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CURRENT DIRECTIONS IN NURSING RESEARCH: TOWARD A POSTSTRUCTURALIST AND FEMINIST EPISTEMOLOGY

There has been an intellectual ferment in nursing over the past few decades. Not only have nurses been conducting rigorous programs of research, they have also become articulate participants in debates about science, and what constitutes legitimate forms of scientific inquiry. This may well be remembered as the time when many nursing scholars explored multiple approaches in the conduct of research, and when logical positivism lost its privileged status as *the* approach to scientific inquiry. As Dzurec (1989) points out: "Non-logical positivist research is no longer equated with sloppy science. It is now accepted that rigorous scientific research can incorporate either logical positivist methods or other methods" (p.75). Some nurse researchers turned to phenomenology in the search for a method that would allow them to address questions of meaning and the lived experience - questions that are germane to the development of nursing science, and that cannot be tackled within the paradigm of logical positivism.

Yet, while phenomenology as a research method has been thriving, it is only one of the paradigms that has provided an alternative to logical positivism. A review of articles in nursing journals over the past decade shows that some scholars are moving not only away from logical positivism, but beyond phenomenology and hermeneutics. The search for a paradigm "beyond phenomenology", as it were, may have arisen from the need for a method that will help researchers not just to describe the lived experience, but to unmask the context of that experience. Feminist and postructuralist forms of reasoning seem to provided a way to do just that.

Many of us operated from the premise that phenomenology and feminism share similar theoretical underpinnings. However, scholars like McPherson, as early as 1983, presented feminist methods as a new paradigm for nursing research. She points out that:

> Feminist theories provide the base for the paradigm shift and ensuing feminist research methods. These theories have a dual function. They offer descriptions of women's oppression, and prescriptions for eliminating it. They are empirical insofar as they examine women's experience in the world, but they are political insofar as they characterize certain features of that experience as oppressive and offer new visions of justice and freedom for women (p.19).

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There are many variations in feminist theory (e.g. liberal feminist theory, Marxist feminist theory, radical feminist theory, socialist feminist theory), yet it would seem that each allows us to address the context of experience. As Dorothy Smith puts it, in speaking of a feminist research strategy, "The aim is to explicate the actual social processes and practices organizing peoples' everyday experience from a standpoint in the everyday world" (1987:151).

But it is not just feminist theorizing that is making its impact on current thinking in nursing. Postructuralist perspectives are surfacing as a paradigm that holds promise for the development of nursing science. As well, some feminist scholars in other disciplines are now examining the convergence between poststructuralism and feminism. Diamond and Quinby (1988), for example, argue that there are strong convergencies between the works of the late Michel Foucault, a leading poststructuralist scholar, and feminism. My own work has evolved in this direction.

The theoretical insights generated by this convergence of ideas, I believe, will be valuable to nurse researchers, as they provide the conceptual apparatus that will help us to address issues in the lives of women, men and children, and compel us to reflect not just on inter-gender "operations of power" but on intra-gender power relations as well. They challenge us to extend our analysis of phenomena relating to the lives of clients or patients beyond the micro level of analysis to an examination of the broader social processes that influence health and illness behaviour. This has the potential for the development of nursing science that will be inclusive of the complex socioeconomic, historical and political nexus in which human experience is embedded.

From speaking with graduate students one gets the impression that there is a receptiveness to the emergent trends in nursing scholarship. Many students find that the questions that are of interest to them cannot be tackled by using conventional research methods. As we get more Ph.D. programs in nursing in Canada, we can expect that the intellectual debate will become even livelier. I predict that the new generation of nurse researchers will continue to explore new and innovative methods for conducting nursing research, so that they can address the complex questions in health care delivery today.

This intellectual activity in nursing promises a rigorous nursing science. Yet, as we look to the future with optimism, we must also be cognizant of the pragmatic issues that govern the conduct of our research. As we encourage students to explore new ways of questioning, and to tackle new ways of answering their questions, we must also ensure that, as the researchers of tomorrow, they will have access to the funds they will need to conduct their research.

Some scholars conducting phenomenology or qualitative research studies have found that the methods they use are a barrier in obtaining research funds. Although many reviewers are well informed about these methods, others still view logical positivism as the only legitimate form of scientific enquiry. "Qualitative" studies, if they are accepted at all, are usually seen as "first level", "exploratory" studies that will form the basis for more powerful quantitative studies. This is not to say that getting funds for *any* research study is easy! It seems like an extra hurdle, however, when the people reviewing the proposal question the legitimacy of the science.

One wonders how a research proposal that is explicitly "feminist" will fare amongst reviewers in the granting agencies that we now approach for funds. Yet, as we encourage our graduate students to think critically, and to embrace multiple paradigms of research, we can anticipate that the research of the future will not always be recognizable as complying with the tenets of logical positivism, or even phenomenology. Nor should it. Furthermore, we will do our future researchers a disservice if we encourage them to mask their ideas in the guise of positivism for the sole purpose of satisfying the reviewers of their grants.

For this reason we need to give serious consideration to the kind of funding agency that will best serve the future generations of nurse researchers. Different intellectual perspectives in nursing are here to stay. Because of the issues that are paramount in the discipline, feminist methods, like phenomenology, have a prominent place in nursing science. Grants written from these perspectives cannot be disguised as positivist. It's also reasonable to expect that other paradigms for nursing research will evolve in the future. We therefore must work toward getting a funding agency for nursing research that has as its mandate the development of nursing science, and that is flexible enough to accommodate the multiple paradigms that are needed to build a rigorous science of nursing.

Joan M. Anderson

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TENDANCES ACTUELLES DE LA RECHERCHE EN SCIENCES INFIRMIERES: VERS UNE ÉPISTÉMOLOGIE POSTSTRUCTURALISTE ET FÉMINISTE

Depuis plusieurs dizaines d'années, les sciences infirmières se sont considérablement intellectualisées. Non seulement les infirmières ont mené des programmes de recherche très rigoureux, elles ont également participé de manière très articulée à plusieurs débats sur la science et sur ce qui constitue les formes légitimes de la recherche scientifique. Il se peut fort bien que l'on se souvienne de cette époque comme celle d'un examen attentif des multiples méthodes de recherche de la part des chercheurs en sciences infirmières et comme l'époque à laquelle le positivisme logique a perdu son statut privilégié de *seule* méthode de recherche scientifique. Comme l'indique Dzurec (1989): "La recherche positiviste non logique n'est plus synonyme de science bâclée" (p. 75). Quelques chercheurs en sciences infirmières se sont tournés vers la phénoménologie en quête d'une méthode pouvant leur permettre d'étudier la question de la signification et de l'expérience vécue -- questions qui sont étroitement liées au développement des sciences infirmières et qui ne peuvent être abordées au moyen du paradigme du positivisme logique.

Or, alors que la phénoménologie a considérablement prospéré comme méthode de recherche, il ne s'agit que d'un des paradigmes ayant fourni une alternative au positivisme logique. L'examen des articles parus dans les revues de sciences infirmières au cours des dix dernières années démontre que certains chercheurs s'éloignent non seulement du positivisme logique mais également de la phénoménologie et de l'herméneutique. La recherche d'un paradigme "au-delà de la phénonénologie" peut très bien découler du besoin d'une méthode qui aidera les chercheurs non seulement à décrire l'expérience vécue mais également à dévoiler le contexte de cette expérience. Les formes féministes et poststructuralistes du raisonnement semblent leur en avoir fourni les moyens.

Nous sommes nombreux à être partis du principe que la phénoménologie et le féminisme partageaient les mêmes bases théoriques. Toutefois, des chercheurs comme MacPherson ont présenté les méthodes féministes, dès 1983, comme un nouveau paradigme de la recherche infirmière. Elle précise à ce titre:

> Les théories féministes sont à l'origine de ce glissement de paradigme et des méthodes de recherche féministe qui ont suivi. Ces théories ont une double fonction. Elles permettent de décrire l'oppression des femmes et les moyens visant à l'éliminer. Elles sont empiriques dans la mesure où elles examinent l'expérience des femmes dans le monde mais sont également politiques puisqu'elles caractérisent certains aspects de cette expérience comme oppressive et donnent une nouvelle vision de la justice et de la liberté pour les femmes (p. 19).

La théorie féministe comporte de nombreuses variations (théorie féministe libérale, théorie féministe marxiste, théorie féministe radicale, théorie féministe socialiste). Or, il semble que chacune d'entre elles permette d'étudier le contexte de l'expérience. Comme l'indique Dorothy Smith lorsqu'elle parle de la stratégie des recherches féministes, "le but est d'expliquer les pratiques et procédés sociaux qui organisent l'expérience quotidienne des gens à partir de la vie de tous les jours" (1987: 151).

La théorie féministe n'est pas la seule à influencer la réflexion actuelle en sciences infirmières. Les perspectives poststructuralistes constituent de plus en plus un paradigme prometteur pour l'épanouissement des sciences infirmières. De plus, certains chercheurs féministes d'autres disciplines étudient à l'heure actuelle la convergence entre le poststructuralisme et le féminisme. Diamond et Quinby (1988), par exemple, prétendent qu'il existe de sérieuses convergences entre les travaux de Michel Foucault, grand spécialiste du poststructuralisme, et le féminisme. Mes propres travaux ont d'ailleurs suivi cette direction.

Les idées théoriques découlant de cette convergence d'idées seront, selon moi, précieuses aux chercheurs en sciences infirmières puisqu'elles leur fournissent l'appareil conceptuel qui les aidera à étudier les problèmes inhérents à la vie des femmes, des hommes et des enfants et qui les obligera à réfléchir non seulement aux "relations de pouvoir" intersexes mais également aux relations de pouvoir intrasexes. Ils nous poussent à étendre notre analyse des phénomènes liés à la vie des clients/patients au-delà du micro niveau d'analyse pour privilégier l'examen des procédés sociaux plus vastes qui influencent les comportements des personnes saines et malades. Ce phénomène a le pouvoir de faire progresser les sciences infirmières en tenant compte du nexus socio-économique, historique et politique complexe dont relève l'expérience humaine.

En parlant aux étudiants de 2e/3e cycle, on a l'impression qu'ils sont réceptifs aux nouvelles tendances de la recherche en sciences infirmières. De

nombreux étudiants estiment que les questions qui les intéressent ne peuvent être étudiées à l'aide de méthodes de recherche conventionnelles. Les programmes de Ph.D. en sciences infirmières au Canada allant se multipliant, nous pouvons nous attendre à ce que le débat intellectuel prenne de plus en plus de vie. Je pense que la nouvelle génération de chercheurs en sciences infirmières continuera d'envisager des méthodes de recherche nouvelles et novatrices afin de pouvoir résoudre les questions complexes de la prestation des soins de santé aujourd'hui.

Ce dynamisme intellectuel promet l'épanouissement d'une science infirmière rigoureuse. Nous envisageons l'avenir avec optimisme mais nous ne devons pas perdre de vue les questions pragmatiques qui régissent le déroulement de nos recherches. En invitant nos étudiants à envisager de nouveaux questionnements et à chercher à répondre autrement à leurs questions, nous devons également nous assurer que les chercheurs de demain auront accès aux crédits qui leur permettront d'entreprendre leurs recherches.

Certains chercheurs mènent des études qualitatives/phénoménologiques et estiment que les méthodes qu'ils utilisent les empêchent d'obtenir des subventions de recherche. Même si de nombreux évaluateurs connaissent fort bien ces méthodes, d'autres estiment que le positivisme logique est la seule forme légitime de recherche scientifique. Les recherches "qualitatives", si elles sont approuvées, sont généralement perçues comme des études exploratoires de "premier niveau" qui forment la base des études quantitatives. Cela ne veut pas dire qu'il soit facile d'obtenir des crédits de recherche! Par contre, lorsque les évaluateurs s'interrogent sur la légitimité de la science, les choses se compliquent davantage.

On se demande comment un projet de recherche explicitement "féministe" sera perçu par les évaluateurs des organismes subventionnaires auxquels nous faisons appel pour obtenir des subventions. Or, comme nous poussons nos étudiants vers la pensée critique et les invitons à épouser de multiples paradigmes de recherche, nous pouvons nous attendre à ce que la recherche de demain ne soit pas toujours basée sur le positivisme logique ou sur la phénoménologie. Par ailleurs, nous ne rendrions pas service aux futurs chercheurs en les poussant à cacher leurs idées sous le couvert du positivisme dans le seul but de satisfaire les personnes chargées d'évaluer leur demande.

Pour cette raison, il nous faut réfléchir sérieusement au type d'organisme subventionnaire qui sera le mieux à même de servir les besoins des futures générations de chercheurs en sciences infirmières. Différentes perspectives

intellectuelles en sciences infirmières ont vu le jour. Du fait des questions essentielles de notre discipline, les méthodes féministes, comme la phénoménologie, jouent un rôle important dans les sciences infirmières. Les demandes de subvention qui ont épousé ces perspectives ne peuvent se prétendre positivistes. Il est également raisonnable de s'attendre à ce que d'autres paradigmes de recherche émergent à l'avenir. Il nous faut par conséquent essayer d'obtenir un organisme subventionnaire pour la recherche en sciences infirmières ayant pour mandat de favoriser l'épanouissement des sciences infirmières qui soit suffisamment souple pour accepter les multiples paradigmes nécessaires à l'élaboration d'une science infirmière rigoureuse.

Joan M. Anderson

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Directrice ou directeur de l'École des sciences infirmières

L'École des sciences infirmières offre présentement un programme de baccalauréat qui compte près de 200 étudiantes et étudiants à temps plein. Elle offre aussi une formation complémentaire à temps partiel à un grand nombre d'infirmières diplômées qui désirent obtenir le baccalauréat universitaire. Ces cours à temps partiel sont offerts à partir des trois constituantes de l'Université à Moncton, à Edmundston et à Shippagan. L'École des sciences infirmières est appelée à se développer considérablement au cours des prochaines années. En premier lieu, le baccalauréat sera exigé comme formation minimale pour l'entrée à la profession à compter de l'an 2000. Dans cette perspective, le gouvernement provincial précisera ses attentes face au rôle attendu des universités et des écoles de formation infirmière de deux ans. De plus, l'École a comme projet à court terme le développement de la maîtrise en sciences infirmières.

Sous l'autorité immédiate du vice-recteur à l'enseignement et à la recherche, la personne titulaire assure le fonctionnement scolaire et administratif de l'École. Elle est responsable de la qualité des programmes, préside le Conseil de l'École et représente l'École au Sénat universitaire ainsi qu'auprès des organismes extérieurs. Dans l'exercice de ses fonctions, elle coordonne les activités d'enseignement et de recherche des professeurs, assure une bonne gestion des dossiers étudiants et gère de façon générale des activités reliées au bon fonctionnement de l'École et de ses programmes.

La candidate ou le candidat doit être titulaire d'un doctorat en sciences infirmières ou dans un domaine connexe ou encore elle ou il possède la maîtrise en sciences infirmières et une expérience importante dans le domaine. La candidate ou le candidat doit posséder une expérience administrative. Elle ou il doit également démontrer des caractéristiques de leadership de même qu'un style participatif et faire preuve de compétences permettant le développement des ressources humaines et de la recherche en sciences infirmières. La candidate ou le candidat doit maîtriser la langue française tant orale qu'écrite.

Date d'entrée en fonction : le 1er juillet 1992 pour un mandat régulier de cinq ans se terminant le 30 juin 1997. Les candidatures seront étudiées à compter du 2 janvier 1992. Les personnes intéressées sont priées de faire parvenir un curriculum vitae détaillé, un dossier professionnel complet et le nom de trois répondants à **M. Guy Savoie, directeur, Affaires professorales, Université de Moncton, Moncton (Nouveau-Brunswick) E1A 3E9.**

La personne actuellement en poste étant rendue à la fin de son mandat, l'Université sollicite des candidatures au poste de directrice ou directeur de l'École des sciences infirmières.

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FOLLOW-UP OF GENERIC MASTER'S GRADUATES: VIABILITY OF A MODEL OF NURSING IN PRACTICE

Hélène Ezer, Judith MacDonald and Catherine Pugnaire Gros

In the early 1970's, on the initiative of Dr. F. Moyra Allen, the School of Nursing at McGill University launched a new educational program at the master's level. It was intended to prepare nurses to assume leadership roles in a rapidly changing health care system. This "generic master's" program is specifically tailored to meet the needs of a particular group of students and to capitalize on their individual competencies and past achievements. The students admitted to this program are non-nursing university graduates of high academic standing with general arts or science degrees, and undergraduate courses in both the physical and social sciences.

This innovative venture in nursing education, unique in Canada, is one of a relatively small group in North America that offer entry to the nursing profession through a non-traditional route (Diers, 1987). The very idea of allowing non-nurses to enter the profession at the master's level has alternately sparked interest and controversy from nurse educators in both Canada and the United States. However, there is no doubt that such programs represent an ingenious attempt to advance the practice of the profession. At McGill, the decision to mount the generic master's program was based on the belief that mature students, with solid academic preparation in the biological or social sciences, would have the potential to contribute to the development of nursing in a unique way. The existing programs vary widely in terms of prerequisites for entry, duration of studies, curriculum design and degree offered (Slavinsky, Diers & Dixon, 1983) and each represents a "special case" in the mainstream of nursing education. Thus, descriptions of individual programs and follow-up research have important implications not only in terms of "in-house" evaluation, but also for guiding the proliferation and development of similar programs in the future. It is with these ideas in mind that the following study was conducted.

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The generic master's program at McGill University is a three-calendar-year program. A description of the curriculum was published during the early stages of its development. (Attridge, Ezer and MacDonald, 1981). The "qualifying" year and second year are each ten months in duration; the third year is a normal seven-month academic session. Clinical placements in the first year and a half are structured by the faculty in order to expose each student to a broad range of field experiences. In the latter half of the program, students proceed to systematic clinical and research study in their own areas of interest. The degree granted is a Master of Science (Applied) in Nursing. The advanced knowledge component of the degree is seen to be in nursing. The absence of a named area of specialization within the degree reflects McGill's Model of Nursing, which does not lend itself to existing traditional fields of specialization.

The model of nursing on which the curriculum of the program is based, was emerging at the same time as this graduate program began. It was an innovative conceptual view of nursing developed by Allen and her colleagues at McGill that emphasized mobilizing strengths or potentials within families and social groups for the promotion of health. This view was markedly different from the more traditional illness-related, physician's assistant or physician-replacement styles of nursing that were then in vogue. In the decade that followed, demonstration projects in both urban and rural settings, as well as further clinical study and research in acute care institutions and in the community have led to the refinement and elaboration of this conceptual view, now known as the McGill Model of Nursing or as the Allen Model (see Gottlieb & Rowat, 1987, Kravitz & Frey, 1989).

