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A TIME FOR REFLECTION: A PRELUDE TO CHANGE

A change of editorship of a journal does not occur very often. But when it does occur, it presents a unique opportunity to reevaluate the direction that the journal is taking. Therefore, this is a time to take stock; to see where we have been and where we are going. It is time for each of us to ask; is this the path that we want to be on? what are our objectives? and what role can I play to ensure that these objectives are met?

Any reevaluation requires an understanding of the past when setting a future course. The *Canadian Journal of Nursing Research*, originally called *Nursing Papers*, was "born" 24 years ago. It was brought into being by Dr. Moyra Allen who identified a need for a forum in which ideas could be exchanged and plans of actions shared among persons concerned with nursing research and nursing education in our universities. Dr. Mary Ellen Jeans, who assumed the editorship upon Dr. Allen's retirement in 1984, continued to emphasize the importance of a refereed journal devoted to original research in nursing and health and research-related issues.

This journal, as any endeavour, has followed its own developmental course. During the infancy of this journal, there were many theoretical articles dealing with research and education issues and fewer dealing with original research, a reflection of the small number of research-scholars in this country. With the increasing number of researchers in this country, the journal grew into adolescence. Many more papers based on original research were published, as well as articles dealing with theoretical and methodological issues. However, these articles dealt with practice not only directly, but indirectly, by examining such areas as education and administration.

There are indicators in this country that suggest that the journal is ready to enter adulthood. We have developed a critical mass of nurse-scholars whose research is known nationally and internationally. Our graduate programs at the Master's level are firmly established and our doctorate programs are well underway. The demand for University-prepared nurses is ever-increasing. Moreover, the need for professionally-based, rationalized practice is pressing. Thus, the importance for a mature, quality research journal is apparent.

The question that we must ask ourselves is what do we want this journal, during its adult years, to be? In order to address this fundamental question, all aspects of the Journal's present operations, including its mission statement, the quality of the manuscripts, the review-process, the Journal's format, marketing and financing will be examined critically. This review

is my first priority so that I will know how best to guide and nurture this journal into full maturity.

Let me illustrate some of the questions that must be addressed and the issues that should be tackled. The overall orientation of the journal will continue to be devoted to the dissemination of original research and the discussion of research-related issues. However, the time has come to ask ourselves what we mean by nursing or health-related research. Should the journal be devoted to original research and theoretical and methodological articles that deal primarily with the *practice* aspects of the discipline, or, should the journal continue to give equal voice to research that only indirectly affects practice?

Once the Journal's mission is clear, we will require quality manuscripts. The success of a journal is determined by the quality of submitted manuscripts. Moreover, the quality of the manuscripts influences, and is influenced by, the review process, the "packaging", the actual dissemination process and so forth. Thus, we need to ask: What do we need to do to encourage scholars to select this journal as a vehicle for their writings? How can we strengthen and improve these various components?

In this country, the Canadian Journal of Nursing Research has played, and must continue to play, a central role for disseminating research findings to academics, researchers, educators, clinicians, and administrators. It is an important voice of Canadian nurse-scholars. It has been used, and will continue to be used, as an important barometer of where we are as a scientific discipline and as a practice profession. Thus, my vision is to create a journal of the highest quality that is an accurate reflection of the caliber of research taking place.

I invite you to become a partner in setting the future course of the Journal. I count on your support; support in the form of providing suggestions and advice, sending manuscripts, serving on review panels, and subscribing to the journal. Together we will bring the *Canadian Journal of Nursing Research* into full adulthood.

Laurie Gottlieb

UN MOMENT DE RÉFLEXION : PRÉLUDE AU CHANGEMENT

Ce n'est pas souvent qu'une revue change de rédaction mais lorsque cela arrive, c'est l'occasion rêvée de procéder à une nouvelle évaluation de la direction qu'elle prend. Voici donc le moment venu de faire le point, pour voir ce que nous avons fait et ce que nous allons faire. C'est le moment pour chacun de nous de demander : est-ce la direction que nous voulons prendre ? quels sont nos buts ? quel rôle puis-je jouer pour que ces objectifs soient atteints ?

