981). The model identified the concepts of support networks, concurrent losses and coping skills as intervening factors for adaptation. While Dimond's model is interesting, she did not include culture, which may influence support networks and coping skills.

The relationships between grief, coping, resources and health function was explored in a study of older Catholic widows, which found that resources rather than coping strategies influenced health function (Gass, 1987). In this quantitative study, religious beliefs and practices were included as resources that assisted the widows. In a thematic analysis of accounts of bereavement by adults who experienced the death of loved ones, Carter (1989) identified the following themes of grief: being stopped, hurting, missing, holding and seeking. This qualitative study did not differentiate cultural dimensions or relationships to the deceased.

Psychiatric literature on grief included Lindemann's classic work (1944) which described acute grief as a four- to six-week crisis with specific psychological and somatic symptoms. A longitudinal study by Glick, Weiss and Parkes (1974), which examined males and females 45 years of age or younger in the first year after death of a spouse, refuted Lindemann's (1944) findings that recovery from grief is resolved in a few weeks. Rather, they claim that death of a spouse leads to many years of grief that include numerous crises. Additional studies have demonstrated that widows are at risk for illness and death (Ball, 1976-77; Bornstein, Clayton, Halikas, Maurice & Robins, 1973; Parkes, 1975; Shneidman, 1980).

Three predictable stages to recover from grief were identified by Engel, (1964): shock and disbelief, developing awareness and restitution. He found that cultural grief practices provided important supports for grief-stricken persons.

Most psychiatric research literature focused on grief as intrapsychic emotional pain that either terminated or led to health problems such as depressions. Grief was generally viewed along a health-illness continuum with resolution of grief being health at one end, and prolonged grief being illness at the other end.

Schlesinger (1977), a social worker, has classified the problems that widows experience as economic, social and emotional. He recommended community supports, family counselling and interdependence with community members to assist the grieving family. Lopata (1979) conducted a study of Chicago widows of all ages, identifying a number of common problems such as lack of opportunity to grieve, lack of emotional supports, lack of supports for the children, loneliness, lack of job training and financial problems.

Themes of caring, intimacy, family feeling, reciprocal identity, support and a sense of home, which may continue to give comfort to the surviving spouse, were identified by Moss and Moss (1984-85). Wambach (1985-86) conducted a grounded theory study of widow support groups and found that aid that emphasized grief as a process was more helpful than aid that set out a timetable for reaching points along the way.

Grief phenomena in 78 cultures were studied by Rosenblatt, Walsh and Jackson (1976). Finding that people in all cultures build long-term, caring relationships for which termination caused emotional distress, the investigators concluded that people work through the loss in ways that are facilitated by culture.

Funerals have been described as a rite of passage that served to "incorporate the deceased into the world of the dead," and reintegrate the survivors into society (van Gennep, 1960, p. 146). Gorer (1965) studied grief in Britain, finding that grieving in Britain followed stages similar to those identified by Engel (1964). However, his research refuted findings of American studies (Engel, 1964; Lindemann, 1944) that identified guilt and anger as universal components of grief, demonstrating variability in grief phenomena.

The death rituals of rural Greece were studied by Danforth and Tsiaras (1982). They found that death-related practices such as memorial services, eating special foods and displaying the body, helped the grieving person face the reality of the death, as well as reorganize the small community.

While many investigators have described grief phenomena in death related situations (Gorer, 1965; Kalish, 1985; Kalish & Reynolds, 1976), other authors have focused on grief phenomena of widows. The grief phenomena of widows were investigated cross-culturally by Mathison (1970). She discussed the many institutional controls that societies establish to regain social equilibrium after a death. One purpose of marriage is to strengthen the community and widows are viewed as vulnerable to malevolent powers or ghosts; as such, the widowed are often subject to cultural controls during a specified period of mourning. She viewed grief phenomena as a cultural means for widows to become detached from their spouses. Wearing special clothing and engaging in anger releasing activities such as hair cutting and self-mutilation were examples of such cultural manifestations.