Lindeman, in her critique of the model supports the notion that its conceptual definitions constitute a significant departure from the more traditional and well-known models of nursing currently available (Lindeman, 1985).

The central concepts of the model form the core of the curriculum of the generic master's program. Throughout the three years of graduate study, students are encouraged to challenge the traditional view of health as the absence of illness. They are assisted to identify the abilities, potentials and resources present in people undergoing normal transitional events, as well as in those grappling with potentially debilitating crises. They are encouraged to work actively with the family, in order to understand the meaning of an event and its impact on feelings and behaviour. Students are supported by faculty as they carry out nursing interventions that mobilize the resources within the family or social network. They are also assisted to approach the nurse-client relationship as a collaborative venture where the client's input is actively incorporated as an integral part of the nursing assessment, plan and evaluation. Moreover, students are encouraged to work with their caseload of

families over extended periods of time, in order to participate with the client(s) in the process of learning and development. This process is valued as an important and desired outcome of nursing intervention.

Purpose of Study

This study has two main objectives. First, it is an attempt to document the characteristics of incoming university graduates and to track their career paths in nursing following program completion. Secondly, given the strong philosophical orientation of the curriculum and the need to examine the relevance of the McGill Model, it was important that a follow-up study explore the extent to which the model of nursing being taught in the program was evident in the professional practice of the graduates.

Methods

Given the practical difficulties associated with first-hand observation and interview of research subjects, the data about subjects' nursing practice were obtained through self-report. Data were collected through a two-part questionnaire mailed to all graduates of the program. Data collection began in the fall of 1985 and was completed in the summer of 1987. In all, a total of eleven graduating classes were surveyed. Respondents were informed that this was a follow-up study of the program and that anonymity would be assured in the reporting of findings.

Part I of the questionnaire consisted of a series of items regarding the nature of the respondents' undergraduate studies, work experiences prior to admission and reasons for entry to the program. Additional data were collected on their satisfaction with career choice and educational program in nursing, on the nature of their professional practice since graduation and on the degree of their involvement in professional activities.

In Part II of the questionnaire respondents were asked to describe an incident that captured for them the quintessence of nursing. They were asked to include why the incident was important, the context of the situation and the nature of their involvement in it. Qualitative analysis of these data was undertaken in order to determine whether critical elements of the McGill Model of Nursing were evident in the situation that each respondent chose to describe. The process of data analysis was similar to that used by Allen, Frasure-Smith and Gottlieb (1982) and Gottlieb (1982) in their studies of this model of nursing in other settings.

Sixty-two students had completed the program by the end of the data collection period. Fifty-six questionnaires were mailed to those graduates whose whereabouts were known. Forty-eight questionnaires were returned: a response rate of 86%.

Findings

Pre-entry profile of respondents

Seventy-five percent of respondents had a Bachelor of Science degree on entry to the program; twenty-five percent entered with a Bachelor of Arts. Four of the 48 respondents had completed a second university degree prior to entry and eight had begun another program of university studies but chose not to complete it. Sixty-five percent of respondents had achieved a CGPA of between 3.00 and 3.49 (maximum 4) in their undergraduate studies. Eighteen percent had a GPA of between 2.8 and 2.99 and 15% had GPA above 3.5. Fifty-six percent were between the ages of 21 and 23, 25% were between 24 and 26 and 19% were over 26. The mean age at entry was 24.8 years Seventy-seven percent of entrants were single, 17% were married and had children. Forty-three percent had never been employed full-time prior to entry, while 57% had been employed in a full-time capacity for varying lengths of time. No particular pattern emerged from the data on the nature of past employment.

Post-graduation profile

Nature of employment in nursing practice: The data on employment suggest high employment and retention rates in nursing of these graduates despite reported developmental changes in their family status following graduation. Virtually all graduates were currently employed or about to begin work in the field of nursing. Only one was seeking work. At the time of data collection 69% of respondents had been working two years or less, with a group mean of 1.9 years. Seventy-seven percent of the respondents reported their place of employment as being in-patient services in acute care institutions.

In the breakdown of nursing activities, the majority of respondents (69%) reported spending at least 50% of their time in direct nursing care. Fifteen percent were spending that proportion of time in teaching (not linked to direct patient care), while 10% reported that the greatest proportion of their time was spent in administrative activities. Clearly, the large majority of these master's-prepared nurses were actively engaged in "hands-on" nursing practice.

In examining the constellation within which the nursing takes place - i.e. individual, family, group, or community - 70% of respondents reported spending more than 50% of their time with individual clients. However, it is interesting to note that, while the majority of respondents are employed on hospital wards where working with the individual is an accepted norm, 56% of them report spending 25% or more of their time providing nursing care to families.

Feelings of professional competence: Graduates' feelings of satisfaction with career choice, the extent to which they felt prepared to deal with the demands of their current position, and the extent to which they felt they had been able to use their master's level preparation were each rated on four-point Likert scales. Eighty percent of graduates indicated that they make use of their master's preparation. Seventy-eight percent, reported that they felt well prepared to meet the demands of their current position and 87% felt satisfied with their career choice. There was no significant correlation between satisfaction with career choice and length of time since graduation.

In describing the factors that were felt to contribute to feeling prepared, the model of nursing was clearly important. "The strong focus on families has helped me feel prepared" and "the knowledge about systems and how individual behaviors affect and are affected by them...the ability to teach, to motivate and promote strengths in others" are examples of the comments that the respondents included. Other characteristics fostered in the graduate program - independence, initiative and the ability to articulate ideas - were also seen as contributing to feeling prepared to meet the demands of practice.

A sense of feeling inadequate with regard to technical skills in the acute care settings was described by some graduates, despite the fact that these same respondents may also have reported that they felt well prepared to meet the demands of their current position. "Technically I was somewhat slow, but the graduate preparation taught me to learn how to learn. Hence, within a few months, in terms of technical skills I was functioning at or above the level of others."

By contrast, a small minority of graduates (n=2) did describe their difficulty in attempting to practise nursing in a way that they found satisfying. They perceived their nursing to be directed and limited by the system rather than shaped and developed by their own knowledge and ability.

> The conditions of the work environment in a hospital do not allow us the opportunity to apply our knowledge....As a registered nurse working on a medical floor...I am too busy trying to [do] the menial tasks of feeding patients and giving other basic care that I do not have the time and energy to apply what I have learned. What is taught in school is too idealistic to meet the demands of working on a floor.

For these graduates, their educational preparation was not sufficient to arm them with the skills to overcome the many real obstacles that the system can present. Most graduates working as staff nurses had similar responsibilities, therefore the demands of "working on a floor" is clearly not the variable that accounts for these different responses.

Professional involvement: Forty percent of respondents reported membership in professional interest groups and 27% had been engaged in research since completion of their master's study. Only a few graduates reported publications in professional journals. For that subgroup of graduates who had been out of school three years or more (n=12), 40% had been involved in research and 35% cited authorship on one or more publications. In addition, a 5% increase in professional interest group membership was noted for this subgroup of graduates.

The use of the Model in practice

In Part II of the questionnaire, each respondent was asked to describe a critical incident from their nursing. Twenty-eight critical incidents were used in the qualitative analysis. In three cases the data supplied were not examples of the graduate's own practice and consequently were excluded from the data set for this analysis. Some respondents chose to leave Part II unanswered stating that they were not currently involved in direct patient care. The remainder left Part II unanswered but gave no reason why.

The incidents described ranged from relatively simple nursing encounters with one individual or family over a brief period of time to long-standing situations that involved many family members and other professionals. Overall, however, the nurses were describing events that clearly had strong personal and professional meaning.

> I was appalled. I could not believe this woman had been hospitalized for 6 days and no one bothered to find out how she or her husband were coping with the situation. I was appalled at this blatant incident of nursing malpractice--as serious as a med error in my book.

Keeping in mind the essential elements of the McGill Model of Nursing, six categories were derived from these data. These were: perspective of the situation, unit of concern, assessment sources, attributes used in the plan of care, time frame for intervention and evaluation. Each category contained two divergent approaches to nursing practice: Type I reflecting the McGill Model and Type II reflecting the more traditional models of practice (see Table 1). The categories that emerged from data analysis were similar to those in the studies by Allen, Frasure-Smith and Gottlieb (1982) and Gottlieb (1982). The category sets are described in Table 1.

In the Type I model, a health-related perspective of the situation is one that involves the client's process of coping, adjusting or learning from events; a process that reflects the complex past and present life experiences of the client(s). A family focus views events as affecting and being affected by more than one person. An exploratory approach to assessment suggests that

Table 1

Approaches to Nursing Practice

Dimensions of Nursing	Model Type I McGill Model	Model Type II Traditional Model
Perspective of Situation	Health-related (broad view)	Illness-related (contained view)
Unit of concern	Family	Individual
Assessment sources	Exploratory	*A priori*
Attributes used in plan of care	Potentials	Deficiencies
Time frame for intervention	Client readiness	Professional schedule
Evaluation	Client outcomes	Professional objectives

the nurse has actively sought input from the client(s) to analyze the situation. The strengths, abilities or other positive forces within the individual or family are used in developing a plan of care, and the nurse intervenes when she has confirmed with the client his readiness for a particular intervention. Finally, the nurse uses the responses of the client(s) as the primary data source in evaluating outcomes.

In the opposing Type II model, the nurse perceives the situation as a relatively circumscribed response of the client to a particular illness-related event. The response is directly related to the event and is not affected by past and present life experiences. The focus is clearly on the individual's immediate response. The roles of the family members and "significant others" may be mentioned but are not described as important to or involved in the situation. An *a priori* approach to assessment suggests that the nurse relies primarily on her own or other professionals' existing knowledge and experience to analyze the situation. In developing the plan of care, the emphasis is on overcoming the deficits, gaps or weaknesses within the client and the nurse intervenes according to a professionally derived time frame for action. Finally, nurses use professional judgement as the primary data source in evaluating the outcomes of their interventions.

Independent raters were asked to code the data into one of the two available choices for each category. Interrater reliability was determined by the Kappa statistic, which corrects for possible exaggerations of reliability when only

two options are available for coding each category. (Krippendorff 1980). The Kappa statistic for the categories were: perspective of situation, .66; unit of concern, .64; assessment sources, .64; attributes used in plan of care, .45; time frame for intervention, .55; evaluation, .78.

Looking across each of the six categories, it was possible to determine to what extent each category was coded as either Type I or Type II practice. The Type I model was predominant for each of the six elements approximately 80% of the time (range=75-88%). In an alternate approach to the data, each critical incident was analyzed in order to see which of the two models it reflected. This analysis revealed that 54% of respondents described situations that reflected the Type I model on all six categories. Another 14% reflected use of the model in all but one, while the remaining 32% had a varying number of McGill Model elements in their practices. In no case did any one incident reflect Type II nursing exclusively. Clearly, the graduates were describing clinical situations that reflected Type I practice.

What follows are excerpts from one situation that was rated as Type I on all six categories. The elements of health, family focus, exploratory approach to assessment, care based on working with potentials, interventions based on clients' readiness and using the client outcomes as the data source to evaluate the nursing are all clearly evident in this example.

> I held her as the tears burst forth. Mrs. G. began to discuss her concern about her daughters, wondering how they would be able to understand and cope with losing their father. I highlighted for her the many ways she had already described for me how she was helping her children to understand, and what strategies they were apparently using to cope. I encouraged her to bring the children in to visit.
>
> During the next six weeks...Mr. G. found that being around his "girls" helped him to relax and find the drive to work through his feelings....The girls would phone each morning and then come in to visit in the evenings and do their homework. Mrs. G. ensured that the girls' regular extra-curricular activities were maintained (dance, swimming). Both parents expressed concern that their daughters were not talking to them about Mr. G.'s dying, and felt awkward about how to initiate such a conversation. I gave them two annotated bibliographies on broaching the subject of death with children, along with a list of children's books available at the...public library....Both parents found this useful, especially since "researching" on their own fit well with their style of resolving problems.
>
> Three weeks later, Mr. G. was readmitted to the unit to die. While at home he had written a letter to each of his daughters, to be opened

after his death. Despite the hectic work at this time, I set aside several 'breaks' for myself in the day where I would spend brief but attentive visits with Mr. and Mrs. G....I encouraged Mrs. G. to tell me about her husband and the times they had shared, and allowed her to review the last difficult year they had together.

The second week of this final admission I was attending conferences and thus was not on the floor. Knowing that Mr. G. might not be alive when I returned to work, at midweek I went to visit. I reviewed with him our relationship, how at first he didn't think that anyone could cope with dying, how he had risen to the challenge and indeed faced his death "head on" as he had other life crises. I told him how proud I was of him, and for him. Mrs. G. later revealed that he had told her about our conversation and that it had meant a lot to him. When I finally returned to the unit, Mr. G. was alive but not responsive. He died at 9:00 a.m. that morning, just one hour prior to his wife's arrival.

The doctor and myself told Mrs. G. of her husband's death when she arrived on the unit, and provisions were made for a private parting in his room when she was ready. Mrs. G. later sent a beautiful letter thanking the staff, with special mention of the people and actions that had helped her and her family through this crisis.

Possible relationships between the nature of graduates' practices (Type I or Type II) and other variables such as reasons for entry to program, nature of undergraduate degree, time employed in nursing since graduation, career satisfaction, etc. were explored using Chi-square tests. A significant relationship was found only between type of practice and current work setting (X^2 $(2,n = 28) = 6.62$, $p < .05$). Virtually all respondents employed in out-patient settings described clinical incidents that reflected Type I nursing in each of the six categories. It should be noted however, that 46% of those employed in acute care settings also described situations that reflected all or all but one element of Type I nursing.

Discussion

The number of graduates from this generic master's program has maintained an average of approximately 10-12 per year, growing from 62 at the time of data collection to 94 as of June 1989. The findings of this study which indicate high employment rates within nursing and high degrees of satisfaction with career choice and with the educational program, suggest that graduate education as entry level preparation in nursing coupled in this case with a particular set of beliefs about nursing practice, is a viable and personally fulfilling option for academically strong young adults. This is an

important finding in today's climate where low retention rates, dissatisfaction with nursing and decreasing enrollment have been a problem.

Our findings and continued experience suggest that most of our applicants are much younger than first anticipated, and in fact, that they have not been away from academia for any length of time. Marketing and recruitment strategies in nursing have not been specifically directed in the past towards the new university graduate. As we look to recruit leaders and committed individuals to the practice of nursing, we must tap this pool as a resource for nursing and shape our programs to build on the skills and knowledge of these young people.

The study's findings related to the nature of the practice of the graduates supports Slavinsky's observation that "college graduates...stay committed to practise both during their educational experiences and after graduation" (Slavinsky, et al., 1983). The graduates from this program have strongly demonstrated satisfaction as well as competence in giving nursing care, and are clearly not using the graduate degree as a means to move away from the "bedside". On-going data collection following the completion of this study seems to provide continuing evidence of a commitment to the practice dimension of nursing, even as program graduates take positions in ambulatory care or in a community-based practice. There is also a clear indication that graduates are assuming leadership positions in nursing in all areas of practice and, at the same time, are maintaining an active involvement in direct patient care. An important number are pursuing studies at the doctoral level.

The findings in Part II of the questionnaire that indicate that the elements of the McGill Model of Nursing are firmly entrenched in the practice of program graduates are however, the most important feature of the study. Despite the strongly in-patient, hospital-based nature of their current workplace, which reflects the availability of positions for new graduates, it was important to note the relatively high proportion of time that the graduates spent with families. That they are able to generate such a family-based practice in settings where family members arrive only as "visitors" is a significant finding. It indicates that the strong orientation in the curriculum to family-centred nursing practice is one that remains central to their beliefs and values about nursing. Moreover, the significant association found between this model of nursing and the nature of the work setting is an important one. Graduates working in ambulatory setting are reporting Type I practice consistently among all six dimensions. However, the large number of Type I situations (46%) described by those working in acute care environments suggest that Type I nursing is also evident in hospital-based practice, despite the existing illness orientation and professionally driven norms for care of the institution.

In addition, the richness, variety and complexity of the clinical data described in these incidents suggest other recurrent themes that could also explored. These include the importance of long-term relationships with patients and families, patient advocacy and fostering healthy behaviours during illness. The data also suggest that these nurses were actively engaged in challenging and shaping their colleagues' views on nursing. Thus, leadership roles were being assumed even at the staff nurse level. This suggests that leadership skills cannot be adequately reflected by considering only the position that the graduate holds.

Secondary analyses to pursue these themes would certainly be worthwhile. A follow-up study of the program graduates at the baccalaureate level is currently under way at McGill. In addition, a comparative look at other groups of nursing graduates, such as other master's-prepared nurses, would add needed insight into the practice of nursing at different educational levels.

We have spent considerable time in nursing arguing for a theoretical base for nursing practice, but have been slow to examine and to document whether and how, theory-based practice makes a difference. This is an important question not only for developing nursing theory, but also for nursing education research. To date, educational research has focused heavily on the evaluation of styles of teaching. There has not been an equal attempt to examine how the content of curricula affect outcomes for nursing practice. The questions we should be asking are: Does it make a difference to *practise* if we emphasize to a family-oriented approach? Does it make a difference to *practise* if we define health in broader terms? Does it make a difference to *practise* if we can teach students to work with strengths and abilities? These questions capture the essence of nursing. They must continue to be addressed if we are to demonstrate that nursing has a knowledge base that is unique and that this knowledge makes a real difference in the delivery of care to individuals, families and communities.

This particular study attempted to see whether or not the model of nursing in the curriculum of a generic master's program shapes the practice of the program graduates. The findings indicate strongly that it does.

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RÉSUMÉ

Suivi des diplômées de la maîtrise générique: viabilité d'un modèle de sciences infirmières dans la pratique

Une étude de suivi des diplômées du programme de maîtrise générique de l'École des sciences infirmières de l'Université McGill a été entreprise dans le but d'examiner leur cheminement professionnel et de déterminer dans quelle mesure le modèle d'enseignement des sciences infirmières de McGill se reflétait dans l'exercice de leur profession. Les données ont été réunies par le biais d'un questionnaire qui a été envoyé à toutes les diplômées et dans lequel ces dernières devaient décrire la nature de leur travail, leur cheminement professionnel depuis l'obtention de leur diplôme et leur satisfaction quant à leurs choix professionnels et leur préparation pédagogique. Les répondantes ont par ailleurs été invitées à décrire un incident critique survenu dans le cadre de l'exercice de leur profession et qui, selon elles, représentait la quintessence des sciences infirmières. Les analyses révèlent des taux de rétention élevés en sciences infirmières, un fort degré de participation aux activités directes liées aux soins à prodiguer aux patients et un fort degré de satisfaction quant aux choix professionnels et à la préparation pédagogique. L'analyse qualitative des incidents critiques révèlent que les volets santé, famille et exercice collaboratif qui caractérisent le modèle de McGill étaient présents dans les descriptions des répondantes. Les résultats donnent à penser que ce programme unique permet de former un contingent d'infirmières petit mais stable, que celles-ci participent activement aux soins directs et que l'exercice de leur profession témoigne d'un ensemble de croyances non conventionnelles sur la nature des soins infirmiers.