Toute réévaluation exige que l'on comprenne le passé lorsqu'on s'attache au futur. La *Revue canadienne de recherche en sciences infirmières* (autrefois intitulée *Perspectives en nursing*) naquit il y a 24 ans. Elle fut créée par la Dre Moyra Allen qui voyait la nécessité d'une tribune où des idées pourraient être échangées et des plans d'actions partagés par des personnes s'intéressant à la recherche et à l'enseignement en sciences infirmières dans nos universités. Lorsque la Dre Allen prit sa retraite en 1984, la Dre Mary Ellen Jeans assura la direction et continua de souligner l'importance d'une revue de référence consacrée à la recherche fondamentale en sciences infirmières et en santé, de même qu'aux questions liées à la recherche.

Cette revue, comme toute entreprise, a suivi son propre cours de développement. Pendant la petite enfance de la *Revue canadienne de recherche en sciences infirmières*, beaucoup d'articles théoriques portaient sur les questions de recherche et d'enseignement, tandis que peu d'articles portaient sur la recherche fondamentale ; c'était le reflet du petit nombre de chercheurs au pays. ê mesure que leur nombre augmentait, la revue entrait dans sa période d'adolescence. De nombreux autres articles basés sur la recherche fondamentale furent publiés ainsi que des articles portant sur les questions théoriques et méthodologiques. Cependant, ces articles portaient non seulement directement sur la pratique mais aussi indirectement sur des domaines comme l'enseignement et l'administration.

Certains indices ici au pays nous laissent penser que la revue est prête à entrer dans sa phase adulte. Nous avons formé une masse critique d'experts en sciences infirmières dont les recherches sont connues à un niveau national et international. Nos programmes de Maîtrise sont bien établis et nos programmes de Doctorat sont en cours. Les infirmiers diplômés de l'université sont de plus en plus sollicités. De plus, le besoin d'une pratique professionnelle et rationnelle se fait pressant. D'où l'importance d'une revue arrivée à maturité pour une recherche de qualité.

La question que nous devons nous poser est la suivante : que voulons-nous que soit cette revue pendant sa phase adulte ? Pour aborder cette question fondamentale, tous les aspects du fonctionnement actuel de la revue, y compris sa vocation, la qualité des articles, le processus de révision, la taille de la revue, les besoins de la commercialisation et du financement doivent être soigneusement examinés. Ce bilan est pour moi LA priorité afin que je sache la meilleure façon de guider et d'élever cette revue à sa maturité totale.

Permettez-moi d'illustrer certaines questions qui doivent être posées et les problèmes qui doivent être abordés. L'orientation globale de la revue continuera d'être la diffusion de recherches originales et de discussions sur les questions liées à la recherche. Cependant, le moment est venu de nous demander ce que nous entendons par recherche en sciences infirmières ou recherche liée à la santé. Est-ce que la revue doit se consacrer à la recherche fondamentale et aux articles théoriques et méthodologiques portant principalement sur les aspects *pratiques* de la discipline ou est-ce qu'elle doit continuer à donner la même place à la recherche qui ne touche qu'indirectement la pratique ?

Une fois la mission de la revue déterminée, nous exigerons des articles de qualité. Le succès d'une revue est fonction de la qualité des manuscrits présentés. De plus, la qualité des manuscrits influence et est influencée par le processus de révision, le "conditionnement", le processus de diffusion, et caetera. Nous devons donc demander : que devons-nous faire pour encourager les experts à choisir cette revue pour véhiculer leurs écrits ? Comment pouvons-nous renforcer et améliorer ces différentes composantes ?

Dans ce pays, la *Revue canadienne de recherche en sciences infirmières* a joué et doit continuer de jouer un rôle central pour diffuser les résultats des recherches aux intellectuels, aux chercheurs, aux éducateurs, aux cliniciens et aux administrateurs. C'est l'éminent porte-parole des experts canadiens en sciences infirmières . Elle a servi et continuera de servir de baromètre important pour nous positionner en tant que discipline scientifique et en tant que profession pratique. Je prévois donc de créer une revue de la plus haute qualité et qui soit le reflet fidèle de l'envergure de la recherche qui a actuellement lieu.