In a study of depressed Hopi Indian women, Matchett (1972) reported hallucinatory experiences during grieving. The women stated that they had "visits" by family members who had recently died. Yamamoto, Okanogi, Iwasaki and Yoshimura, (1969) examined grieving among Japanese widows. They found that the grief practice of ancestor worship served to aid the widows in their adaptation: their husbands became ancestors who were talked to, fed and given gifts.

It is evident from the anthropological literature that grief phenomena exist in most cultures, but are expressed in diverse cultural forms requiring understanding of cultural context.

Method

Data were collected in settings in three Ontario communities with entry made possible through the assistance of church and Greek-Canadian community leaders. Ethnonursing, which is ethnography focused on nursing phenomena, guided the study of people's beliefs and practices about health, grief and care as well as their general lifeways, beliefs and values. Life health-care history (Leininger, 1985a) was used to acquire descriptions of the widows' health and care experiences.

Prolonged contact was maintained with 12 widowed key informants and 30 general informants, who provided views about the cultural values, experiences, meanings, linguistic expressions and context. The key informants were the most knowledgeable of those who consented to share their experiences in depth (Leininger, 1985a; Werner & Schoepfle, 1987). Criteria for their selection were: widows who identified with the Greek culture, 50 years of age and older, widowed for six months or more, able to speak and understand English and willing to participate in the study by sharing their experiences.

Widows were purposefully chosen to represent a variety of dimensions such as age, length of widowhood and generation of immigration. Key informants ranged in age from 50 to 81 years and were widowed from 6 months to 24 years. Eight were first generation immigrants and four were second generation immigrants. Informant interview sessions continued as an on-going process, until no new information was being presented.

General informants were interviewed to reflect upon meanings expressed by key informants (Leininger, 1985a). They consisted of ethnohistorians, Greek community leaders, widows, family and friends of widows. General informants added credibility to patterns that emerged from key informants (Werner & Schoepfle, 1987).

The research conformed to qualitative evaluation criteria of credibility, confirmability, meanings-in-context and saturation (Leininger, 1990; Lincoln & Guba, 1985).

Data Collection

Interview guides consisted of semi-structured and open-ended statements. Meanings and observations were checked with informants on an on-going basis. Interviews were conducted primarily in informants' homes.

Investigator observations and feelings, and informant verbatim expressions were recorded in a field journal. The journal consisted of a condensed account of interviews and observation-participation, with an expanded account entered into a computer and a personal journal.

The *Leininger Life History Health Care Protocol* provided a systematic view of informants' health care history (Leininger, 1985a). The tool was used to gather data as the informants reminisced about care and health experiences.

A comparison of the acculturation of first generation key informants with second generation key informants was made, using Leininger's *Acculturation Rating and Profile Scale of Traditional and Non-Traditional Lifeways* (1972). This scale plotted profiles based upon 15 cultural indicators of traditional and non-traditional lifeways.

Data Analysis and Findings

Data were analyzed using Leininger's *Phases of Analysis for Qualitative Data* (1990) to progress systematically through four phases of higher abstraction. The phases were collecting and documenting raw data; identification of descriptors; pattern analysis; and finally, theme formulation. The

Leininger, Templin, Thompson *Ethnoscript* software (1984) was used to code and retrieve the extensive raw data.

The two major themes that represented commonalities regarding grief phenomena among the informants are presented with supporting verbatim descriptors to permit the reader to follow the investigator's analytical process.

Theme 1: Greek-Canadian meanings and expressions of grief focused on beliefs about the endurance of the husbands' life spirit as an integral part of the widows' cultural care lifeways.

The reality of death transformed each woman from wife to *hira*, the Greek word meaning widow. The grief beliefs, practices and emotional expressions all had impact on the widows' lives and expressions of care.