ÉLABORATION D'UN QUESTIONNAIRE D'IDENTIFICATION DES FEMMES VIOLENTÉES EN MILIEU CONJUGAL

Colette Gendron

La violence conjugale est un problème de société particulièrement important et ce, tant en raison de l'ampleur qu'il a, que des séquelles qu'il laisse aux femmes qui la subissent. Désormais, leur état de santé est considéré comme alarmant. Pourtant, bien que les recherches et les enquêtes sur la question se soient multipliées depuis les années 70, la collectivité québécoise commence à peine à s'éveiller à cette réalité et à prendre conscience de la gravité de la violence qui sévit en milieu conjugal. A cet effet, le gouvernement canadien vient de constituer un comité chargé d'examiner la violence faite aux femmes à l'intérieur de la famille (Gouvernement du Canada, 1991).

Les personnes intervenant en milieu hospitalier ainsi que dans les centres de services sociaux occupent certainement une position stratégique tant pour le dépistage et l'identification des femmes violentées que pour leur acheminement vers les services appropriés. En effet, selon une étude du Conseil consultatif sur la situation de la femme (1985), 18% des femmes qui se présentent aux urgences des hôpitaux ont été des cibles de la violence conjugale. De plus, des entrevues réalisées auprès de femmes battues révèlent que 40% des femmes violentées demandent des services médicaux au moins à cinq reprises (Dobash et al., 1985) et que 80% d'entre elles signalent leurs blessures au moins une fois au personnel hospitalier. En fait, les membres du personnel de la santé seraient souvent les seules personnes à qui les femmes se confient. D'un autre côté, le personnel médical et infirmier ne dispose que de très peu d'outils leur permettant de reconnaître les femmes violentées par leur conjoint. Le but de cet article est donc de présenter les résultats d'une recherche visant le développement d'un tel instrument d'identification.

Contexte théorique

Mentionnons comme point de départ qu'il existe une certaine confusion dans les recherches traitant du rôle du personnel hospitalier vis-à- vis des

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femmes violentées. En effet, la distinction entre le rôle du personnel infirmier et celui du personnel médical y est rarement faite; ce qui a alors pour conséquence qu'on ne sait jamais très bien de qui il est question au juste.

Par ailleurs, il semble aussi que le personnel médical et infirmier ait du mal à saisir la question des femmes violentées. Il ignore, minimise ou doute que la violence familiale soit un véritable problème. Ainsi, des études révèlent que le phénomène de la violence conjugale passe à peu près inaperçu dans le monde médical (Hilberman et al., 1977-78; Stark et al., 1979).

Un pourcentage relativement négligeable de femmes maltraitées qui recourent aux services médicaux font l'objet d'un diagnostic juste et de soins appropriés; probablement moins d'une femme sur 25, si l'on en croit les études qui ont tenté d'en estimer l'importance (Stark et al., 1981). En effet, en plus de se voir attribuer des étiquettes punitives lors des consultations médicales, les femmes violentées risquent davantage de recevoir des ordonnances pour des analgésiques ou des tranquillisants légers (Stark et al., 1981). Rien d'étonnant alors, comme le constatent Bowker et al. (1987), que le personnel médical, même s'il est celui qui est consulté le plus fréquemment, soit aussi celui qui est jugé le moins utile et le moins efficace auprès des femmes battues. Donc, même si à prime abord les établissements de santé apparaissent comme des lieux privilégiés pour reconnaître et aider les femmes violentées, il semble bien que dans les faits ce ne soit pas le cas.

Les préjugés et la méconnaissance du personnel médical et infirmier envers le phénomène de la violence conjugale constituent une des raisons qui concourent au fait que toutes les femmes violentées ne sont pas reconnues comme telles et ne reçoivent pas un traitement et un support adéquat en milieu hospitalier. Cependant, l'absence d'outil ou de protocole permettant de repérer les cas de violence conjugale en est une autre (Gendron, 1987).

A l'heure où les drames familiaux se multiplient au Québec, il est essentiel que le personnel hospitalier, et plus particulièrement les infirmières et les infirmiers, puissent disposer d'instruments adéquats pouvant les aider à identifier les femmes violentées. Or, un tel outil leur fait défaut actuellement. La validation d'un instrument approprié permettant d'identifier les femmes qui sont des cibles de la violence conjugale est donc un pas nécessaire pour que le personnel infirmier et les membres des autres équipes professionnelles soient en mesure de procéder avec efficacité au dépistage des femmes violentées.

Tout comme celles et ceux qui ont déjà tenté de construire un protocole d'identification des femmes violentées (Klingbeil et al., 1984; Larouche, 1985; Lichtenstein, 1981; OIIQ, 1987; Viken, 1982), nous nous sommes

inspirées des études de Flitcraft (1977) et de Stark et al., (1981) qui font figure de pionnières en la matière et qui donnent un profil statistique et médical des femmes violentées en milieu conjugal.

Ensuite, nous avons procédé à l'examen attentif des travaux de Campbell (1989), de Christiano et al. (1986), de Ghent et al. (1985), de Helton (1986), de Jaffe et al. (1986), de Jacobson et al. (1987), de Kurz et al. (1988), de McGrath et al. (1980), de Rosewater (1985) et de Stark et al. (1981), qui ont décrit les caractéristiques de ces femmes en explorant leurs réactions physiques et psychologiques à la violence.

Finalement, c'est l'étude de Campbell (1989) qui a retenu notre attention: d'une part, parce que les conclusions auxquelles elle en arrive sont dans la continuité de celles des autres études faites sur la question, et d'autre part, parce qu'elle s'inspire des travaux faits en soins infirmiers.

En résumé, cette étude de Campbell arrive à la conclusion que les femmes battues se distinguent des autres femmes en ce qui a trait à l'estime de soi, à la capacité à prendre soin de soi et à entretenir des relations satisfaisantes avec autrui. Ces résultats l'amènent d'ailleurs à dire que les variables associées au modèle de "la résignation apprise" permettent autant d'expliquer le comportement des femmes violentées que celles qui sont associées au modèle de "l'incapacité à assumer le deuil". Ceci signifie donc que les femmes battues restent avec leur conjoint, autant parce qu'elles ne sont pas capables de mettre un terme à une relation qui n'est pas satisfaisante que parce qu'elles ont l'impression que les choses peuvent changer.

C'est à Orem (1985) qu'on doit principalement la notion de "self-care", traduite ici comme étant la capacité à prendre soin de soi. C'est d'ailleurs à partir de cette notion que l'auteure a élaboré un modèle théorique sur le rôle des infirmières et des infirmiers en milieu hospitalier. Brièvement, ce modèle confère au personnel infirmier le rôle de combler les besoins que les personnes sont habituellement en mesure de satisfaire elles-mêmes.

Orem a constitué une liste de besoins qui, selon elle, devraient être comblés pour qu'une personne en arrive à prendre en charge sa santé, et de façon plus globale aussi, tous les aspects de sa vie. Ainsi, une personne peut évoluer normalement si elle est capable

1. de répondre à ses besoins primaires;
2. de maintenir un équilibre entre ses périodes d'activités et de repos;
3. de maintenir un équilibre entre la solitude et les interactions sociales;
4. de prévenir les risques qui menacent sa vie, son fonctionnement et son bien-être;
5. de se préoccuper de sa santé et de son développement.

Le modèle d'Orem associe à ces besoins, une série d'actions qui vont permettre de les satisfaire. Le développement d'une personne implique donc qu'elle puisse accomplir les actions nécessaires à la satisfaction de tous ses besoins et sinon, qu'elle soit alors capables de demander l'aide appropriée.

En nous référant à cette théorie, nous postulons pour notre étude que les femmes violentées sont dans un contexte où elles ne sont pas en mesure de poser les actions nécessaires à la satisfaction de leurs besoins, ou plus simplement encore, de prendre soin d'elles. Nous définissons alors la violence conjugale comme un ensemble de gestes d'agression perpétrés en milieu conjugal qui ont pour effet de contrevenir à la croissance de la personne qui en est la cible.

Méthodes

Le choix des indicateurs

En nous inspirant du modèle d'Orem, et des différentes études précédemment mentionnées, nous avons dégagé les indicateurs qui, selon nous, seraient les plus susceptibles d'identifier les femmes violentées. En fait, en examinant la liste des actions nécessaires à la croissance personnelle selon Orem, nous avons choisi, en nous référant aux conclusions de la revue des écrits, celles que des femmes, dans un contexte de violence conjugale, n'étaient probablement pas en mesure d'accomplir.

Ceci nous a alors amenée à privilégier comme facteurs les actions manifestant

1) la capacité de maintenir une image réaliste de soi; ce que nous avons défini comme étant l'indice de *l'estime de soi.*
2) la capacité à se prendre en charge; ce que nous avons défini comme étant l'indice d'*autonomie.*
3) la capacité d'entretenir des relations sociales satisfaisantes; ce que nous avons défini comme étant l'indice de *socialité.*
4) la capacité d'assurer son intégrité et son bien-être; ce que nous avons défini comme étant l'indice de *sécurité.*

L'élaboration des items

Après avoir consulté des banques de données en soins infirmiers (Campbell, 1989; McFarland et al., 1989; OIIQ, 1987; Orem, 1971), après avoir fait un examen critique des différents instruments en usage actuellement en médecine, en psychologie et en service social (Christiano et al., 1986; Flitcraft, 1977; French, 1989; Goldberg, 1978; Goldberg et al., 1979; Gough, 1975 (California Psychological Inventory - CPI); Guilford, 1956 (Guilford et

Zimmerman Temperament Survey); Hathaway, 1967 (Minnesota Mulphasic Personnality Inventory - MMPI); Hoffman, 1984; Hudson et al., 1981; Jackson, 1974 (Personnality Research Form - PRF); Strauss, 1979; Summers, 1989) et après avoir procédé à une consultation auprès des membres des Écoles de psychologie et de service social associées au Groupe de recherche sur la violence faite aux femmes à l'Université Laval (REVIF), nous avons élaboré une première liste de 515 items pouvant être reliés à un vécu de violence conjugale et pouvant être associés aussi à nos quatre indicateurs. Ensuite, en éliminant de nous-mêmes les items qui présentaient des répétitions évidentes ou qui s'appliquaient plus ou moins au contexte de la violence conjugale, nous avons obtenu une liste de 178 items.

La validation du contenu des items

Cette liste a été soumise à vingt juges expertes pour qu'elles estiment la validité de contenu des items que nous leur présentions. En fait, pour chacun des items, nous leur avons demandé d'établir leur degré de pertinence pour identifier des femmes violentées en milieu conjugal. Toutes les juges expertes ont été contactées par lettre et une copie du questionnaire contenant les 178 items leur a été transmise.

Le groupe des juges expertes était composé de vingt femmes dont dix reconnaissaient avoir vécu des situations de violence conjugale avec leur conjoint, et dix autres étaient soit, infirmières, médecins, psychologues ou travailleuses sociales spécialisées dans les problèmes de violence conjugale.

L'évaluation des items par les juges s'est faite par écrit et les résultats de leurs travaux nous ont amené à ne retenir que les 106 items qui leur apparaissaient pertinents parmi les 178 que nous leur avions proposés. Par ailleurs, cette consultation nous a également donné l'occasion d'améliorer l'énonciation des items.

La stratégie d'échantillonnage

Un certain nombre de femmes, violentées ou non par leur conjoint, les unes sélectionnées suite à une demande de services, et les autres, au hasard, ont contribué à valider les éléments de ce questionnaire.

Deux cent cinquante femmes violentées et 350 femmes présumément non violentées ont été choisies pour cette étude. Les femmes violentées ont été recrutées grâce à la collaboration des responsables des maisons d'hébergement pour femmes violentées et des CLSC. Les femmes non violentées ont été sollicitées de manière aléatoire à leurs lieux de travail soit à l'Université Laval, dans des cégeps, des hôpitaux, des organismes gouvernementaux, des centres sportifs et des restaurants de la région de Qué-

bec. Elles proviennent de différents milieux socio-économiques. La manière dont nous avons procédé nous a donc permis de rejoindre un éventail très large de la population mais ce, sans toutefois nous assurer de la représentativité de l'échantillon.

Les femmes de ces deux groupes ont répondu personnellement et de manière anonyme au questionnaire puis ceux-ci nous ont été retournés dans une enveloppe prévue à cet effet.

Résultats

Les répondantes

Des 250 questionnaires qui ont été distribués dans les maisons d'hébergement pour femmes violentées et auprès des membres du personnel des CLSC, 81 (32.4%) seulement nous ont été retournés. Deux raisons expliquent cet état de fait. D'une part, certaines des femmes violentées considéraient qu'elles ne vivaient plus avec leur conjoint au moment où elles étaient sollicitées. Elles n'ont donc pas répondu au questionnaire puisque la population qu'on cherche à identifier par le biais de cette recherche est celle des femmes vivant avec un conjoint.

D'autre part, des questionnaires n'ont pas été retournés parce qu'ils étaient incomplets. En effet, il semble que certaines femmes violentées aient démontré de la réticence à se confier, entre autres, par crainte de représailles ou pour protéger leur agresseur. De plus, nous avons pu réaliser suite aux observations des intervenantes et lors de nos fréquents passages sur le terrain, que certaines femmes violentées qui, au départ acceptaient de répondre au questionnaire, étaient psychologiquement incapables d'aller jusqu'au bout de l'exercice. On peut alors faire l'hypothèse que le fait de répondre au questionnaire les obligeait à mettre à nu des situations qu'elles avaient tenues secrètes jusqu'à présent, et que ceci leur était difficilement supportable.

Le questionnaire auquel les femmes identifiées comme non violentées ont répondu était similaire en tous points à celui que recevaient les femmes violentées. Des 350 questionnaires distribués aux différents lieux énumérés précédemment dont certains milieux de travail, 203 (58.0%) nous ont été retournés. Le fait ici que seules les femmes vivant avec un conjoint devaient répondre au questionnaire peut expliquer en partie le nombre de copies qui n'ont pas été remplies.

Malgré tout, une analyse des données socio-démographiques (âge, nombre d'années de vie commune, nombre d'enfants, occupation et occupation du conjoint) indique que les deux groupes de femmes à partir desquels nous avons fait notre expérimentation sont comparables.

La validité prédictive de l'instrument de mesure

L'instrument que nous avons conçu a pour objectif d'identifier les femmes violentées et il est utilisé à la façon d'une échelle de type Likert. Cela signifie donc que les scores obtenus à chacun des items s'additionnent pour obtenir un score total reflétant les probabilités que la répondante soit violentée en milieu conjugal. Par ailleurs, cela implique aussi que les items mesurent tous un même construit.

Nous avons procédé à une analyse d'items afin de raffiner les qualités métrologiques de ce questionnaire. Cette démarche a pour but de détecter les items étrangers au construit, peu discriminants ou tout simplement redondants. En effet, la présence de tels items risque d'affecter la fidélité de l'échelle, sa validité et bien sûr l'interprétation rendue.

Nous avons donc fait des tests "t" pour identifier, parmi les 106 items qui nous restaient suite à la première sélection effectuée, ceux de qui on pouvait dire qu'ils discriminaient réellement les femmes violentées des femmes non violentées. Au départ, nous avions fixé à .05 le seuil à partir duquel nous jugions que les différences obtenues entre les deux groupes pour chacun des items étaient significatives. Cependant, les résultats se sont avérés insatisfaisants puisqu'en procédant de cette façon, il nous restait 80 items alors que l'objectif était plutôt d'en arriver à une quarantaine.

Nous avons donc décidé de faire la sélection des items en nous basant sur l'ampleur des différences entre les moyennes obtenues pour chacun des items. De cette façon, nous avons pu éliminer 57 des 106 items, et il ne nous en restait plus que 49. Un examen des courbes caractéristiques des items a indiqué que tous discriminaient bien les deux groupes de femmes. Nous avons ensuite procédé à des corrélations item-total. La plus petite corrélation étant de .41, aucun item n'était donc mauvais. Nous avons alors examiné les corrélations inter-item et là, en fixant à .70 le niveau à partir duquel une corrélation entre deux items serait trop élevée, nous avons constaté que plusieurs des 49 items étaient redondants. Afin d'éliminer un des deux items qui étaient redondants, nous avons donc considéré d'abord le contenu des items puis leur variance. De cette façon, 19 items ont été éliminés et nous nous sommes retrouvées avec une échelle comportant 30 items.

Une analyse factorielle a finalement été effectuée (voir annexe). La méthode de rotation orthogonale qui a été utilisée, est celle de l'analyse en composantes principales avec Varimax. Ainsi, des 30 items qui nous restent, l'analyse fait ressortir quatre indicateurs (estime de soi, socialité, autonomie, sécurité) qui constituent autant de facettes différentes du même construit. Nous avons donc une échelle de 30 items qui présente un coefficient alpha de .975.

Discussion

Repérer des femmes violentées qui habitent toujours avec leur conjoint et qui acceptent de répondre au questionnaire n'est pas une chose facile. En effet, lorsqu'on veut sonder des femmes qui ont été violentées en milieu conjugal, on est souvent aux prises ou bien avec des femmes qui habitent encore avec l'homme qui les violente et qui, psychologiquement, ne sont pas en mesure de compléter un questionnaire de cette nature, ou bien avec des femmes qui n'habitent plus avec l'homme qui les a battues.

Le seul fait d'ailleurs de vouloir obtenir un échantillon composé uniquement de femmes qui vivent avec leur conjoint peut poser problème. Celles qui ne demeurent pas sous le même toit que ce conjoint sont certaines qu'elles sont exclues de la catégorie et celles qui viennent d'entamer une nouvelle relation et de délaisser un conjoint de vieille date se demandent à quelle expérience au juste elles doivent se référer.

La méthode que nous avons utilisée pour élaborer notre questionnaire comporte certaines limites. Tout d'abord, la constitution même de l'échantillon des femmes non violentées peut poser problème. En effet, même si ces femmes sont considérées comme non violentées pour les besoins de l'étude, il demeure qu'il y en a peut-être parmi elles qui, dans les faits, sont violentées en milieu conjugal. Dans une étude ultérieure, il faudrait donc tenter de trouver un moyen sûr de discriminer les femmes violentées de celles qui ne le sont pas. Pour ce faire, on pourrait, par exemple, utiliser les scores obtenus à certains items.

Par ailleurs, les résultats de l'analyse factorielle peuvent, à certains égards, sembler peu concluants. Par exemple, la variance expliquée par les quatre facteurs est d'environ 18%, ce qui, selon le point de vue considéré, peut apparaître assez faible. De plus, le résultat, assez faible aussi, obtenu pour le quatrième indicateur, l'indice de sécurité pourrait mettre en doute la pertinence de le retenir.