Je vous invite à vous joindre à l'élaboration du cours futur de la *Revue canadienne de recherche en sciences infirmières.* Je compte sur votre soutien, soutien sous forme de suggestions et de conseils, soutien en envoyant vos manuscrits, en vous joignant aux comités de révision et en vous abonnant à la revue. Ensemble, nous porterons la *Revue canadienne de recherche en sciences infirmières* à sa phase adulte.

Laurie Gottlieb

FACULTY PRACTICE COMPETENCIES: NURSE EDUCATORS' PERCEPTIONS

U.K. Choudhry

In recent years the importance of practice as an integral part of the faculty role has been receiving greater attention. Traditionally, nursing faculty teach students in classroom and or clinical settings but do not engage in clinical practice themselves. Just as Nichols (1985) has stated, "When we teach but do not touch, we lose our specialized competence" (p. 85), many faculty members feel that they must remain clinically competent because they cannot teach what they no longer practise. This has prompted many university nursing programs to place practice as one component of the faculty role along with teaching, research and service. Faculty practice is not universal. In some institutions it is mandatory, while in others it is optional. Community colleges in Ontario have no system of faculty practice in place.

It is generally assumed that those who teach in clinical settings are clinically competent. Yet what constitutes faculty practice competencies is not noted in the literature. In one study (Yonge, 1986), it was found that faculty members did not view clinical competence as a simple and concrete behaviour. Instead they associated it with "evaluation, delivery style, priorizing of content, climate, selection of materials, assignments and relationships with students and nursing staff" (p.23). This survey grew out of the need to identify specific clinical competencies required by nurse faculty members in order to meet their multiple role demands. Nursing faculty at universities and community colleges in Ontario were asked to rate and rank the practice competencies for a beginning nurse educator and give their opinions regarding this aspect of their roles.

Faculty practice - defined

There still exists a great deal of confusion and disagreement about faculty practice and faculty practice roles (Acorn, 1987). Faculty practice is often confused with faculty supervision of students during their clinical placement. According to Christman (Machan, 1980) however, faculty practice goes beyond the clinical teaching role. He defines it as involving a practitioner-teacher who delivers health care to clients by her- or himself while undertak-

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ing primary nursing in a hospital unit. Each practitioner-teacher teaches using her or his own set of patients, sharing them with the students while teaching. Faculty practice goes beyond the mere acquisition and maintenance of clinical skills.

Faculty practice need not be confined to a hospital setting. The same concept can be utilized in a community setting (Machan & Roberts, 1980) or in a variety of clinical practice arrangements (Collison & Parson, 1980).

Importance of faculty practice

The advantages of integrating education and practice have been widely noted in the nursing literature. Although faculty practice is not new, because of the increasing chasm between education and service, there is a general acknowledgment that the profession and discipline must integrate. According to Mauksch: "How did it come about that so many faculty members who teach a 'practice' [nursing] are not engaged in it themselves? Professionals in other fields such as medicine, dentstry, architecture, and the ministry teach through their practice." (1980, p. 20).

Algase warns that there are, "dangers inherent in the continued separation of discipline and profession...a profession without connections to its discipline turns elsewhere for answers to its problems...stunting its autonomy...subjugates us to the powers of others...for the health and survival of nursing, it is necessary for nurse faculty to take hold of the practice arena." (1986, p. 75).

She believes that the academicians should form the critical connection between theory, research and practice otherwise they risk getting out of touch and becoming irrelevant. Faculty members who are engaged in practice teach from their current clinical experience rather that from textbooks and periodical articles (Wakefield-Fisher, 1983), thus enhancing the quality of their teaching. A non-practising faculty member has a negative impact on the education of student nurses. Mauksch (1980) says that, "increasingly the students ask whether their teachers are capable of nursing practice" (p. 21). Holzmer (1984) claims that the outcome of faculty practice is that students are better prepared to face the real world of nursing.