A number of grief care practices were reported. Widow informants reported that, immediately upon notification of their husbands' death, family and friends rallied to give comfort. All informants said that, in the early days after the death, family and friends brought food, visited and gave encouragement to go on with life. All widow informants said they cried. Several said they tried to restrain themselves. One widow informant said, "Life (is) to take it how it comes, and to be strong. It's not fair to yourself to make so much scream [sic]. His life and your life separate. You have to live."

Considerable data showed grief to be an emotional expression that was more restrained in second generation widows because of acculturation. A key informant related how her Greek-born mother-in-law "lamented dirges (which) are mournful songs that people born in Greece often sing when they're mourning."

Several widows said they did not want to be called a widow. The daughter of a key informant said, "The Greek word for widow is *hira* and people don't use that word. They call you by name or they call you 'grandmother'." Despite varying attitudes to being called a widow, all key informants agreed they experienced "numbness" upon the death of their husbands. A typical statement by a key informant was, "I couldn't believe that my husband was dead."

Grief practices were documented in the field journal, after attending the funeral of a general informant.

> A *Trisayio* prayer service was conducted at the funeral home and church by the priest to pray for forgiveness of her sins. At the cemetery, following services at both the funeral home and church,

more prayers were said in Greek. The priest made a cross marked by olive oil on the flower covered casket. The family then sprinkled earth on the casket. Ladies brought bread, *prosphora*, specially baked on the day of the death for everyone to eat and say, "May the Lord forgive the dead person." A Greek born key informant said only "clean" women who are not menstruating or who had not participated in recent sexual intercourse may bake this special bread.

Except for one informant, all widows took pride in the honour accorded their husbands by a large attendance at their funerals. The exception was one widow who had a private funeral with a closed casket because, "I was afraid of the emotional demonstration (by others)."

Grown children spoke about their widowed mothers as if their mothers were vulnerable to renewed sadness. An example of such a statement was, "My mom has been through a lot. I don't want to see her sad again."

Informants reported that prayers sustained them as sources of care from God. A key informant said "God helps me." Another key informant said "I kneel and pray. And I think I find relief. "Prayer served other purposes, in addition to bringing care to the widows from God. Along with other grief practices, prayer maintained family honour by showing respect for the deceased husbands. Prayer also served as symbolic care by offering the deceased's soul forgiveness from sins. Informants said *Mnimosina* services, which were memorial services to honour and protect the souls of their husbands, were conducted on the fortieth day after their husbands died, the time being symbolic of the Ascension of Jesus. All key informants reported additional *Mnimosina* services occurred during the following time periods after death: three months, six months, nine months, one year and three years. Thereafter, the major prayers for the dead were conducted during Soul Saturdays in church. Sweetened boiled wheat, *koliva*, was distributed on these occasions. Informants said the wheat in *koliva* was symbolic of death and resurrection: wheat must be buried for it to grow, similarly people must die before they are resurrected.

Key informants agreed that the meal served after the funeral (*makaria*) in the church or a restaurant was important for their own care as well as to honour their husbands. Many key informants said tending their husbands' graves was important for honouring their memories - a symbolic form of care.

Widows said the wearing of black for varying time periods symbolized the sadness they felt. One key informant wore black only until the funeral ceremony was completed. Two key informants wore black until the forty-day period was over and two wore black for one year. The remaining seven

key informants wore black for one year and then planned to wear dark colors or dark prints for their lifetimes.

In conjunction with grief practices that fostered the memories of their husbands, many informants discussed giving away their husbands clothes and possessions to assist them in getting on with their lives. One key informant said her mother demonstrated care by removing her husband's clothes when she was not at home. Most informants said they disposed of their husbands' clothes and possessions with the assistance of their grown children, a most difficult tie-breaking task.

Informant data and investigator observations showed grief practices to be paradoxical functions of tie-breaking and attachment. Key informants' descriptions of removing their husbands' belongings was an example of a tie-breaking practice. Conversely, informants participated in many forms of memorializing their husbands. All key informants agreed that grief practices, which included memorial services, visiting and caring for their husbands' graves, and lighting candles at their graves, continued for years. Most of the widows continued to wear their wedding rings, saying "I will never forget him."