Compte tenu des limites que nous venons d'évoquer, il est bien évident que cet instrument doit être encore considéré comme un outil expérimental. On peut dire ici que la théorie d'Orem a donné lieu, à venir jusqu'à maintenant, à une certaine intensité dans le domaine de la recherche et de l'élaboration d'instruments de vérification face auxquels la démarche ici décrite ne constitue qu'une très modeste contribution (Gast, 1989). D'autres recherches devront donc poursuivre l'étude de sa validité prédictive et tenter de l'améliorer. En effet, sa spécificité et sa sensibilité pour détecter les femmes violentées restent à démontrer. Il serait important pour l'avenir d'établir par exemple, si cet instrument permet vraiment de distinguer les femmes violentées de celles qui sont dépressives ou qui vivent des problèmes conjugaux autres que la violence.

Par ailleurs, les intervenantes qui ont accepté de distribuer le questionnaire, ont constaté que cet instrument peut atteindre un autre objectif que celui d'identifier les femmes violentées. Elles ont remarqué que le questionnaire pouvait également servir de support à une discussion entre les intervenantes et les femmes violentées et que cette discussion avait souvent aussi pour conséquence de permettre aux femmes de remettre en question des attitudes et des comportements de violence, qui dans le quotidien, avaient été banalisés tant ils étaient devenus fréquents. Répondre à ce questionnaire permet donc aux femmes de prendre conscience du climat de violence dans lequel elles vivent.

Cet apport inattendu du questionnaire peut, somme toute, être assez considérable dans le milieu hospitalier, si on considère qu'il peut conférer au personnel infirmier des salles d'urgences ou des unités de soins en périnatalité par exemple, le support nécessaire pour engager une discussion auprès des femmes, et rompre le silence qui entoure le phénomène de la violence conjugale. Ainsi, peut-on espérer briser l'isolement de ces femmes et leur donner enfin une aide et des soins adéquats.

Conclusion

Même si cet outil comporte certaines faiblesses lorsqu'il s'agit de distinguer les femmes violentées par leur conjoint des femmes aux prises avec différents types de difficultés conjugales, il comporte tout de même certains avantages. Le premier est peut-être de sensibiliser les praticiennes et praticiens en santé à la réalité et à la gravité de certaines situations de violence vécues par des femmes de tous milieux et à la nécessité de leur apporter une aide, par une prise en charge de leur santé.

Il faut donc, que soient mis en place des mécanismes de prévention et des programmes de recherche susceptibles à plus ou moins longue échéance, afin que ces femmes trouvent des solutions à leurs difficultés conjugales.

La recherche effectuée pour mettre au point ce questionnaire, participe, en outre, à la discussion théorique entourant la notion de capacité à prendre soin de soi telle qu'introduite par Orem et à la nécessité d'établir la jonction entre la théorie et la pratique pour l'avancement de la science infirmière.

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ABSTRACT

The Development of a Questionnaire to Identify Women as Victims of Their Male Partner's Violence

The purpose of this article is to present a questionnaire that permits the identification of women victims of their male partner's violence. Four indicators inspired by Orem's theory (1985) of nursing care were utilized to elaborate the different items in this research instrument: self-esteem, autonomy, social interaction and prevention of life hazards.

The content validation process involved presenting 178 items for validation to 20 expert female judges. Then, the predictive value of 106 out of these items was tested with two comparable groups of women: one group of 81 women victims of family violence and another of 203 women identified as having never been victims. T-tests ($p<.05$) were calculated on each of these 106 items, but finally it was the difference between the averages obtained by the t-tests that was used as the criterion of selection. Correlations item-total and correlations inter-item were run on the 49 items remaining, and this procedure brought to 30 the number of items retained for the questionnaire. Finally, factorial analysis showed that the degree of variance explained by the four indicators is about 18%, and that these indicators constituted many different facets of the same construct.

NURSES' PERCEPTIONS OF BURNOUT: A COMPARISON OF SELF-REPORTS AND STANDARDIZED MEASURES

Deborah Pick and Michael P. Leiter

Human service professionals have traditionally sought more from their careers than mere monetary rewards. They expect their jobs to increase feelings of self-worth, fulfill achievement needs and provide a sense of purpose. Nurses are no exception. In a survey of nearly 17,000 nurses, the opportunity for professional growth was rated as the most important job consideration (Godfrey, 1978). Nurses in another survey (Donovan, 1980) ranked a sense of achievement, knowing they helped others and intellectual stimulation as the most crucial aspects of their careers. A comparison of these ideals and the reality of their jobs, however, revealed a theme of frustration for most. While 92% rated a sense of achievement as very important, only 33% were satisfied with the degree to which they experienced it in their jobs. A comparison of the percentage of nurses who valued intellectual stimulation and those who felt it was available to them yielded a similar discrepancy.

That there is a gap between nurses' expectations and the reality of the workplace is not surprising. In his study of new human service professionals, Cherniss (1980) identified four unexpected sources of stress that impeded healthy career development. The first and most critical was the crisis of competence. Despite years of formal training, the new workers often felt inadequate and uncertain about the quality of their performance. Secondly, although helping others was a primary goal for the novices, they soon became aware that their clients were not always motivated, cooperative in treatment or appreciative of the efforts made to assist them. Thirdly, they were unprepared for the frustrations of bureaucratic interference, which undermined their professional autonomy. Organizational demands also included more routine tasks than they had bargained for, and many soon became discouraged by the lack of challenge, variety and intellectual stimulation in their jobs. Finally, they were disheartened by the elusiveness of supportive, rewarding relationships with colleagues. Rather than being a source of support, interactions with peers were often a source of conflict.

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Although new professionals may be most vulnerable, these sources of stress can hinder feelings of efficacy and well-being at any stage in one's career. Responses to these and other stressors often lead to a loss of idealism and commitment, and may result in burnout.

Nurses are particularly susceptible to these pressures because of the nature and context of their work. Their competence as skilled workers is constantly on trial (Marshall, 1980), yet this high level of responsibility is combined with low decision-making power. Working for bureaucratic organizations, they often experience conflict between expectations adopted during training and actual work practices. Despite their struggle for increased professional recognition, nurses remain under the control of doctors (Vredenburgh & Trinkaus, 1983). Furthermore, the kinds of accomplishments that constitute success in nursing are not always clear (Firth, McKeown, McIntee & Britton, 1987).

The primary purpose of this study was to identify issues relevant to the nursing profession that have implications for the prevention and treatment of burnout. The researchers were interested in individual nurses' perceptions of the nature and causes of burnout. Open-ended questioning was deemed to be the most appropriate method of eliciting this information because it would allow the participants to reveal the unanticipated and assume the role of expert. As Shinn, Rosario, Morch and Chestnut (1984) have pointed out, the majority of studies in this field have applied only standard inventories of job stress to human service work. These studies, "do not assess the special stressors associated with human service work or pit those stressors against more standard measures in predicting outcomes" (p. 865). In this study, we chose a comparative approach on two levels. First, the participants' self-diagnoses (burned out or coping well) were compared with their scores on a standardized measure of burnout. Secondly, the responses to both open-ended questions and other standardized measures were contrasted according to these self-diagnoses.

A second line of exploration in this study involved the contribution of personality traits to the burnout process. In her review of the literature on stress in nursing, Marshall (1980) has suggested that, because the job is unusually high in potential stressors, researchers have concentrated on environmental aspects and assumed universal effects on nursing staff. Little or no allowance has been made for possible differences due to personality or ability to tolerate stress. In the psychology literature, as well, there is a paucity of research regarding the influence of personality on employees' reactions to their jobs. While worksetting characteristics may be more strongly related to burnout than individual ones, the fact remains that, given the same stressors, some individuals burn out while others do not.

The few studies that have previously investigated the relationship of personality to burnout have generally focused on a single trait or a small cluster of traits rather than using a comprehensive measure. Cognitive hardiness is one personality characteristic that has been associated with the absence of burnout (Holt, Fine & Tollefson, 1987; Nowack, 1986). It is a meta-construct composed of commitment, control and challenge. According to Kobasa (1979) these three cognitive appraisals are relatively stable and buffer the effects of life and work-related stress by influencing both the individual's perception of and response to events. Cognitively hardy persons are more likely to appraise an event as a challenge rather than a threat, view situations as meaningful and act on the assumption that they are influential. Thus, they are likely to use active rather than passive strategies to cope with job-related stress.

While some characteristics may decrease the possibility of an individual experiencing burnout, others appear to increase it. Type A behaviour is one characteristic that has been associated with increased levels of burnout (Nagy & Davis, 1985; Nowack, 1986; Nowack & Hanson, 1983). Type A individuals have been described as having unrealistic expectations for their own success; they are extremely competitive, impatient, achievement-striving and have a strong need for control. There are contradictory findings in research on Type A behaviour, however. A study by Frankenhaeuser (1980), for example, has shown Type A individuals to be capable of carrying a heavier workload and working at a faster pace than their Type B counterparts without any apparent health risks. This seeming contradiction led him to theorize that Type A persons may cope effectively as long as they have control over their situations. It is only when they perceive that they have lost control or have low coping ability that they experience distress to a harmful degree.

While the studies presented thus far suggest some relationship between personality and burnout, these researchers did not attempt to measure a wide range of traits. In a more comprehensive study, McCranie and Brandsma (1988) used the *Minnesota Multiphasic Personality Inventory* (MMPI) to assess personality. In this longitudinal study physicians' MMPI scores obtained at the time of admittance to medical school were compared with their burnout level an average of 25 years later. Their results indicated that physicians who were burned out at the time of the study were likely to have demonstrated the following characteristics 25 years earlier: an admission of personal and psychological difficulty; unhappiness and depression; anxiety and feelings of incompetence; and, discomfort in social situations. Those who were coping well at the time of the study were more likely to have been energetic, sociable, interested in the arts and science and adhering to religious or moral rules 25 years earlier. These results support the notion that burnout may be influenced to some degree by enduring personality traits.

A third line of exploration in this study involved the relationship of career orientation to burnout. As discussed earlier in this paper, human service professionals enter the workplace with certain expectations that, if not fulfilled, may increase their propensity to burn out. The concept of career orientation represents one type of work expectation and has been defined as an individual's needs, values and aspirations (Cherniss, 1980). Cherniss identified four general types of career orientations in his work with new professionals. Self-investors were workers whose primary concern was with their lives outside of the workplace. Family and other outside interests were more important than their careers. Social activists were idealists and visionaries who wanted to affect social change through their careers. Careerists placed a great deal of importance on traditional measures of success: prestige, advancement and financial security. Artisans valued professional growth, independence and challenge; prestige and financial success were less important than working to their own high standards.

Research in this area has shown that individuals often change their original career orientations in response to the work environment, and this change generally represents a loss of idealism. Burke (1987) developed a questionnaire to measure the four career orientations identified by Cherniss and, in a sample of police workers, those who changed career orientations experienced greater burnout than those who did not (Burke & Deszca, 1987). Burke and Greenglass (1988) also reported greater burnout for changers than non-changers. Among those individuals who did not change their orientations, self-investors and careerists were more burned out than either social activists or artisans.

Method

Subjects

Thirty-four female registered nurses from across Nova Scotia responded to an advertisement in the Registered Nurses Association Bulletin calling for participants at either end of a continuum from feeling burned out to coping well with job stress. Their ages were: less than 31 (6), 31 to 40 (16), 41 to 50 (10) and over 50 (2). They were mostly married: single (2), married (26), divorced (2) and other (4). In addition to holding nursing diplomas, there were five BNs, one MN and one PhD. They had been in nursing an average of 15 years and in their present worksettings an average of 9 years. Twenty-three worked full-time, eight part-time, two casually and one nurse did not indicate her status. They worked in a variety of health-care and educational settings, representing a wide range of roles: Administrator (2), supervisor (1), head nurse (6), staff nurse (23) and professor (2). In addition to completing a questionnaire package, 31 of the nurses also took part in an interview. At the time of the study 11 nurses indicated that they were feeling burned out and 20 were coping well, though 16 of them had been burned out in the past.

Instruments

The *Maslach Burnout Inventory* (MBI) (Maslach & Jackson, 1986) was used to assess burnout. The MBI is a 22-item measure that produces three scores: emotional exhaustion, depersonalization and personal accomplishment. The burnout profile consists of high scores an emotional exhaustion and depersonalization, and a low score on personal accomplishment.

Two similar structured interviews were used: one for nurses who felt they were burned out at the time of the study, and another for those who were coping well.

The *Personality Research Form-E* (PRF-E) (Jackson, 1987) was used to provide a profile of each participant in terms of 20 personality traits. The PRF-E was selected because it is a comprehensive measure of personality and in contrast to the MMPI, is designed for normal rather than pathological populations. The PRF-E measures the following personality traits: abasement, achievement, affiliation, aggression, autonomy, change, cognitive structure, defendence, dominance, endurance, exhibition, harmavoidance, impulsivity, nurturance, play, sentience, social recognition, succorance and understanding. It also includes two validity scales: desirability and infrequency.

Career orientation was measured using a questionnaire developed by Burke (1987) in which participants rank-ordered four descriptions of workers according to how well they portrayed them at the beginning of their careers. They then indicated which description best represented their career orientations at the time of the study.

Procedure

Details of the study, including the issue of confidentiality, were discussed with the participants in an initial telephone contact. They were informed that all questionnaires would be numbered in order to match each individual's scores on objective measures with data obtained in the interview. The questionnaires were subsequently mailed to the nurses and, upon their completion, arrangements were made for individual interviews. Interviews were taped, and conducted either in person or by telephone, depending on the geographical location of the participant.

Results

Burnout

The mean level of emotional exhaustion for this sample was significantly higher than the mean for a normative sample of 10,000 human service

professionals from across North America (Maslach & Jackson, 1986). The mean for personal accomplishment was significantly higher than the norm, and the mean for depersonalization was at the normative level. In other words, the nurses in this study were more exhausted than workers in the normative sample, though generally maintaining positive attitudes towards the recipients of their care (e.g., patients, students) and having a greater sense of accomplishment (see Table 1).

Table 1

Mean Burnout Scores by Self-Diagnoses

	Present sample n=34		Normative sample n=10,000			
Burnout Component	Mean	SD	Mean	SD	t	sig
Emotional exhaustion	34.00	13.35	20.99	10.75	7.06	$p < .001$
Depersonalization	9.68	6.87	8.73	5.89	0.94	n.s.
Personal accomplishment	40.44	6.49	34.58	7.11	4.81	$p < .001$
	Burned out (n=11)		Normative sample			
Emotional exhaustion	42.64	8.69	20.99	10.75	6.68	$p < .001$
Depersonalization	10.64	8.16	8.73	5.89	1.07	n.s.
Personal accomplishment	38.91	8.47	34.58	7.11	2.02	n.s.
	Coping well (n=20)		Normative sample			
Emotional exhaustion	28.65	13.83	20.99	10.75	2.48	$p<.05$
Depersonalization	8.40	6.21	8.73	5.89	0.24	n.s.
Personal accomplishment	41.95	5.08	34.58	7.11	6.49	$p<.001$

The participants were divided into two groups: Burned out and coping well on the basis of their self-diagnoses. When the mean MBI scores of these two groups were compared with the normative means, both were significantly more exhausted than the norm. There were no significant differences between the means of either group and the normative sample on depersonalization. The twenty nurses who diagnosed themselves as coping well at the time of the study scored significantly higher, (i.e., less burned out) than the norm on personal accomplishment. The eleven nurses who were feeling burned out scored at the normative level on personal accomplishment (see Table 1).

T-tests were performed to determine differences in MBI scores for the nurses who reported feeling burned out versus those who felt they were coping well. The 11 nurses who identified themselves as burned out at the time of the study were, according to their scores on the MBI, significantly more exhausted than the 20 who reported they were coping well (t (29)=3.03, $p<.01$). There were no differences between the two groups in levels of depersonalization (t (29)=0.86, $p>.05$) or personal accomplishment (t (29)=-1.26, $p>.05$).

Interview findings

Fictitious names have been assigned to the participants in the following summary of responses to various items in the interview section of the study. In each case, there could be more than one response per question.

How would you describe burnout? What does it feel like? When asked to describe burnout, most of the 31 participants drew upon their own experience. The most frequently reported symptoms were: a lack of interest in or enjoyment from work (n=21); feelings of frustration and anger, which resulted in irritability and a negative outlook on the workplace (n=17); exhaustion (n=13); and, dreading work (n=11). For these nurses, problems with coping while burned out ranged from feelings of helplessness and difficulty concentrating to mood swings and feelings of persecution. For some, exhaustion manifested itself only in the workplace, resulting in lowered productivity and loss of interest. For others, however, feelings of exhaustion prevailed throughout their waking hours, affecting not only work but their personal lives as well. Tina's experience with fatigue was overwhelming:

> I was feeling burned out for so long I lost control of everything. All I could do was get up in the morning and go to work. Then I'd come home from work and I'd have a bath and press my uniform and I'd go lie down in the bed. And it would be the next morning before I'd wake up. That went on for three or four months.

Several of the nurses who had experienced burnout remembered dreading work. Lisa described her loss of satisfaction from work as, "kind of a disenchantment. No emotion except kind of a sick feeling. No thrill of going to work any more...there were a lot of times I couldn't go. I just couldn't get myself up to go." Anger or frustration on the job was usually directed at supervisors and co-workers, who were perceived by the exhausted nurses as unsupportive, misdirected and incompetent. Much to the participants' own dismay, however, it was also sometimes directed at the patients. Betty remembered herself when she was feeling really burned out:

> I just didn't seem to care about anything. I didn't care whether or not someone laid in their dirty bed for hours upon hours. After all, it wasn't my fault they did that and why couldn't they just smarten up? And of course, when I felt that way, I'd feel guilty, which would make me feel even worse and make me feel like a horrible person, and that maybe I didn't belong in this job. And why didn't other people feel that way?

When did you first notice that you were feeling burned out? (asked of the 27 nurses who had been burned out at some point in their careers). The onset of burnout, according to this sample, is so subtle that one might not recognize the state until it has become very severe or even once it has dissipated. Terry explained:

> It's the kind of thing that creeps up on you. You know, you might feel that way for a short spell today and then tomorrow or the next day it might be a short spell. It's not the kind of thing that BOOM! happens today. It sort of comes and goes and you're able to cope with it and then eventually it gets to the point where you can't cope with it any longer. It takes over your being.

Tina's experience was more disturbing:

> I couldn't say when the burnout symptoms started because I didn't have time to think about them. I mean, I was so busy I didn't really say, 'Stop! I'm burning out!' I just said, 'Keep going, Keep going, Keep going!' And the day I realized I was really sick was one day my brain started to feel like it was burning. Like, I was really, really, really burned out. It wasn't a headache. It's just like your brain is on fire. And I knew there was something very wrong with me.