There are several other advantages to faculty practice; the following are the main ones:

1. Currently, most nursing programs are conceptually based. At first, this provides theoretical images of nursing for student nurses that can be translated into practice. Secondly, academic and clinical teaching both proceed from a conceptual framework(s) (Neely, et al., 1986). This has the additional

advantage of allowing faculty members to refine conceptual frameworks through research as well as helping in the advancement of nursing science.

2. Role modelling for students is an important faculty role that is improved by faculty practice. Students should model their own practice by watching and working with faculty members in action (Archer & Fleshman, 1981). If faculty members do not practise, the students are forced to seek their role models from among hospital staff - a problem often voiced by many faculty members, who lament the poor quality of nursing care in some settings where students are having clinical experience and the failure of nursing staff to implement research findings. (Mauksch, 1980; Schlotfeldt & MacPhail, 1969).

3. Faculty practice obliges faculty members to become familiar with hospital settings and personnel and thereby help in creating an environment conducive to learning. Instead of being viewed as guests or intruders, they come to be viewed as master practitioners (Basteyns, 1980; Roncoli, 1985). Their advanced education enables them to act as a resource to staff nurses, and thus help their professional growth. This, in turn, improves staff-teacher relations.

4. Faculty practice increases the faculty members' acceptability among other health professionals who often question their right to decision making in an arena where they do not participate in the delivery of the very services they proclaim to promote (Mauksch, 1980). In one of their studies, Chute and Oechsle (1986) discovered that, while faculty members perceived themselves to be competent both as teachers and as practitioners, hospital RNs indicated a relatively low level of confidence in the competence of faculty members for either role. Therefore, it may be said that faculty practice improves members' credibility among professional colleagues.

5. Faculty practice is reported to result in improvement in the quality of nursing care (Basteyns, 1980; Schlotfeldt & MacPhail, 1969). Pierik (1973) reported, from her own experience, that patients said they received better quality care as a result of her joint roles in teaching and practice.

Barriers to faculty practice

In spite of the reported benefits, faculty practice is not free from problems. Role overload, (that is, excessive demands and lack of time to meet expectations adequately), is of real concern to faculty members who practice. The inability to meet the demands of an academic position and the obligations of a practitioner (Duffy & Halloran, 1986; Wakefield-Fisher, 1983), as well as the inability to engage in sufficient research or professional writing are some of the frustrations experienced by faculty members who are engaged in clinical practice (Lambert & Lambert, 1988).

Faculty members who practise interface with two value systems - academia and practice. Having to deal with two normative worlds, each with different goals, standards, protocol and expected behaviour, leads to role strain (Batey, 1969; Sweeney & Ostmol, 1980). The adoption of a second profession (education), while maintaining the first (nursing), demands contradictory responses, actions and thought. One of the criticisms of faculty practice is that the patients, rather than the students, become the focus (Smoyak, 1978). Having to decide between the needs of patients and those of students produces role conflict and role strain (Kuhn, 1982). It was reported in one study that faculty members who tend to be more student-oriented than patient-oriented experience increased role strain (O'Shea, 1981).

Lack of recognition and limited rewards for practice deter many from engaging in clinical practice. Many researchers recognize that practice is considered less important than teaching and research, and that it is not highly valued when the issue of promotion and tenure is considered (Radcliff & Andresky, 1988; Yonge, 1985).

Some models of practice

Several avenues by which faculty practice may be encouraged are described in the literature. A collaborative agreement between a service and an educational institution for a joint appointment is the most common (Schlotfeldt & MacPhail, 1969; Collison & Parsons, 1980; Christman, 1980; Roncoli, 1985; Cook & Finelli, 1988).

Independent practice, whereby nurse educators develops their own practice setting to provide service to clients and to allow students to provide care under her or his guidance has also been suggested (Millonig, 1986).