Many key informants shared a belief in the persistence of their husbands' souls to bring them continued care and companionship. Sometimes they "saw" their husbands. Other widows had experiences in which they could feel their husbands' proximity. Several widows stated that the presence took the form of the husbands' directing their decisions. One informant said she was in contact with her husband's spirit when she was in church. Whatever way the informants experienced the presence, the data supported these experiences as continuation of care within spiritual dimensions.

The transition from wife to widow never meant that the widows totally accepted their new status. Instead, what the informants described was yielding to widowhood with resignation. They courageously went on with their lives as they memorialized their husbands and continued the husbands' care values and lifeways.

Theme 2: For Greek-Canadian widows, status transition from wives to widows meant resignation to the husbands' death based on the belief that "life goes on", with the active remembrance of the husbands' care values and lifeways.

Regardless of the length of widowhood, many of the informants spoke of periodic waves of grief that were expressed in different ways. These grief expressions took different forms that included crying, disbelief, yearning and talking about their husbands. With the exceptions of early crying and dis-

belief, the data did not yield definitive stages of grief. Sometimes the waves of grief came during happy times. A key informant who had been a widow for 23 years said, "I still have pain when something nice happens: marriage, christening, graduation. I think that it's too bad he's (her husband) not around to see the kids." Another key informant, widowed for four years, described her experience poignantly:

> I find that it's not as sharp a pain as it was before. It's like shutters that open and close. It's like a block square. All the edges have rounded off....But the pain is still there. That is why when a woman (friend) said 'period of adjustment', I don't think you can put people in segments. I didn't have a period of adjustment, my whole life is a period of adjustment.

Key informants had conflicting beliefs about crying: "Crying is helpful," and "Crying is futile". A key informant who expressed both beliefs said, "Cry (it helped)," as well as, "You don't cry, no come back [sic]." Even though all widows said that they had cried after their husbands died, few stated that crying had benefits. A widowed general informant expressed a typical belief about crying, saying, "Some ladies stay home and cry and go every day to the cemetery. Husband not there, spirit not there [sic]. [They should] try to make a nice life." Many widows said they continued to cry periodically, even though many years had passed.

Another pattern of grief expression by key informants was disbelief about their husband's death primarily during the time period immediately following death. A key informant said, "It took a while until it sunk in about my husband." However, two informants said they still experienced disbelief long after their husbands died. A key informant whose husband died three years ago said, "Sometimes I even still don't believe he's dead."

Only one key informant expressed anger, documented in the investigator's field journal: "As she spoke about the death of her husband, her voice rose, she clenched her fists and said angrily, 'My husband die [sic], I lost everything'." However, several informants spoke about overlooking the negative remembrances of the marital relationships. A key informant said, "(The widow) has to cover up all those bites and think of her husband the way what (that) he meant to her life."

All informants said religion and their families gave them care that generated courage to carry on with life. A key informant said, "You need your family and religion more than anything else." Many informants also indicated that they controlled their grief expressions, "keeping a happy face," to appease their grown children. The memorial services gave them permission to express their grief intermittently while according honour to their husbands.

Many informants talked about "life going on" despite their loss. Four key informants said there were "reasons" for occurrences over which they had no control such as the deaths of their husbands. A key informant shared her experience:

> The church helped me. I believe there is a reason for a person dying. The more I read and the more I spoke to Father (the priest) and my mother - there is a reason for it. Asking why - you'll never find the reason.

Believing that they must go on with life, many widows stated that they carried on with their husbands' lifeways and values by surrounding themselves with family, being involved in the church and making decisions the way their husbands would have made. Even though key informants tried "to have life go on," most of the informants indicated they would not consider remarrying. Of the 30 key and general widow informants, only one had remarried. Many informants said they married one man for life.