What do you think caused you to feel burned out? (asked of the 11 nurses who were burned out at the time of the study). For this question, there was generally more than one response per individual. The most frequently reported cause of burnout was interpersonal conflict (n=10). This conflict

occurred with supervisors for the most part, though occasionally with co-workers or subordinates as well. None of the nurses felt that their interactions with patients or the work itself was responsible. For a few of the participants (n=4), the combined effect of work-related and family stress was perceived to be the cause. Pressures at work were causing them to feel stress, but a serious illness in the family, divorce, or separation made it impossible to endure.

Changes in nursing was a stressor that was brought up by many of the nurses, and three felt it had contributed significantly to their burnout. With increasing emphasis on theory in nursing education, legal issues and technology in the workplace, bedside nursing has taken a back seat. Angela was very discouraged by this shift in emphasis:

> I was getting really tired of (pause) that it was more important what you wrote down on a piece of paper than what you did for a person and nursing in general is getting like that. Cover your ass type of thing, like the legal aspects. As long as it was documented it will stand up in court. Like, you didn't look after the person properly but who's to prove it? I used to want to do things for the patient, you know. They're sick or they're dying, or they have pain. They want to talk. I won't say it's not appreciated but it's not expected and that's where it comes second.

Sheila was disheartened by these changes to the point where she was planning to leave nursing:

> I find my work as a nurse increasingly stressful because I am not able to do the things I know should be done. The emphasis is changing. The emphasis is no longer on the things that I consider important in patient care. The emphasis is more high-tech. We're more interested in machines than we are people. You know, it's more important to be monitoring what the machines are saying than to be looking at the patient and see that maybe this person needs somebody to hold their hand for 5 minutes or needs their face washed or needs something explained. I don't want you to think that I feel machines are not important. I think they have a place, but I don't think they are more important than looking after the individual.

Workload was a contributor to burnout as well (n=3). Most of the participants felt overworked because of increasing amounts of paperwork combined with decreased staffing. A related issue that was raised often is that because most nurses are also mothers and housekeepers, they have a steady diet of work.

Do you think there is anything about you that makes you more susceptible to burnout than others? (asked of the 11 burned out nurses). Participants who felt there were personal attributes that made them *more* susceptible to burnout reported that they expected too much of themselves and others (n=5), were too sensitive (n=2) and kept their feelings inside (n=2).

Do you think there is anything about you that makes you less susceptible to burnout than others? (asked of the 20 nurses who were coping well). Participants who felt they had some attributes that made them *less* susceptible to burnout were more likely to respond that they talked about problems before they got worse (n=7). They also placed importance on being easy-going and having a sense of humour (n=6).

Do you think there is anything about your work situation which helps you cope with stress? (asked of the 20 nurses who were coping well). Most of the nurses who were coping well felt that having administrators (n=5) or co-workers (n=8) in their organizations who were supportive, caring and effective, was a great contribution to their ability to cope with job-related stress. Autonomy, flexibility, challenge and variety were other job characteristics that improved their ability to cope.

Is there anything else you'd like to add? (asked of all participants). This question raised a variety of nursing-related issues, but one recurring theme was "something has got to be done about burnout". Several of the participants had given this particular issue a great deal of thought because of the grief burnout had caused them. According to these individuals, support is needed for nurses to help prevent burnout. They suggested that this support could come in various forms: information regarding specific symptoms of burnout so it may be identified and dealt with before it is intensified; and acknowledgement from health care administrators that burnout is an increasingly prevalent problem which should no longer be avoided. Information on burnout might be most appropriately distributed through the educational system for nurses in training, and through the Registered Nurses Association for those who have completed their formal training.

The participants suggested that hospital administrators could assist in preventing and treating burnout by placing more emphasis on occupational health programs (e.g., workshops, counselling) and implementing policies supporting job-sharing, time off for educational advancement and more input from nurses to decisions affecting their jobs and patient care.

Personality traits

The following personality traits were significantly related to one or more aspects of burnout: affiliation, impulsivity, nurturance, play, social recogni-

tion and understanding (see Table 2). Descriptions of high-scorers on these scales (Jackson, 1987) are also included in the table. One validity scale, desirability, was related to the MBI subscales. Only one trait, impulsivity, was related to all three MBI subscales.

Table 2

Pearson Correlations of Personality Traits and Burnout

Trait and description of high-scorer	MBI subscales EE	DP	PA
Affiliation- Enjoys being with friends and people in general; accepts people readily; makes efforts to win friendships and maintain associations with people.	.26	-.39*	-.04
Impulsivity- Tends to act on the "spur of the moment" and without deliberation; gives vent readily to feelings and wishes; speaks freely; may be volatile in emotional expression.	.37*	.31*	-.36*
Nurturance- Gives sympathy and comfort; assists others whenever possible, interested in caring for children, the disabled, or the infirm; offers a "helping hand" to those in need; readily performs favors for others.	-.21	-.35*	.13
Play- Does many things "just for fun", spends a good deal of time participating in games, sports, social activities, and other amusements; enjoys jokes and funny stories; maintains a light-hearted, easy-going attitude toward life.	.05	.20	-.30*
Social Recognition- Desires to be held in high esteem by acquaintances; concerned about reputation and what other people think of her/him; works for the approval and recognition of others.	.19	.43**	-.19
Understanding- Wants to understand many areas of knowledge; values synthesis of ideas, verifiable generalization, logical thought, particularly when directed at satisfying intellectual curiosity.	.32*	-.13	.06
Social Desirability- Describes self in terms judged as desirable; consciously or unconsciously, accurately or innacurately, presents favorable picture of self in response to personality statements.	.44**	-.54***	.32*

*p<.05; **p<.01; ***p<.001

Table 3

Nurses' Career Orientations

Career orientation	At beginning of career	At time of study
Self-investors	n=6	n=8
Social activists	n=8	n=1
Careerists	n=2	n=5
Artisans	n=18	n=12
Total	34	26

Only 26 participants indicated their present career orientations.

Career orientation

Table 3 shows the nurses' career orientations when they began their careers and at the time of the study. Of the 26 nurses who completed all sections of the career orientation measure, 20 had changed career orientations since they began their careers. A t-test was performed to determine whether there were differences in burnout levels of changers versus non-changers. Changers were significantly more exhausted than non-changers (t (24) =-2.26, $p<.05$) but there were no differences between the two groups on measures of depersonalization (t (24)=-1.79, $p>.05$) or personal accomplishment (t (24)=0.84, $p>.05$).

How the nurses saw themselves when they began their careers was not related to their present level of burnout but their career orientations at the time of the study were. Because there was only one social activist, this category was not included in the following analysis. The results of a one-way analysis of variance revealed differences in levels of emotional exhaustion (F (2,22)=4.05, $p<.05$) and personal accomplishment (F (2,22)=5.52, $p<.05$) for the various orientations. A Tukey test (with a criterion level of .05) was performed to determine which pairs were different. Nurses who identified themselves as artisans were significantly less exhausted than self-investors. In addition, artisans felt they were accomplishing more in their jobs than careerists.

Discussion

A comparison of self-diagnoses and MBI scores indicate that for this sample, burnout was defined mainly by emotional exhaustion. The mean level of emotional exhaustion for nurses who diagnosed themselves as burned out at the time of the study was more than two standard deviations

above the normative mean. Even nurses who described themselves as coping well at the time of the study were significantly more exhausted than the norm, yet they had a high level of personal accomplishment. This finding suggests that a moderately high level of emotional exhaustion, such as that found in the coping group, is not necessarily indicative of burnout. It does, however, suggest a potentially serious problem in these nurses' relationships with their careers. If they were to experience this level of emotional exhaustion for an extended period of time, a depletion of personal resources may result, making it increasingly difficult to meet future work demands. This would decrease the likelihood of these nurses using effective coping strategies, which may lead to a diminished sense of personal accomplishment.

The average level of depersonalization in this sample was somewhat surprising, considering the degree of exhaustion these nurses were experiencing. Because the data were not anonymous, these low depersonalization scores might be explained by social desirability. This is also indicated by the rather strong negative relationship between MBI depersonalization scores and PRF social desirability scores in this sample, which suggests an unwillingness to endorse MBI items pertaining to depersonalization. The relationship also exists for emotional exhaustion, but it is weaker. It is perhaps more acceptable to feel exhausted than to admit to negative attitudes towards patients when as a nurse one is expected to be nurturing. Another explanation is that the depersonalization scores are accurate and high exhaustion is the norm for this particular group of nurses. Perhaps for them, just getting the job done depletes energy resources beyond what most workers would consider to be an acceptable level.

The interviews revealed that the majority of the nurses attributed their burnout to interpersonal conflict with persons other than clients. This finding concurs with recent research on burnout in human service organizations (Leiter, 1988a; Leiter, 1988b; Leiter & Maslach, 1988). Change in the nursing profession was a stressor for several of the participants and some felt it had contributed to feelings of burnout. This issue represents a special source of stress that may have been omitted if the study had included only standardized measures. It is also a stressor that may not be entirely nursing-specific. Increasing emphasis on theory, legal issues and technology in the workplace would be expected to apply to all of the helping professions.

Analyses of relationships between PRF scores and burnout revealed that only one personality trait, impulsivity, was related to all three MBI subscales. If this relationship does reflect a real connection between personality and burnout, it might be explained by individual differences in coping strategies. People who are low in impulsivity may be more likely to use control-oriented, problem-solving techniques to manage stress. They may

likewise interpret events as less stressful than individuals who are highly impulsive. There is evidence to suggest that the type of strategies used (e.g., Holt et al., 1987) and the number of strategies used (e.g., LeCroy & Rank, 1987) affect an individual's potential to burn out. More specifically, action-oriented, problem-solving approaches to work-related problems have been fairly consistently associated with low levels of burnout (Kahill, 1988).

Although personality may play a part in individuals' selection of coping strategies, these strategies are learned and are thus more amenable to change than enduring traits. Because coping approaches appear both to affect burnout and to have the potential to change, they are perhaps a more useful focus than personality characteristics for research and intervention in the future. In the interviews, workshops and counselling for employees were mentioned among strategies to reduce the incidence of burnout. Coping skills training represents one type of intervention that could be included in these programs. Nurses could also benefit from access to training in communication or team-building as a means of preventing or reducing interpersonal conflict on the job. This training may also help to facilitate open discussion of changes in the profession and the subsequent development of effective strategies to cope with them.

The finding that change in career orientation was associated with increased emotional exhaustion is consistent with previous research by Burke and his colleagues. A change in career orientation may represent an attempt to cope with persistent feelings of exhaustion. On the other hand, exhaustion may result from shifting work expectations to an orientation that is less conducive to coping. As this and previous research has indicated, some career orientations appear to be more consistent with coping than others. Although individual factors such as personality and career orientation appear to be related to burnout, they should not be used as criteria for entrance to professional training or the workplace. Rather, coping skills training and education regarding potential job stressors should be emphasized in both training programs and on the job. In addition, nursing programs should explicitly address the transition from professional training to the workplace. It is also important that employers provide on-going support by increasing possibilities for nurses' professional growth, challenge, variety and autonomy.

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RÉSUMÉ

Perception de la nature et des causes du "burnout": comparaison entre les auto-évaluations et les mesures normalisées

Trente-quatre infirmières agréées de Nouvelle-Écosse ont participé à cette étude; certaines jugeaient qu'elles étaient en "burnout" et d'autres qu'elles négociaient bien leur stress. Les infirmières ont rempli le Maslach Burnout Inventory, le Personality Research Form et un questionnaire sur leur orientation professionnelle en plus de relater leur expérience en matière de stress dans le cadre d'une entrevue. La comparaison entre les auto-évaluations et les mesures objectives révèle que les infirmières qui se décrivent comme victimes de "burnout" affichent des résultats significativement plus élevés à la sous-échelle d'épuisement émotif du MBI que celles qui parviennent à négocier correctement leur stress professionnel. Il n'existe par contre aucune différence entre les deux groupes au titre des scores de dépersonnalisation ou d'accomplissement personnel. Seule une caractéristique, l'impulsivité, est liée aux trois sous-échelles du MBI. Les participantes ont indiqué lequel des quatre profils les décrivait le mieux au début de leur carrière et au moment de l'étude. La manière dont les infirmières se perçoivent en début de carrière n'a aucun rapport avec leur sentiment de "burnout" actuel. Il existe toutefois des différences significatives dans les niveaux de "burnout" au titre de l'orientation professionnelle au moment de l'étude. Les résultats de cette étude donnent à penser que les programmes de sciences infirmières devraient comporter un volet sur la transition entre l'apprentissage et le milieu de travail et que les employeurs devraient fournir des services de soutien en matière d'épanouissement et de bien-être professionnel.

HOW PRIMARY NURSES OPERATIONALIZE ACCOUNTABILITY

Josefina E. Richard and Phyllis Noerager Stern

Primary nursing has been suggested as a method of nursing care delivery that promotes individualized care (Marram, Schegel & Bevis, 1979), higher quality patient care (Felton, 1975), continuity of nursing care, professional practice and accountability (Ciske, 1980; Zander, 1980). The authors suggest that 24-hour accountability is the essence of care in primary nursing. However, the concept of accountability has not been clearly defined; hence, this study was conducted to determine what 24-hour accountability means to primary nurses and how they operationalize it in their practice.

Background research in primary nursing

The concept of primary nursing is not new. It was developed at the University of Minnesota Hospital in the early 1960s and was introduced in the literature by Manthey, Ciske, Robertson and Harris, (1970) from the University of Minnesota. In an extensive literature review it was found that only 21% of more than 150 articles on primary nursing were classified as research (Giovanetti, 1982). The majority of the articles (56%) contained no emperical data and 23% were classified as descriptive-evaluative. Most of the research studies have evaluated the effectiveness of the primary nursing care system when compared to functional or team nursing. These studies focused on several variables: patient-centered variables including patient satisfaction and patient-outcome criteria; process-outcome criteria related to the quality of patient care; cost effectiveness; and, job satisfaction.

Studies focusing on patient-centered variables

Several studies (Daeffler, 1975; Marram et al., 1979; Sellick, Russel and Beckman, 1983) reported more patient satisfaction with primary nursing care system than the team nursing system. Daeffler (1975) compared patients' perceptions of care under team and primary nursing, using 52 non-random patients from two acute medical-surgical nursing units in a 160-bed hospital

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in the Southwestern United States. Patients in the primary nursing unit reported higher satisfaction with care and fewer omissions in expressive activities than those in the team nursing unit. In another study, Hedegus (1980) investigated 160 patients from four medical units in one hospital: two primary nursing units and two units practising functional nursing. Results from this study revealed that stress scores of patients in primary nursing units were significantly lower than those of patients in functional nursing units. Marram et al. (1979) compared patients' perceptions of nurses' behaviour in primary nursing, case method, team nursing and functional nursing units. This study involved 360 patients from two different hospitals, using 120 patients from primary nursing units 120 patients from team nursing units, 60 patients from case method nursing units and 60 patients from functional nursing units. Results revealed that patients in the primary nursing care units reported higher levels of satisfaction with their care, valued the ability of the nurse to know and treat them as individuals and perceived their care to be more highly individualized and personalized. In contrast, studies done by Hamera and O'Connell (1981) and by Ventura, Carley and Mercurio (1982) found no difference in patient satisfaction between the team and primary nursing patients.

Studies focusing on quality of care

Felton (1975) evaluated the quality of care patients received, comparing a primary nursing unit with a team nursing unit of a large children's hospital. Nursing competence and quality of care were found to be higher in primary nursing than in team nursing. The author used the Qualpac Phaneuf nursing audit and Slater nursing competencies instruments. Using the same instrument, Frevert and Galligan (1975) published findings consistent with those in Felton's study.

In another study, Gross-Miller (1981) published the results of a survey of 48 patients were from an 80-bed rehabilitation center, with varying diagnoses; 19 patients from primary nursing units and 29 patients from team nursing groups not randomly assigned. Results revealed fewer urinary tract infections, a lower incidence of skin breakdown and fewer patient falls in the primary nursing unit than with team nursing. In contrast, Giovanetti (1980) reported that there was no significant difference in the quality of care between the primary nursing unit and team nursing unit. This was the first study to report that primary nursing care system does not necessarily provide a higher quality of care. However, the instruments used in this study were different from those used in the previous studies on quality of care,so comparisons of the results of these studies is difficult. A similar study by Shukla (1981) showed that primary nursing did not influence the quality of care the patients received. The findings implied that the nursing competencies of the staff nurses might have affected the quality of nursing care, not the nursing care delivery system that was used.

Studies on cost effectiveness

Several studies reported no increase in cost in implementing primary nursing (Gross-Miller, 1981; Hedegus, 1980; Marram, 1976). Marram compared a primary nursing unit with an all R.N. staff and another team nursing unit with various categories of health care provider and found no difference at all in the cost of operating each unit. Costs of operations included sickness, vacation, inservice education and number of positions filled and budgeted. This study is one of the most comprehensive studies done on cost-effectiveness, taking into consideration the long-term expenses incurred in inservice education. Furthermore, the investigation was done over a longer period of time than most studies use. In contrast, Giovanetti (1980) reported that nursing care cost more in a primary nursing than in a team nursing unit. One limitation of this study was that data were collected for only 40 days and the hidden costs of nursing care, such as orientation of new staff and inservices for continuing education, were not considered.

Studies focusing on job satisfaction

A number of studies indicated greater satisfaction among nurses in primary nursing than in other nursing care systems (Carey, 1979; Marram et al. 1979). On the other hand, Giovanetti (1980) reported that nurse job satisfaction was higher in team nursing than primary nursing. More recently, McPhail, Pikula, Roberts, Browne and Harper (1990) reported finding that there is no differerence in the levels of nurses satisfaction in work environment between primary and team nursing.

The literature reviewed revealed that the components of primary nursing and the implementation and evaluation of this nursing system have been inconsistently defined (McPhail et al., 1990). The lack of description of how well the elements of primary nursing are being operationalized is evident in most of the research studies. Variations in the practice of the original concepts of primary nursing were noted by Servellen (1981), who did a survey of 118 hospital practising primary nursing in the United States. These findings suggest that the operationalization of the elements of primary nursing, especially accountability, needs further clarification. This is essential before conclusions regarding the effectiveness of the primary nursing care system can be documented.