Employment of faculty members during the summer months or other free time has also been tried (McGriff, 1985; Smith & Basch, 1984). However, taking an occasional, part-time clinical position is not seen as true faculty practice by purists (Wakefield-Fisher, 1983; Algase, 1986).

Background of the Study

The literature on faculty practice deals primarily with university nursing faculty; issues in relation to faculty teaching in other than a university setting are not specifically addressed. For faculty practice to be an integral part of nursing education, it should be equally applicable to all faculty members who are engaged in the preparation of future registered nurses. Therefore, faculty members, regardless of the type of institution, should engage in practice, and do so with competence.

Competencies for beginning level practitioners and for many masters level clinical nurse specialists are well-established. In contrast, practice competencies for nurse educators are not spelled out in the literature. However the literature suggests that nurse educators practice occurs at an advanced level (Algase, 1986), possibly because of an education that includes graduate work and clinical specialization (Cook & Finelli, 1988). A clinical specialist may or may not engage in teaching and research. A faculty member who teaches and, depending on the institutional mandate, conducts research and engages in scholarly activities, may also practice. Hence the faculty role is seen as the synthesis of education, practice and research (Neely et al., 1986).

The purpose of this study was to establish competencies that are essential for a faculty member to adopt a practice role. As well, nursing faculty in universities and colleges were surveyed to determine if they differ in rating these competencies.

Theoretical framework

According to role theory, roles are learned through a process of symbolic interaction by which a person acquires the required knowledge, skills and dispositions, and responds accordingly (Hardy & Conway, 1978). "Learning from observing a model...is one of the most efficient and pervasive methods" (Sarbin & Allen, 1968, p. 548). Student learning takes place by observing and internalizing the practice of their teachers - a practitioner role that they are encouraged to emulate. Therefore, role theory was used to identify competencies necessary for the practice role. These competencies are listed in Table 1.

Method

Design

This study grew out of a larger one which developed a questionnaire from a conceptual model of multiple roles of nurse faculty (Choudhry, 1992). The 15 competencies listed under each subgroup were either explicit or implicit in the literature. They establish that the practitioner is an expert care provider, has interpersonal competence, is an agent of change, is a researcher and an educator. This ensured content validity of the questionnaire. The questionnaire was pilot-tested on a sample drawn from universities and colleges (N=20) for clarity, redundancy, comprehension, ease and accuracy. Based on the comments received the questionnaire was refined and validated for its internal consistency (Cronback's alpha >.88).

Competencies were rated on a Lykert-type scale (1 being least desirable and 5 being most). The respondents were asked to rate each of 15 com-

petencies that they considered a nurse educator should have "ideally" and which, in their view, a "beginning" educator needs. The "ideal" level rating provided a point of reference for rating "beginning" level competencies. The questionnaire also included a series of opinion questions dealing with the importance of the practice role, nurse educators' credibility as it relates to clinical competence, need for faculty members to act as role models and how clinical competency is maintained.

Sample

All full-time faculty members teaching in eight university nursing programs, and 50% of all faculty members teaching in twenty-three community college nursing programs in Ontario were sampled. The questionnaires were mailed, along with a stamped self-addressed envelope. Although the anonymity of responses was assured, it was important to compare them - therefore, the questionnaires were colour-coded. Out of a total of 626 questionnaires, 291 (46.7%) were returned. Not all respondents answered all the questions, therefore only 250 (191 college faculty and 59 university faculty) were used in the final data analysis.

Analysis of Data

Multivariate repeated measures of analysis of variance was used to test for any difference between university and college respondents. The repeated factor compared levels ("beginning" and "ideal"). Wilks' multivariate F-test was then used to test the significant difference between the groups. Where a significant MANOVA F was obtained, analysis of variance (univariate F) on each dependent variable was examined to determine which of these variables were statistically significant and contributed to the overall significant multivariate F. Chi-square analysis was used to compare the opinions of the two groups. The alpha level was set at .05.