Many spoke about the importance of a peaceful death. A key informant said:

> My husband (was) happy 'till the last minutes. He died peacefully. At 9:30 I kiss him good night. I went up at 10:30. I woke up at 1 AM, I couldn't sleep. At 3:30 I heard coughing. I get up. He say 'you sit down. I gonna die.' In five minutes he was dead.

Many of the key informants stated that they also hoped for a peaceful death for themselves in order to decrease the burden on their families. A key informant explained, "You live your days in peace and you have a peaceful death and a quiet death, that's part of the prayer in the church service."

In summary, the emotional expressions of grief never completely left the widows, despite passing of time and resignation to their loss.

Discussion

Grief care practices such as visiting, bringing food and giving encouragement eased transition from wife to *hira* (widow) for the Greek-Canadian widows. Grief practices such as prayer services and the wearing of mourning clothes also helped. An important function of these spiritual practices was to give posthumous spiritual care to their husbands by honouring their memories.

During the mourning period, the widows were in a transitional stage whereby they had already separated from their spouses, yet were not fully

reintegrated into "life in society" (van Gennep, 1960). It was during this time that memorial prayers were said at specific intervals until the conclusion of the three-year period. In Greece, this transition period was clearly completed when the deceased were exhumed and their bones were laid to rest in the village ossuary (Danforth & Tsiaras, 1982). In Canada, where the cultural practice of secondary burial is not performed, the transitional period could not clearly end with that incorporation ritual. Thus, it may be speculated that the incorporation phase for Greek widows in Canada might be delayed, particularly for first generation immigrants who were enculturated into this exhumation practice.

Several grief practices served paradoxical functions of tie-breaking and attachment to their deceased husbands. This finding was congruent with that of van Gennep (1960) who stated that the transition period is very complex, with on-going processes occurring at the same time for the deceased and for the mourners. The tie-breaking ritual of giving away the deceased husbands' clothes may be interpreted as a rite of separation from the husbands as well as a cleansing ritual to avoid death pollution. The rite of separation was superimposed on the transitional period of mourning and was marked with memorial services of declining frequency until replaced with group memorial services on Soul Saturdays.

Widows received solace from belief in their husbands' spiritual presence. This finding was consistent with Greek Orthodox Christian spiritual literature (Carlson & Soroka, 1954) but conflicted with psychiatric literature that categorized sensing husbands' presence as pathological (Clayton, Desmarais & Winokur, 1968). The findings from this investigation and anthropological studies give substance to cultural variability of grief expressions.

The process of grief identified by Greek-Canadian widows did not follow linear stages of grieving. Instead, grief expressions ebbed and flowed as waves of sorrow that abated but did not terminate. The widows did not totally accept the death of their husbands, but yielded to widowhood with resignation. This finding was supported by Carter's (1989) study which identified core themes of grief.

Much of the classic literature on grief (Engel, 1964; Freud, 1917; Lindemann, 1944) has identified a final stage of mourning that implies acceptance of the death of a loved one. Findings from this investigation did not support such a concept as the primary meaning of status transition from wife to widow.

Widows demonstrated that, although they did not fully accept their husbands' deaths, they became resigned to the deaths as they became reintegrated into the Greek community.

As the process of grief continued with the widows, they gained courage to carry on with life from the continuity of care that they received from family, friends and religion, and from feeling needed as they gave care to others. Their strong cultural care values derived from family and religion influenced their well-being. The belief that "life goes on" with active remembrances of their spouses was a prominent finding in this study. This supported Leininger's (1988) theory which predicts that world view, social structure features, language and environmental context influence care expressions and practices that lead to health.

Even though crying may be a universal expression of grief (Rosenblatt, Walsh & Jackson, 1976), the findings indicate that there are diverse cultural beliefs about the value and appropriateness of crying.