Accountability is one of the most difficult concepts to operationalize in nursing practice. It is unclear, both to the public and to nurses themselves, what nurses are accountable for and how they maintain and operationalize accountability in their practice (Zander, 1980). This lack of clarity could be attributed to the fact that, in their traditional role, nurses had responsibility but not personal accountability. Primary nursing makes the distinction

between task responsibility and case-outcome accountability. According to Zander, accountability can only be determined in the context of results (i.e. patient care outcomes). Passos (1973) emphasized that responsibility differs from accountability in the sense that it is a means to an end, while accountability implies that actual performance will be judged against expected performance. Ciske (1980) defined accountability as being answerable for ones acts and being willing to live with the results or outcomes of one's practice. Increased consumer attention to the quality of nursing care and nurses' desire to establish credibility have created demands on individual nurses to be accountable for their practice. However, in the past only lip service was paid to this concept.

The American Academy of Nursing, in its 1990 Scientific Conference, focused on "Differentiated Nursing Practice" - the basis of which is primary nursing. Primary nursing, for the purpose of this paper, is defined as a nursing-care system in which each patient is assigned to a registered nurse, the primary nurse, who is accountable for the total nursing care provided to the patient 24 hours a day, from admission to discharge (Manthey at al., 1970). Primary nurses also act as associate or co-primary nurses for patients other than their primary patients. The associate nurse, who is either a registered nurse or certified nursing assistant, represents the primary nurse in her or his absence. All primary nurses in this study assumed the role of associate nurse as well as their primary duties. Primary nursing is believed to provide the nursing profession with a mechanism for accountability (Ciske, 1974). We suggest that it results in quality care because it demonstrates individual competencies: "It puts nurses on the line; their actions can be studied, audited and evaluated" (Zander, 1980, p. 126). With primary nursing, strengths and weaknesses in practice can be clearly traced, allowing practice to be more accurately evaluated. The research problem for this study, then, was: How do primary nurses define accountability and how do they operationalize it in practice?

Method

The research approach used in this study was grounded theory, in which hypotheses emerge rather than being stated (Glaser, 1976). In grounded theory, constant comparative analysis of qualitative data is directed toward the generation of theory. This involves overlapping processes of formulation, testing and redevelopment of propositions until a conceptual framework is generated; one that is integrated, consistent with the data and can be operationalized for later testing (Glaser & Strauss, 1967).

Sample

The population sample was composed of 21 registered nurses working in medical, surgical and psychiatric units of two large teaching hospitals in

Montreal, Quebec. Eligible participant nurses were selected by the principal investigator from among those primary nurses in each hospital who wanted to be part of the study. Inclusion criteria consisted of the ability to speak and understand English and experience working as a primary nurse for at least six months at the time of the interview (the principal investigator believes that it takes a nurse at least six months to operationalize the concepts of primary nursing care system fully). All but two of the primary nurses who volunteered were included in the study (the two were excluded to allow for a balance of sampling from the participating areas). Participants' length of experience as primary nurses varied, with 65 percent of the informants having worked as primary nurses for one to two years and 35 percent having done so for six months to less than one year. The participants' mean experience as a primary nurse was one year and five months. Approximately 30 percent of the participants were graduates of baccalaureate nursing programs, 5 percent had non-nursing baccalaureate science degrees and 65 percent had completed a diploma nursing degree.

Ethical considerations

The study proposal was approved by the ethics committee of Dalhousie University's, Faculty of Health Professions. A general explanation of the interview procedure and purpose was given to all participants. Each participant was asked to give written consent to be interviewed and audiotaped. Participants were advised that they could refuse to answer any questions without reprisal and could withdraw from the study at any time with no risk involved.

Data-collection procedure

Each nurse took part in one interview lasting from forty-five minutes to an hour. Interviews consisted of open-ended questions so as to allow the nurse's freedom of response, as well as to enable the investigator to clarify issues. Questions were directed at the nurses' perceptions of what accountability meant to them, what they were accountable for and to whom, how they maintained accountability in their practice, standards of care and how they evaluated the outcome of patient care. Special attention was also directed at how they felt about accepting the responsibility of being held accountable, and how they prepared themselves to accept and handle that responsibility. As well, the nurses' perception of clients' expectations of primary nurses was an important part of the interview.

Data analysis

The first stage was to examine the transcriptions of the interviews, in which topics and themes were identified. This was the beginning of open coding, in

which the investigators coded each datum incident (response of participant) to create as many codes as possible, sometimes using the participants' words as the code. Stern (1980) refers to these codes as substantive codes, because they are from the "substance of the data" (p.21). For example, when a participant, on being asked how she ensured that her plan of care was carried out in her absence, replied, "I write specific instructions in my care plans," this data was coded specific instructions. During open coding, more than 80 codes were extracted from the data. These codes were then examined to determine their similarities in order to form categories (i.e. coded data that seem to cluster together or belong in the same class). For example, the substantive codes *rapport*, *respect*, *trust* and *intimacy* were grouped under the category of *one-to-one relationship* with the patient. Further categories were developed similarly.

Once the categories were developed, each was examined and compared with others to see how they clustered or connected with each other. As the "linkages" (Schatzman, 1973) emerged, the categories were further collapsed to form more general categories. In this study, the categories of *teaching direct physical care* and *coordinating* were grouped under the major category of *Care Giving*. Other categories were reduced in a similar manner.

Theoretical sampling was used to develop the hypothesis and identifying the properties of the core or central variable. For example, all the participants identified specific instructions in the nursing care plans as a means of ensuring accountability. However, further discussion revealed that specific instruction was not enough. The elements of *trust, respect, reciprocity, collaboration* and *flexibility* were identified as other means of ensuring 24-hour accountability. These were called *Peer Relationship*.

During this phase additional data from the literature and field work were meshed to develop the hypotheses further. The categories were reduced further, to a higher order of categories of *nursing process, communicating* and *consequences*. Communicating and nursing process were were found to be the co-core variables that explained accountability.

Once again, we examined the data to determine the fit of the co-core variables, in order to integrate them into a well-constructed theory. Two processes dominated this phase: theoretical coding and memo writing. Codes that were written in descriptive terms were explained in theoretical terms, for a more abstract discussion of the variable. Writing memos is important as a way to preserve hunches, abstractions, analytical schemes and ideas for the emerging hypotheses. These memos serve as the basis of the research report.

Communicating

Nurses in the study reported that 24-hour accountability for primary nursing care is achieved through a process of communicating. The communication process involves a number of categories, oral and written methods and negotiating. For primary nurses, accountability means being responsible for assessing, diagnosing, implementing and following up a patient's care on a 24-hour basis. They operationalize accountability through communicating the nursing process. In their perceptions, accountability and patient care outcomes are linked intrinsically in the nursing process, which necessarily involved the care of patients, thus binding the nurses to the patients' welfare throughout their hospital stay.

Oral and written communications

All participants emphasized that it is essential to write specific instructions in their Kardexes and care plans, concise and informative documentation in the progress notes, and sometimes "very specific notes" for the associate nurse:

> Well, it's really up to me to have an up-to-date nursing plan in the Kardex and it's really up to my charting to tell people where I am going in terms of planning and what's happening to the patient. It's up to me to communicate how I see things should go, and what my plans are for the patients, gain their cooperation in following through my plans.

Nurses in this study emphasized that nursing care plans should ensure effective communication between nurses and other health care personnel.

> There is one fact that has to be emphasized in primary nursing and that is communications. You have to know how to communicate. You're not here for 24 hours. There are several ways of communicating: giving messages, taping and discussion with the associate nurse. You delegate what you want followed up when you are away. Discuss with the other nurses long-term and short-term goals and what you want to focus on.

The data reveal that written or spoken shift reports provide another means of communicating the 24-hour plan of care. There is also one-to-one discussion between primary and associate nurses concerning the priorities of care. As well, primary and associated nurses hold nursing conferences which allow for consultation and discussion.

The primacy of communication as a means of operationalizing accountability is demonstrated in this study. Our participants who had worked in other nursing care systems, such as functional or team nursing, said they were not always provided the opportunity to communicate their plans of care because of the very nature of the nursing care system. As an example, the medication nurse in a functional system is not expected to communicate the total plan of care for each patient. The essential role of the primary nurse as a communicator should be reflected in the development of performance standards for primary nurses (Beck, 1990, p.37).

Negotiating the care plan

In addition to written and oral communication, peer relationships between primary nurses and associate nurses play a vital role in maintaining accountability in primary nursing. It was evident from the data that writing down specific instructions in the care plans was not enough to ensure that the 24-hour plan of care was carried out. Nurses in this study negotiated with associate nurses to carry out their plans of care. Participants claimed that negotiating is achieved through the establishment of peer relationships that involve the properties of respect, trust, reciprocity, colleagueship, collaboration and flexibility.

Respect. Primary nurses claimed that in order to communicate effectively, nurses must respect one another. Respect means belief in the value and potential of a person (Gazda, William & Richard, 1982). As one nurse stated:

> I respect others' opinions and I expect the same thing from them. I expect that someone will not change my plans of care without justifiable reasons. On the other hand, there are different ways of doing things with the same basic principles. I have to respect that as well.

Trust. One very striking belief voiced by the majority of nurses was a trust in their peers to carry out their plans of care in their absence. One nurse explained it this way: "I trust my peers. I know that I can rely on them to give the best care and follow my plans. I depend on their sense of integrity and they know they can depend on me." Most nurses stated that, to carry out 24-hour accountability, they and their associates must adopt a "give and take" attitude towards one another. One nurse said, "As an associate, if the primary nurses asked me to do something specific, I know what she expects of me. Next time I might have to ask the same thing from her."

Flexibility. Most nurses mentioned that flexibility was vital in maintaining a peer relationship. To be flexible means to be capable of being modified. This requires an open-minded point-of-view. One nurse commented, "Although I

am accountable for the plan of care, it does not have to all come from me. I am open to suggestions and use others' experience and resources."

Colleagueship. The majority of nurses have indicated that colleagueship exists amongst them. Ciske (1980) pointed out that colleagueship in primary nursing entails peer support and being accountable to each other. One nurse stated:

> I'm accountable to my peers for letting them know what I am doing for my patients. I expect the same thing from them. We share each others' ideas and experience, give a lot of feedback. Someone will say, 'I'm having trouble getting Mr. so-and-so up, I've tried this and that and it's not working'. So we consult one another. There is some sort of colleagueship.

Collaboration. All of the nurses in this study claimed that collaboration is essential to maintain 24-hour accountability.

> Although you are the one specific person accountable for the plan of care, you need to work together and collaborate. The primary nurse, alone, can not maintain the 24-hour plan of care without collaboration from peers.

The process of communicating that maintains 24-hour accountability is illustrated in Figure 1.

Nursing process: basis for 24-hour accountability

Although the nurses in this study did not mention "nursing process" as the area of their accountability, it was evident from the data analysis that they were made accountable for its total application. As perceived by the informants, accountability and patient care outcomes are linked intrinsically in the nursing process. This includes knowing the patient, developing a 24-hour care plan, care giving and following through (evaluation). The nurses said that, because they were in direct contact with their primary patients while they gave direct care, they could assess, plan, implement and evaluate the nursing care being rendered. Primary nurses differ from nurses in other modalities of nursing care delivery because primary nursing involves application of the nursing process over time, rather than task completion per shift (Beck, 1990). Nurses developed a one-to-one relationship while "knowing the patient." Primary nurses possessed a "global view"; as such, they had the knowledge necessary to develop a 24-hour care plan throughout the patient's hospitalization. The data from this study indicate that one nurse --the primary nurse -- assesses, plans, implements and evaluates 24-hour care: "I was accountable for all my patient's care, which means that I was the one who,

after I got to know the patient, wrote up the nursing care plan." This finding is congruent with the view of Manthey et al. (1970) that one nurse, the primary nurse, who knows the most about the patient, develops the care plan. In contrast, in team and functional nursing, more than one nurse may develop a plan and no single nurse is held accountable for either the plan itself or the actual total care of the patient.

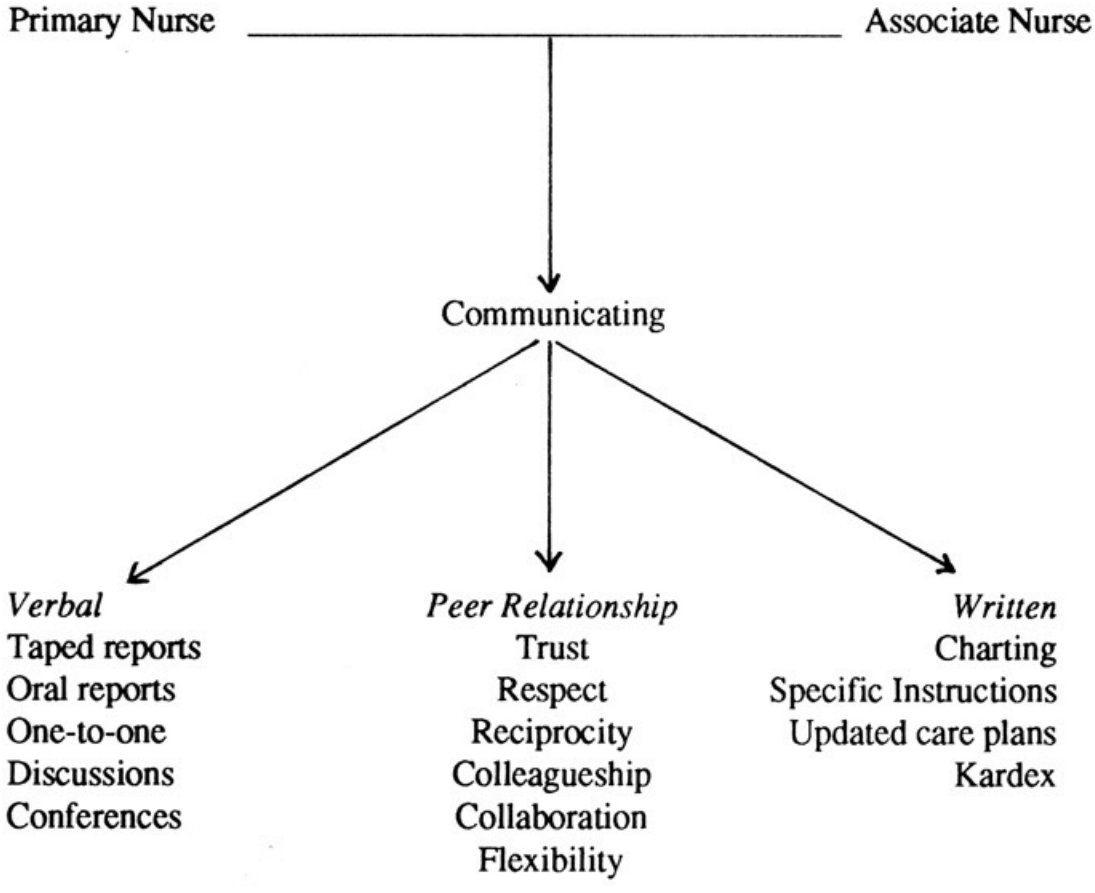

Figure 1

Communicating: the process that maintains 24-hour accountability

Knowing the patient

Nurses in this study claimed that knowing their patients involves establishing a one-to-one relationship with the patient and her or his family, performing a thorough assessment and identifying the patient's problems (nursing diagnosis). As one nurse stated, "It is important that I establish trust and rapport initially, which sets the tone of my relationship with the patient and family throughout the hospitalization." While every nurse must know the patients in order to care for them, the nurses in this study claimed that they develop what they call a "global view" and a "total picture" of their patients. The following are typical descriptions of the primary nurse's attempt to "know the patient".

> When I admit my primary patient, I do an assessment and evaluate the person. I find out what brought the patient to the hospital and then begin to consider those relevant aspects in his life that affects his well-being. What I am basically doing is sifting through pieces of information, physical, social, psychological and emotional aspects and trying to provide diagnostic nursing assessment, then developing appropriate nursing plans for my patients.

Developing a 24-hour care plan

All participants indicated that developing the 24-hour care plan is one area of their accountability as primary nurses. This includes setting up specific written goals and expected outcome of care, discharge planning and consultation referral. As one participant put it, "As a primary nurse, I am accountable for planning the patient's 24-hour care. Since I am not here all day, I have to make it clear in my care plan what I want done or how I want my patients cared for in my absence." According to Kaban and Thompson (1990), in other nursing care systems, no one nurse is accountable for patient care planning, so no one takes responsibility to ensure that all aspects of nursing care are carried out.

Care giving (implementation)

All nurses in this study claimed that they are accountable for all aspects of care giving, which includes *direct physical* care when possible, *patient teaching, coordinating* and *advocating*. Care giving in the nursing process is commonly known as implementation. This refers to the action or actions initiated to accomplish defined goals (George, 1980). To help individuals and families accomplish these goals requires staff who are involved with the caring, and who possess knowledge of teaching-learning theory, psychology, anatomy and physiology, pathology and sociology, to meet clients' needs accurately (Gross-Miller, 1981). While registered nurses possess these skills, it is often the nursing assistants who give the physical care.

Direct physical care. All participants in this study claimed that they are the ones who provided direct physical care to their patients. One nurse stated that the only instance in which she did not care for all her patients while she was on duty was when one of her patients became very ill and required her full attention. The philosophy of primary nursing requires that primary nurses give direct care whenever on duty, which is ideal but in some situations impossible.

Patient teaching. The nurses in this study indicated that, because they were in direct contact giving physical care, it was easier to implement other planned nursing actions such as patient teaching and discharge planning. According to these nurses, patient teaching focused on providing patients with knowledge of their illness, medications, diet, exercise, activities and any psychomotor skills required to care for themselves when discharged. How to maintain health and prevent illness were also stressed as important aspects of patient teaching. One nurse commented:

> Most of the time, teaching the patients is done by the primary nurse, because it is one of these "intangible" things expected of her. I find it difficult to do patient teaching when I work nights, so I have to collaborate with the associate.

These nurses stated that in other nursing delivery systems which are task-oriented, patient teaching is often given low priority because it has low visibility.

Coordinating and advocating. Traditionally, the role of coordinating patient care belonged to the team leaders or the nurse-in-charge. Nurses in this study claimed that they were the "hub" or centers of communication between the patients and other members of the health care team. One nurse described herself as, "the pole in the middle who is responsible for making sure that things go well for the patient." Participants indicated that they were accountable in coordinating their patients' care. Another aspect of care giving (implementation) that primary nurses claimed they were accountable for was advocating for their patients. Advocating in primary nursing differs from that in other nursing systems because the primary nurse is better prepared through knowing the patient and more obligated to be the patients' advocate due to her accountability for the outcomes of care (Zander, 1980).

Following through (evaluation)

Nurses in this study stated that they monitored and followed through the effectiveness of the nursing care given to their patients and that they were held accountable for patient care outcomes. They did this in several ways: observation, written documentation in the patient's charts, identifying

specific goals met by the nursing actions, patient and family feedback, nursing care plans and nursing grand rounds. They agreed that accurate, precise and informative notes are expected, so that primary nurses and their associates are informed of the progress of care:

> If a nursing care plan was changed because of the change in the patient's condition or if the plan was not effective, I expect the other nurses to chart it and let me know about it. I expect my associates to comment in the progress note how my patient is meeting the goals.

It was evident from that data that the primary nurses were held accountable for the total and systematic application of the nursing process, hence were made accountable for patient care outcomes. According to Kaplow, Ackerman and Outlaw (1989), primary nurses have the most consistent contact with the patient and are best able to assess efficacy of therapies, monitor clinical status and revise the plan of care.

Consequences of 24-hour accountability: positive and negative aspects

According to primary nurses, assuming 24-hour accountability has its joys and miseries. The joys emerge from being more involved with the patients and their families and caring in a professional manner. Our participants perceived that, because they are held answerable for the outcomes of nursing care from admission to discharge, the patients received professional, continuous and individualized care and hence were satisfied. Negative aspects include frustrations and the physical and emotional stress that come from increased demands and expectations that go with 24-hour accountability.

The integrated findings of this study

The conceptual framework developed from the study is illustrated in Figure 2. The diagram illustrates that communicating is the fundamental process that maintains 24-hour accountability. It is manifested in written and oral communication and peer relationship. As the arrows indicate, the communication process threads through every phase of the nursing process. The diagram details that the areas of accountability of the primary nurses we studied involve the total application of the nursing process. This consists of knowing the patient, developing 24-hour care plans, care giving and following through. Primary nurses were made accountable for the total application of the nursing process; as such, they were answerable for patient care outcomes.

The arrow at the bottom of the figure points to the consequences of 24-hour accountability for both the nurse and the patient, as represented by sphere A and B. The primary nurses (sphere A) have indicated their satisfaction in

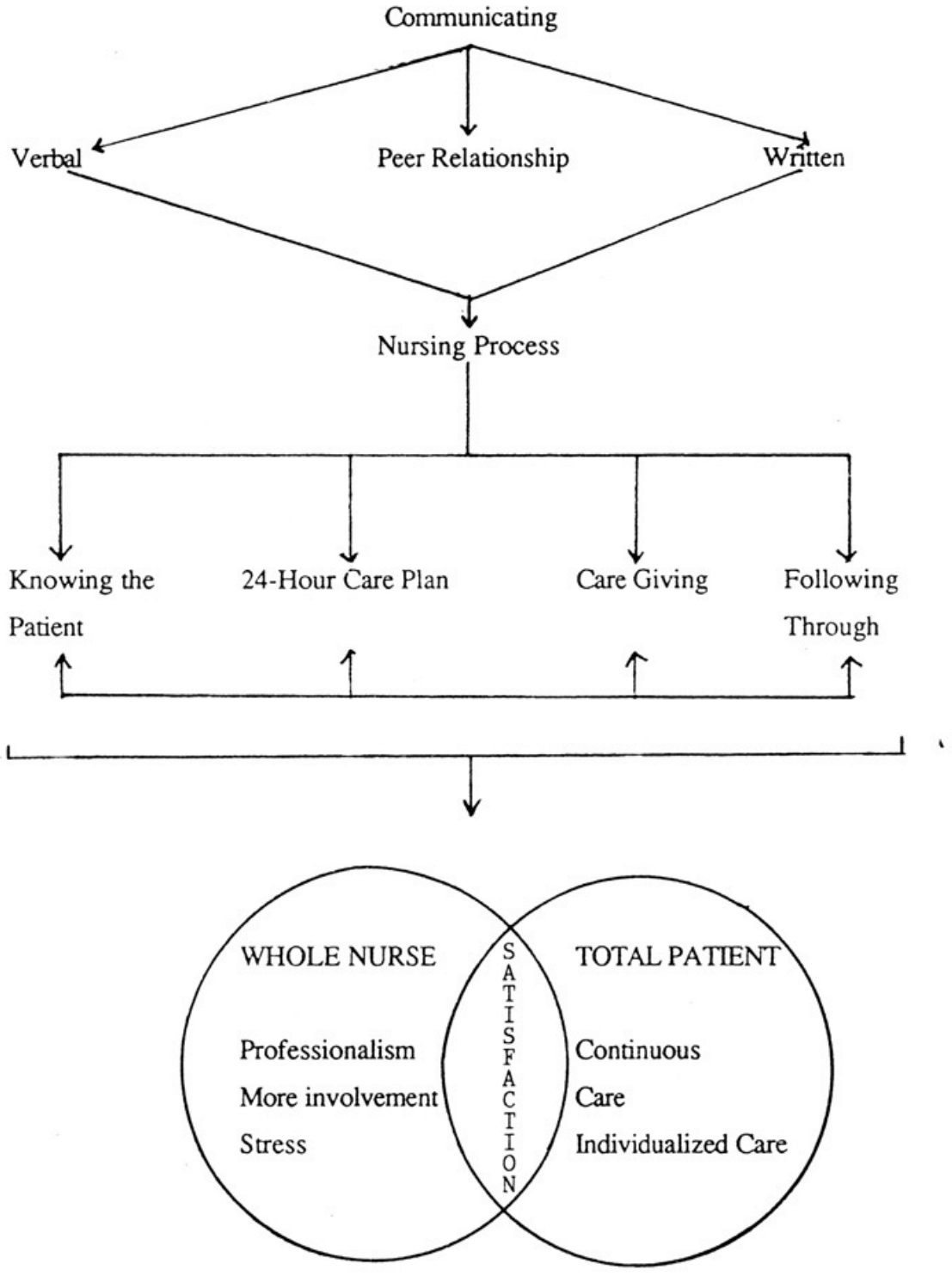

Figure 2

Accountability in Primary nursing

assuming accountability and have also perceived that their patients were satisfied. They have identified increased professionalism through the total application of the nursing process that made them accountable for patient care outcomes. While most participants perceived some benefits from assuming accountability, some indicated that stress is a result of the increased expectations of 24-hour accountability. Sphere B represents the nurses' perceptions of the effects of 24-hour accountability for the patient. These consist of continuous and individualized care as a result of considering the total patient in the delivery of nursing care.

Therefore, the analysis of communicating as the key to accountability; nursing process as the basis for 24-hour accountability; and, the consequences of accountability revealed that these factors are interrelated in the definition and operationalization of accountability in primary nursing. According to our participants, accountability in primary nursing means being answerable for the outcomes of patient care through the total application of the nursing process. This 24-hour accountability is maintained by communicating all aspects of the nursing process.

Implications and Conclusion

Our data indicate that the ability of the primary nurse to communicate with the patients, families, peers and other health care members is essential to their maintaining accountability in providing nursing care. Nurses, regardless of the nursing care system in any setting, should be held accountable for communicating each aspect of the nursing process to patients, families and peers.

Our findings suggest that the primary nurse is accountable for the total application of the nursing process; hence, outcomes of patient care. Therefore, it becomes essential for them to update their nursing knowledge in order to assess the patient, to develop the 24-hour care plans, to give direct nursing and to evaluate patient care. This accountability must be expected, not only from primary nurses, but from all practising nurses.

Data indicate that the demands of primary nursing can be stressful to some nurses, physically and mentally. We suggest that establishing support and interest groups may help primary nurses cope with these stresses. Similar support groups that already exist in such highly stressful units as critical care and oncology nursing can be adopted in primary nursing.

Based on the findings of this study, we recommend that further testing of the concept of accountability be done with a different population using a comparative study, to provide broader generalizability of the present findings; that further comparative studies be done to determine the quality of

communication that exists between nurses and patients, other nurses and other health care workers in primary nursing systems and other nursing systems; that further studies be carried out to investigate the differences in the total application of the nursing process in primary nursing and other nursing systems, focusing on nursing assessments, nurses' decision-making skills, patient teaching, discharge planning, method of documentation and evaluation of patient care; and, that a further study to measure the degree of accountability be conducted, in order to correlate the degree of accountability to the outcomes of patient care.

The accountability that the primary nurses assumed in this study has broader implications for all nurses, in any setting. Nurses must define and operationalize accountability for the application of the nursing process and they should maintain accountability by means of communication. Nursing process is the professional standard by which patient care outcomes are produced; hence, it is a tenent of accountable practice. Primary nurses are more closely involved with their patients; as such, they are in a better position to identify problems in the clinical areas, thus providing more stimulus to nursing research in this area.

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RÉSUMÉ

La reddition de comptes et le personnel infirmier

Selon les auteurs, l'obligation de rendre compte de l'exécution de sa tâche 24 heures sur 24 est l'essence même des soins infirmiers de première nécessité. Toutefois, le concept de reddition de comptes n'a pas été clairement défini; c'est pourquoi on a réalisé cette étude pour déterminer ce que signifie la reddition de comptes 24 heures sur 24 pour le personnel infirmier primordial et pour savoir comment ce personnel intègre ce concept dans ses activités. La méthode de recherche utilisée a été celle de la théorie fondée, qui est une analyse des données qualitatives en vertu de laquelle on élabore une théorie à partir des données. Vingt-et-une infirmières primordiales ayant un niveau de formation variable et appartenant à deux grands hôpitaux d'enseignement de Montréal ont été interrogées pour connaître leur point de vue sur la reddition de comptes 24 heures sur 24 dans les soins infirmiers primordiaux et savoir comment ce concept se manifeste. L'analyse des données a fait ressortir trois grands paramètres : a) la communication comme étant essentielle à la reddition de comptes; b) le processus infirmier comme fondement de la reddition de comptes; et c) les conséquences de la reddition de comptes. Les résultats nous révèlent que la communication est le meilleur moyen de rendre compte de l'exécution de sa tâche 24 heures sur 24 et que le personnel infirmier primordial dans cette étude est tenu responsable de l'application intégrale du processus infirmier dans l'exercice de son métier. Les infirmières ont souligné les conséquences négatives et positives d'être tenues responsables de l'intégralité des soins infirmiers durant toute l'hospitalisation de leurs clients. Cette étude est lourde de conséquences pour l'administration, l'exercice, l'éducation et la recherche dans le domaine des sciences infirmières.

FAMILY NEEDS AND ANXIETY IN ICU: CULTURAL DIFFERENCES IN NORTHEASTERN ONTARIO

Ellen E. Rukholm, Patricia H. Bailey and Ginette Coutu-Wakulczyk

The complex biomedical skills required by intensive care unit (ICU) nurses are recognized and acknowledged. Yet, another less evident dimension of the complex technical practice of ICU nurses relates to dealing with the needs of patients' family members. This paper presents an aspect of a larger study of family needs and anxiety levels in a Northeastern Ontario population (Rukholm, Bailey, Coutu-Wakulczyk & Bailey, 1991). The aspect of this work to be presented here focuses on the influence of mother tongue on family needs and anxiety. For the purposes of this study mother tongue was used as a measure of culture. The concomitant variables measured included worries, knowledge and distance of the residence from the site of hospitalization.

The purpose of the study was to seek information on the perceived needs of family members visiting a patient in an ICU of three hospitals located in Sudbury, Ontario. These three hospitals are regional centres for Northeastern Ontario so that many subjects had travelled considerable distance for medical care. Approximately 30% of families in the region identify themselves as francophone, the remaining families are predominantly anglophone. In order to provide appropriate nursing care the question of possible differences in the expression of needs and anxiety in these two language or cultural groups should be considered. Therefore the specific objectives of the study were: to describe the needs and anxiety (trait and situational) levels of adult family members; to determine the relationship between family needs and anxiety levels; and, to examine the influence of certain socio-demographic factors on the expression of needs and anxiety in these two language or cultural groups.

Present state of knowledge

Previous research has been done on needs of families of patients hospitalized in an ICU environment (Chartier & Coutu-Wakulczyk, 1989; Molter,

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1979; Molter & Leske, 1983; Norris & Grove, 1986). However, others such as Gillis et al. (1989) suggested that family needs of the hospitalized patient have not been adequately considered from a cultural perspective.

Leahey and Wright (1987) further contend that little has been done regarding the influence of culture and the impact of life threatening illness on family needs. Although Chartier and Coutu-Wakulczyk (1989) studied needs of ICU families in a francophone population, the question as to similarities or differences between French- and English-speaking subjects in Ontario remains.

In Molter's (1979) work, spiritual needs are addressed minimally. The spiritual dimension in modern health promotion is sensed as a critical motivational factor (McSherry & Nelson, 1987) too often neglected. Therefore, in order to explore this dimension more thoroughly, spiritual needs were expanded and looked at from a family perspective.

Hospitalization of patients in an ICU not only creates new needs amongst family members within the family system (Leske, 1986; Molter, 1979; Stillwell, 1984) but also may increase stress and anxiety levels. Cipriano (1987) reported that major surgery often generated more anxiety for family members than for the patient. Although Ritchie (1981) related the recurrence of illness as stressor rather than the milieu itself, the intensive care unit does represent a physical environment referred to by family members as intimidating and may contribute as a stressor (Hickey, 1985). Furthermore, expression of anxiety may pose a dilemma in terms of language or cultural difference in a given health threatening situation.

In regard to self-reported evaluation of anxiety, differences were found on the SCL-90-R between the American norms and French-speaking women in Quebec (Fortin, Coutu-Wakulczyk & Engelsmann, 1989), and in the Canada Health Survey (Statistics Canada, 1979). These differences suggest potential cultural influences on the expression of feelings.

Methods and Procedures

Following ethical review by the Laurentian University ethics review committee and participating hospital review committees, this study was carried out in the ICU of three Sudbury hospitals over a 3 month period in the summer of 1988. Interviews were conducted by three bilingual and two English-speaking ICU nurses trained in the interviewing process. All interviewers offered questionnaires to subjects in the language of their choice. As well, training sessions were held to increase inter-rater reliability.

A convenience sample was obtained from the total adult population of immediate family members visiting ICU patients. Prior to all interviews

informed consent was obtained. The criteria of eligibility were an age of 18 or older and able to understand and answer a written questionnaire in either French or English.

In this study, needs of family members referred to a number of factors identified in the literature and practice as important. The instrument used to measure needs was the Critical Care Family Needs Inventory (CCFNI) developed by Molter and Leske (1983) and translated and validated in French (Coutu-Wakulczyk & Chartier, 1990). To the 46 items of the scale, two items were added in lieu of the item "other" to reflect the specific context of the Sudbury's hospital policies and the region (ie: visiting hours, relationship with personnel). The CCFNI is a fout-point Likert-type scale ranging from 1 (not important) to 4 (very important). Although widely used in clinical research in its original format, little is known as to the psychometric value of the complete CCFNI. A small amount of work has been published on its reliability and validity (Cipriano, 1987).

State and trait anxiety were measured using the scales of Speilberger, Goruch and Lushene (1983) scales. Situational anxiety (STAI-A) referred to anxiety as a transient emotion evoked by a specific situation and varies according to the person's perception of the situation as menacing. On the other hand, trait anxiety (STAI-B) referred to anxiety as a relatively stable emotion predisposing individuals to perceive and react to their environment in a characteristic manner.

Both instruments consist of 20 items each with a 4 point-anchored Likert-type scale where 1 = not at all and, 4 = very much. In terms of reliability, the stability has shown a relatively high coefficient for the STAI-B scale on test-retest measures and on the Spearman-Brown homogeneity test, where as the STAI-A scale ranked lower. The internal consistency measured by Cronbach alpha yielded coefficients of 0.93 for the STAI-A and 0.90 for the STAI-B scales. The coefficients observed on the French version by Bergeron (1976) and Landry (1973) were of 0.86 and 0.90 respectively.

Worries were assessed by a five-item scale with a four-point anchor of intensity. The items of worry referred to the feelings experienced by family members when confronted with different environmental stimuli. Knowledge was also measured on a five-item scale ranging from 1-4 pertaining to information about ICU environment obtained through previous experience or a pre-operative education session. Spiritual needs referred to the religious concerns one has such as "the importance of letting the health care giver know what the patient holds as valuable in life". These needs were measured by six items with a four-point scale of importance. Finally, the sociodemographic data collected for analysis were sex, age, income, education, mother tongue, relationship to the patient and the diagnosis of hospitalization.

Statistical analyses were performed on a PC using the SPSS-X software.

Results

Sociodemographic characteristics

In the larger study a convenient sample of 166 subjects was obtained (Rukholm et al., 1991), of these subjects 155 indicated either English or French as their mother tongue. One hundred and seven subjects (69%) identified English and 48 (31%) identified French as the language spoken regularly within family and social interactions (Table 1). However only seven subjects completed the questionnaire in French.

The English-speaking subjects' mean age of 40.8 years, S.D. ± 13.9 was similar to the franchophones' with 41.4 years, S.D. ± 12.7, both groups ranging from 18 to 85 years. There was, however, an over representation of women (mainly spouses) independent of the language group (72% English - 75% French). Although the distribution of subjects by education was similar for high school and college, there was a greater percentage of French-speaking with elementary education (31.3%) as compared to English-speaking subjects (19.6%). All of the French-speaking group were Roman Catholic versus 43% of the English-speaking group. The diagnoses of patients were mainly cardiovascular, either medical or surgical as shown in Figure 1.

As shown in Table 2, the mean scores and standard deviations on the trait and state anxiety scale for francophone subjects were higher than those reported by English-speaking subjects. The state anxiety scores for both English- and French-speaking subjects and the trait anxiety scores for French-speaking subjects were significantly higher when the scores were compared to Spielberger's (1983) norms for working adults.

Total scores were obtained for each of the instruments (CCFNI, Worries, Spiritual Needs and Knowledge) by adding the weighted scores. Mean scores, standard deviations and ranges for French and English subjects are displayed in Table 3.

The Worries Scale item scores demonstrated that noise, staff at the bedside, staff conversations and the sight of other patients were not the most upsetting elements for subjects in either group (Figure 2). For both groups, the item that created the most worry for visiting family members of patients admitted was relative's pain, followed by the level of consciousness and the number of tubes.