The patterns of gratitude of Greek-Canadian widows for their husbands' peaceful deaths, and the wish for their own peaceful deaths was documented in this study. This finding appears related to the traditional Greek cultural belief that a peaceful death was related to a good life (Danforth & Tsiaras, 1982).

Finally, the findings of this investigation raise questions about categorization of grief expressions into "normal" and "pathological" without knowing and taking cultural care beliefs, values and practices into consideration. Future studies of widows from different cultural groups would offer transcultural comparative data to determine commonalities and diversities.

Nursing implications

The provision of culturally-congruent care is an important goal of nursing practice (Leininger, 1985b, 1988). Transcultural nursing research findings in this study have generated insights that have the potential to improve nursing decisions and actions through cultural care preservation, cultural care accommodation and cultural care repatterning.

Older Greek-Canadian widows may benefit from preservation of their cultural lifeways. Strong family and religious ties serve them well. The family should be included in plans for care; grown children will often make sacrifices to assist their mother. At the same time, the widows will benefit from giving care to others, "as life goes on" (Rosenbaum, 1990b).

Prayer may evoke symbolic care for their husbands. Prayers at specified mourning periods will assist transition from wife to widow. Religious and cultural rituals will encourage family, church and Greek community care and reintegrate the widow into the community as a single person. Prayers also bring comfort care from God to the widows.

It is important not to impose the professional value of self-disclosure upon widows of cultural groups that have different values. Many Greek-Canadian widows said it was important to maintain a "happy face." If they find it difficult to express negative feelings about their husbands for fear of dishonouring them, transcultural nurses would respect the widows' reluctance to disclose these feelings. If the widows choose to share these negative feelings, this should done slowly over several sessions to avoid guilt and provide cultural care accommodation.

Professionals often recommend group counselling and self-help groups for widows. For Greek-Canadians, especially the first generation immigrants, ventilation of feelings in a group setting would not be culturally congruent because of the language barrier and their reluctance to disclose negative feelings. Opportunities to discuss their widowhood lifeways with a trusted Greek Orthodox priest, or with staff at a Greek community social service agency might be more beneficial. Acculturated second generation widows may be more receptive to group experiences. Nurses should understand there are diversities between generations of widows and should assess receptivity to group experiences.

Finally, nurses should repattern the practice of diagnosing abnormal grief reactions in Greek-Canadian widows who express waves of sorrow over many years. Nurses will come to understand that the culturally "normal" pattern of grieving for Greek-Canadian widows will be emotional expressions that diminish over time but do not terminate.

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RÉSUMÉ

La douleur du veuvage : point de vue culturel

Le thème de la douleur a été analysé par abstraction à partir d'une étude qualitative de grande envergure menée auprès de veuves canadiennes âgées d'origine grecque. En les conceptualisant dans le cadre de la théorie de la diversité et de l'universalité des soins culturels de Leninger et des rites de passage de van Gennep, on s'est servi des méthodes relatives aux ethnosciences infirmières et à l'histoire des soins de la santé. Par la technique de l'observation-participation et des entrevues menées dans trois communautés héléno-canadiennes, on a interrogé 12 veuves d'importance primordiale et 30 personnes d'ordre général. Les données qualitatives ont été analysées à l'aide des phases de l'analyse de Leninger pour passer progressivement à des niveaux d'abstraction plus élevés. Les deux principaux thèmes de la douleur étaient les suivants : 1) le sens et l'expression de la douleur chez les héléno-canadiens sont axés sur la croyance que l'esprit du mari persiste et fait partie intégrante du mode de vie culturel de la veuve; et 2) pour la veuve héléno-canadienne, le passage du statut d'épouse à celui de veuve implique qu'elle se résigne à la mort du mari en se fondant sur la croyance que "la vie continue", tout en se souvenant activement des valeurs et des habitudes de vie du mari. Par conséquent, le mode culturellement "normal" de la douleur chez les veuves héléno-canadiennes est de ressentir de la tristesse qui diminue avec le temps et qui ne cesse jamais.

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