Table 1

Distribution of English-and French-Speaking Subjects by Age, Sex, Marital Status, Education and Religious Denomination

Characteristics	English N=107	%	French N=48	%
Age				
18 - 34	27	25.2	9	18.8
35 - 51	51	47.7	26	54.2
52 - 68	18	16.8	10	20.8
69 - 85	10	9.3	2	4.2
missing data	1	.9	1	2.1
Total	107	100.0	48	100.0
Sex				
Female	30	28.0	12	25.0
Male	77	72.0	36	75.0
Total	107	100.0	48	100.0
Marital status				
Single	20	18.7	8	16.7
Married	81	75.7	36	75.0
Divorced/Separated	6	5.6	1	2.1
Widowed	0	0.0	3	6.3
Total	107	100.0	48	100.0
Education				
Primary	21	19.6	15	31.3
Secondary	40	37.4	19	39.6
College	21	19.6	9	18.8
University	20	18.7	50	10.4
Refused/Not specified	2	1.9	0	0.0
Total	107	100.0	48	100.0
Religious denomination				
Protestant	53	49.5	0	0.0
Roman Catholic	46	43.0	48	100.0
Other	8	7.5	0	0.0
Total	107	100.0	48	100.0

Table 2

Distribution of English- and French-Speaking Subjects by STAI-A and STAI-B Scores

Instrument	N	*Scores* X	SD	Range	Z
STAI-A					
English	99	43.15	±12.88	20-77	5.74**
French	42	47.32	±15.48	21-76	4.88**
Missing data	14				
Total	155				
STAI-B					
English	97	35.92	±8.91	20-65	1.33
French	43	38.16	±10.74	21-76	1.99*
Missing data	15				
Total	155				

* p<.05. ** p<.0001

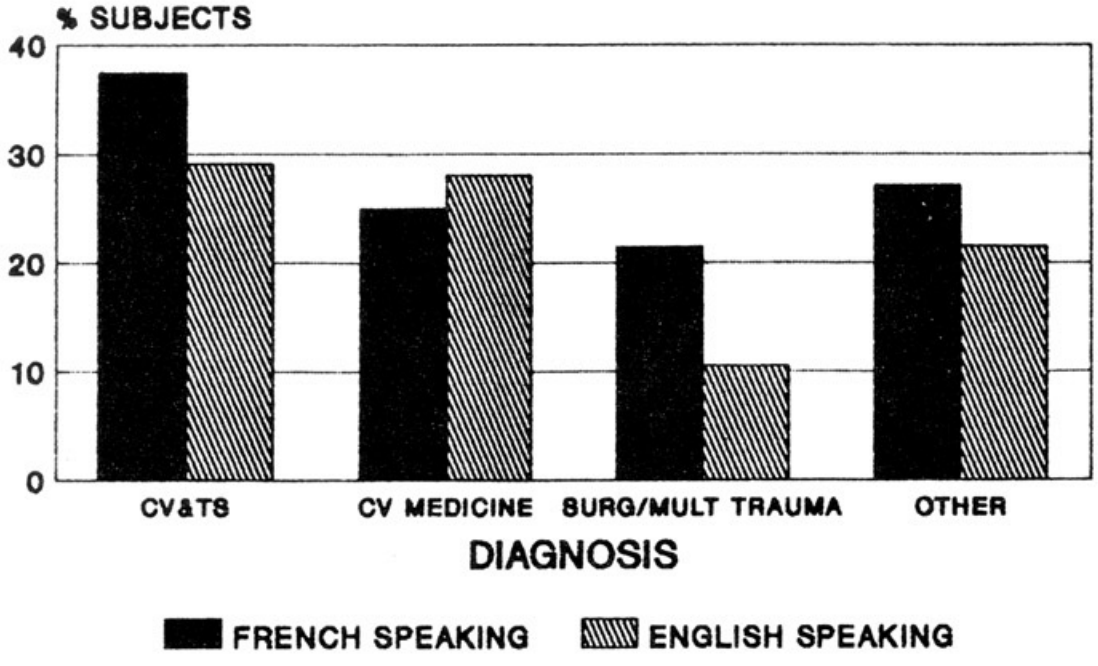

Figure 1

Subjects by Diagnosis of Patient

Table 3

Distribution of English- and French-Speaking Subjects by CCFNI, Worries, Spiritual Needs, and Knowledge Scores

Instrument	N	*Scores* X	SD	Range
CCFNI				
English	96	115.69	±19.51	57-149
French	43	118.58	±19.62	60-142
Missing data	16			
Total	155			
Worries				
English	102	9.02	±4.73	0-20
French	48	9.17	±5.28	0-21
Missing data	15			
Total	155			
Spiritual Needs				
English	101	12.89	±3.21	5-18
French	47	14.40	±3.18	0-21
Missing data	17			
Total	155			
Knowledge				
English	107	7.02	±1.76	4-11
French	47	7.23	±2.01	5-15
Missing data	1			
Total	155			

Analysis of variance

Analysis of variance of the language groups by STAI-A, STAI-B, CCFNI, Spiritual Needs, Worries and Knowledge was done. Subjects who did not complete all aspects of each instrument were excluded from this part of the analysis. Significant differences were found between language groups with respect to how upsetting subjects viewed seeing their relative in pain and expression of spiritual needs. Although worry about relative's pain was high for both groups, English-speaking subjects mean score on how upsetting subjects viewed their relative's pain was significantly higher than the French-speaking subjects scores ($p<.04$), as shown in Table 4. The mean score obtained for French-speaking subjects was significantly higher ($p<.008$) than English-speaking subjects on the Spiritual Needs scale (see Table 5).

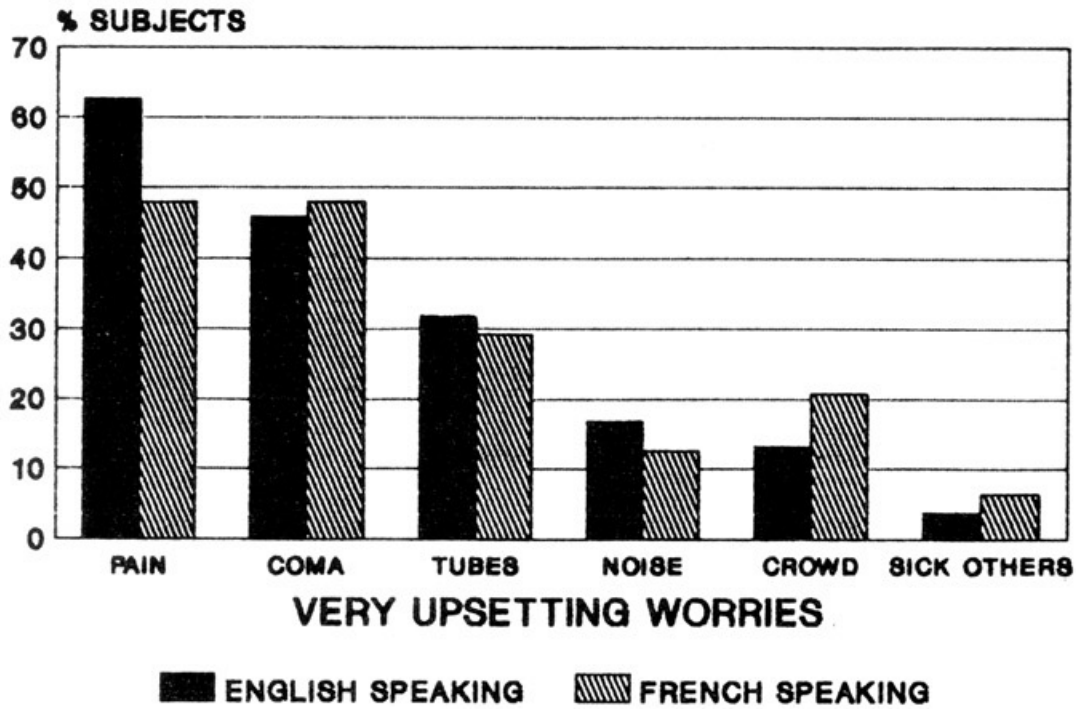

Figure 2

Subjects by Worries

Table 4

Analysis of Variance Between English- and French-Speaking Groups on Reaction to Relatives' Pain

		N	X	SD
English-Speaking		102	2.636	±1.376
French Speaking		48	2.167	±0.975
Source	df	SS	MS	F
Between groups	1	7.284	7.284	4.540

$p<.04$

Table 5

Analysis of Variance Between English- and French-Speaking Groups on Spiritual Needs Scale

		N	X	SD
English-Speaking		101	12.89	±3.21
French Speaking		47	14.40	±3.18
Source	df	SS	MS	F
Between groups	1	73.440	73.440	7.152

p<.008

Multiple regression

Tables 6 and 7 present the correlation matrices of the variables age, situational anxiety, trait anxiety, spiritual needs, distance, worries, family needs and prior knowledge for French- and English-speaking subjects. Again, subjects who did not complete all aspects of each instrument were excluded from this part of the analysis. The relationship between STAI-A and STAI-B (r^2=.248) explains 24.8% of the variability in the two scores for the French-speaking subjects versus (r^2=.166) 16.6% for the English-speaking subjects. The relationship between worries and STAI-B (r^2=.317) explains 31.7% of the variability in the two scores for the French versus (r^2=.076) 7.6% for the English.

Table 6

Correlation Matrix of Age(1), STAI-A(2), STAI-B(3), Spiritual Needs(4), Distance(5), Worries(6), Family Needs(7) and Knowledge(8) for French Speaking Subjects

Variables	1	2	3	4	5	6	7	8
Age	1.000							
STAI-A	-.268	1.000						
STAI-B	-.126	.498	1.000					
Spiritual	-.070	.106	-.197	1.000				
Distance	.043	-.247	-.127	.148	1.000			
Worries	-.145	.424	.563	.19	-.305	1.000		
CCFNI	-.135	.262	.030	.572	.075	.333	1.000	
Knowledge	.312	.260	.024	-.230	-.160	-.194	-.470	1.000

n=34

Table 7

Correlation Matrix of Age(1), STAI-A(2), STAI-B(3), Spiritual Needs(4), Distance(5), Worries(6), Family Needs(7) and Knowledge(8) for English-Speaking Subjects

Variables	1	2	3	4	5	6	7	8
Age	1.000							
STAI-A	-.246	1.000						
STAI-B	-.018	.408	1.000					
Spiritual	.204	.140	.168	1.000				
Distance	.084	.065	-.203	-.066	1.000			
Worries	-.238	.521	.275	.144	.110	1.000		
CCFNI	.024	.350	.313	.458	.143	.367	1.000	
Knowledge	.179	-.084	-.013	.044	-.013	-.138	.012	1.000

n=79

The regression analysis (Table 8) shows that, when family needs are considered as a dependent variable for French-speaking subjects, then spiritual needs and knowledge demonstrate a significant influence and explain 45% of the variance. The regression analysis presented in Table 9 shows that when family needs are considered as a dependent variable for English-speaking subjects, then spiritual needs and worries demonstrate a significant influence and explain 30% of the variance.

Table 8

Regression Analysis of Family Needs with Spiritual Needs and Knowledge for French-Speaking Subjects

Multiple R	.66918			
Multiple R Sq.	.44781			
Standard Error	13.17048			
Analysis of Variance	*Sum of Sq.*	*d.f.*	*M.Sq.*	*Probability*
Regression	4360.80835	2	2180.40417	0.0001
Residual	3772.30930	31	173.46195	
	Coefficient	*Sd error*	*T*	*Probability*
Intercept	107.69035			
Spiritual Needs	2.40757	.67494	3.567	0.0012
Knowledge	-2.83027	1.08557	-2.607	0.01

Table 9

Regression Analysis of Family Needs with Spiritual Needs and Worries for English-Speaking Subjects

Multiple R	.55009			
Multiple R Sq.	.30260			
Standard Error	17.07992			
Analysis of Variance	*Sum of Sq.*	*d.f.*	*M.Sq.*	*Probability*
Regression	9620.04932	2	4810.02466	0.0000
Residual	22170.98865	76	291.72353	
	Coefficient	*Sd error*	*T*	*Probability*
Intercept	71.05608			
Spiritual Needs	2.56785	.60072	4.275	0.0001
Worries	1.26183	.39680	3.180	0.002

Table 10

Regression Analysis of Situational Anxiety (STAI-A) with Trait Anxiety (STAI-B) and Family Needs (CCFNI) for French-Speaking Subjects

Multiple R	.61782			
Multiple R Sq.	.38710			
Standard Error	12.76405			
Analysis of Variance	*Sum of Sq.*	*d.f.*	*M.Sq.*	*Probability*
Regression	3319.05178	2	1659.52589	0.0004
Residual	5376.39297	33	162.92100	
	Coefficient	*Sd error*	*T*	*Probability*
Intercept	-9.65215			
STAI-B	.72820	.21007	3.466	0.0015
CCFNI	.23876	.10359	2.305	0.0276

The regression analysis presented in Table 10 shows that when situational anxiety is considered as a dependent variable for French-speaking subjects then trait anxiety and family needs demonstrate a significant influence and explain 39% of the variance. However, when situational anxiety is considered as a dependent variable for English-speaking subjects (Table 11), then worries and trait anxiety demonstrate a significant influence and explain 34% of the variance.

Table 11

Regression Analysis of Situational Anxiety (STAI-A) with Worries and Trait Anxiety (STAI-B) for English-Speaking Subjects

Multiple R	.58450			
Multiple R Sq.	.34164			
Standard Error	10.96237			
Analysis of Variance	*Sum of Sq.*	*d.f.*	*M.Sq.*	*Probability*
Regression	4801.81070	2	2400.90535	0.0000
Residual	9253.36936	77	120.17363	
	Coefficient	*Sd error*	*T*	*Probability*
Intercept	-9.65215			
Worries	1.18730	.26179	4.535	0.0000
STAI-B	.41282	.13796	2.992	0.0037

Discussion

Although the subjects are representative of English- and the French-speaking people in this region, the study findings are biased by the over-representation of females in this sample. Despite the availability of bilingual interviewers and questionnaires, the majority of French-speaking subjects chose to complete the interview in English. This discrepancy between the spoken language of the francophone subjects and their ability or willingness to use the same language in the written and reading material may be explained by the paucity of French language schools in the Northeastern Ontario Educational system some 20-50 years ago. Therefore, for older subjects, although their spoken language of comfort was French, their preference for written English may reflect the previous lack of French educational institutions in this community.

The study results also suggest that the ICU environment is stressful for relatives in both language groups. Similar to the findings of other studies (Fortin et al., 1989), French-speaking subjects' trait and state anxiety mean scores were significantly higher than English norms. However, analysis of variance revealed no significant difference between language groups.

The French sample size is small compared to the English sample and, as such, the analysis of variance should be viewed with caution. Additional study is needed with a larger randomly selected population to clarify cultural influence on the expression of anxiety for relatives of ICU patients. As well, further research is needed to understand the puzzling finding that English-speaking subjects rated their distress at seeing a relative in pain more highly than French-speaking subjects.

As inferential analysis has demonstrated, spiritual needs contributed significantly to family needs for both language groups. This finding supports the previous work of McSherry (1987) and Wilson (1989) that spiritual needs are an important dimension of family care. However, the groups differed on the second factor contributing to the expression of family needs: knowledge for the French-speaking subjects and worries for the English group.

In addition, for both language groups, trait anxiety was a significant factor in the expression of situational anxiety. For the French population trait anxiety was the most significant factor, followed by family needs. Whereas, for the English population, although trait anxiety was a significant contributing factor, worries was the most important determinant in understanding the expression of situational anxiety.

Similar to Leahey and Wright (1987), if language is accepted as a vital component of culture, then these results suggest that there are cultural influences that affect the expression of family needs and anxiety in an acute illness situation.

In conclusion, despite the limitations of a non-random sample and instruments with limited validity and reliability, the differences identified between these language groups have important implications for further research.

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RÉSUMÉ

Besoins familiaux et anxiété dans les USI: différences culturelles dans le nord-est de l'Ontario

Le but de cette étude est de faire ressortir: 1) les besoins et les niveaux d'anxiété des membres de langue française et anglaise des familles de patients hospitalisés à l'unité des soins intensif; 2) la relation entre les besoins et l'anxiété de caractère et situationnelle des deux groupes; 3) les facteurs socio-démographiques influençant ces variables. L'étude d'une durée de trois mois a regroupé 48 familles de langue française et 107 de langue anglaise. L'échantillon de convenance comptait 166 sujets qui ont été interrogé au moment où ils visitaient un patient à l'unité des soins intensifs de l'un des trois hôpitaux de Sudbury. Les données ont été recueillies à partir des questionnaires auto-administrés Critical Care Family Needs Inventory (CCFNI) (Molter and Leske, 1983) et State Trait Anxiety Inventory (STAI) (Spielberger, 1983). La version française de CCFNI traduite et adaptée par Coutu-Wakulczyk et Chartier (1990) a été utilisée. L'échantillon était majoritairement composée de femmes (75% de langue française/72% de langue anglaise). Les résultats de l'échelle de l'anxiété de caractère du STAI pour les sujets de langue maternelle française étaient significativement plus élevés que ceux obtenus par Spielberger (1983) (Français STAI-B: X=38.16, S.D. +10.74, $p<.05$). Les résultats de l'anxiété situationnelle du STAI ont démontré des scores moyen pour les deux groupes qui sont significativement plus élevés que ceux rapportés par Spielberger (1983) (Anglais: $p<.0001$; Français: $p<.0001$). Pour les deux groupes de langues différentes, les besoins spirituels ont démontré une influence significative sur l'expression des besoins des familles; de plus, l'anxiété de caractère montre une influence significative sur l'expression de l'anxiété situationnelle.

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Manuscript Review: Manuscripts submitted to the journal are assessed anonymously by two members of a Review Board, using the following criteria:

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Internal validity - relatedness: Is the problem the paper deals with identified? Is the design of the research or the structure of the essay appropriate to the question asked? Are the statistical, research and logical methods appropriate? Can the findings be justified by the data presented? Are the implications based on the findings?
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Are the ideas developed logically? Are they expressed clearly? Is the length appropriate to the subject? Does the number of references or tables exceed what is needed?

Publication Information: On receipt of the original manuscript, the author is advised that the editorial board's response will be forwarded within ten weeks. When a manuscript is returned to the author for revision, three copies of the revised manuscript (dated and marked 'revised') should be returned to the editor within four weeks. The complete procedure of review, revision, copy editing, typesetting, proofreading and printing may result in a six to eight month lapse between submission and publication.

RENSEIGNEMENTS A L'INTENTION DES AUTEURS

La revue canadienne de recherche en sciences infirmières accueille avec plaisir des articles de recherche ayant trait aux sciences infirmières et aux soins de la santé. Veuillez adresser vos manuscrits à la rédactrice en chef, *La revue canadienne de recherche en sciences infirmières*, Ecole des sciences infirmières, Université McGill, 3506 rue University, Montréal, QC, H3A 2A7.

Modalités: Veuillez envoyer trois exemplaires de votre article dactylographié à double interligne sur des feuilles de papier de 216mm x 279mm en respectant des marges généreuses, accompagné d'une lettre qui indiquera le nom, l'adresse et l'affiliation de l'auteur ou des auteurs. Il est entendu que les articles soumis n'ont pas été simultanément présentés à d'autres revues. Veuillez inclure avec votre article une déclaration de propriété et de cession de droit d'auteur conformément à la formule suivante: "Je déclare par la présente que je suis le seul propriétaire de tous droits relatifs à mon article intitulé ' ' et je cède mon droit d'auteur à l'École des sciences infirmières de l'Université McGill, pour fins de publication dans *The Canadian Journal of Nursing Research/La revue canadienne de recherche en sciences infirmières*. Date _____, Signature _____."

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