Findings

The ranking of all 15 competencies was the same for both university and college faculty members (Kendall's Coefficient of Concordance, $W=.94$, $p<.002$). Competencies in Table 1 are listed according to the final ranking. All "ideal" level competencies were rated greater that 4, indicating their overall importance for faculty practice.

As can be seen from Table 1, ten of the 15 "beginning" level competencies received a mean rating of 3.1 to 3.8, placing them above the middle of the desirability scale for a beginning faculty member. This demonstrates that faculty members provide expert care with a theoretical and conceptual base, and use research findings in their practices. They also act as educators, preceptors and mentors, and are agents for change.

Table 1

Rating and Ranking of Practice Competencies by University and Community College Faculty, N = 250

Rank	Competencies	Means	SD
1.	Identifies and uses, (thus providing a demonstration of) a conceptual framework for nursing practice.	3.52	1.05
2.	Identifies agencies' philosophy and assesses whether it is congruent with own philosophy of nursing.	3.59	1.04
3.	Designs educational programs for clients/health worker by working with other members of health team.	3.20	1.01
4.	Supports human dignity while engaging in professional practice.	4.78	.52
5.	Prescribes, decides, influences and facilitates change in nursing and health care by selecting appropriate strategies.	3.43	1.09
6.	Functions as a preceptor/mentor/guide to students and other nurses.	3.64	1.10
7.	Demonstrates effective interpersonal skills.	4.58	.64
8.	Participates in the improvement of nursing care through generating and advancing nursing theories.	2.97	1.07
9.	Demonstrates an expertise in a specialized area of clinical nursing.	3.46	1.12
10.	Uses research findings in the practice of nursing to improve client health.	3.44	1.03
11.	Interprets the roles and functions of nurses to others.	3.81	1.03
12.	Collaborates with others within the agency/community for the purpose of improving health care.	3.89	.99
13.	Provides theory-based nursing practice.	3.92	.99
14.	Acts as a client's advocate.	4.27	.93
15.	Demonstrates an understanding of values and beliefs of others.	4.50	.78

The competency that requires faculty members to participate in the improvement of nursing care through generating and advancing nursing theories received the lowest rating (2.8). The remaining four were rated between 4.0 and 4.8 - relatively high on the desirability scale, indicating that competencies for interpersonal skills were rated highest by both sets of faculty (see figure 1). However rating was significantly different between university and college faculty members: $F(15,234)= 2.74$, $p<.001$. The univariate F's revealed that the significant difference arose specifically from the ratings in the competencies numbered 9, 10, 13 and 14 (see Table 2).

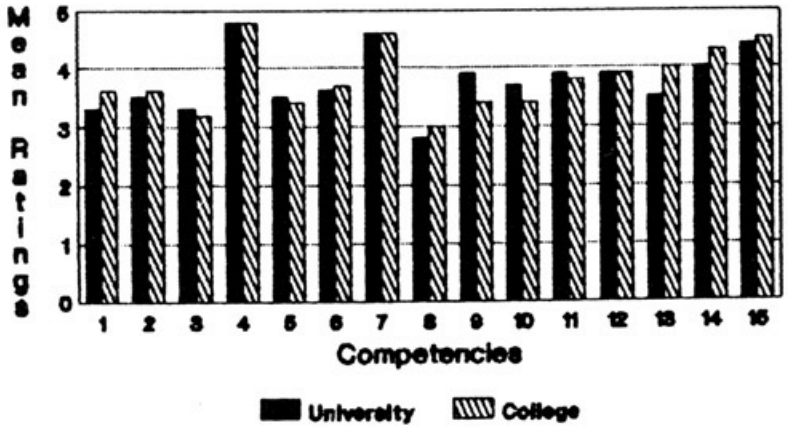

Figure 1
Beginning Faculty and Practice Competencies as Rated by University and College Faculty

Competency #9: The competency to demonstrate an expertise in a specialized area of clinical nursing was rated higher by university faculty members (3.9 for beginning and 4.5 for ideal) than by community college faculty members (3.4 for beginning and 4.0 for ideal). $F(1,248)=9.78$, $p<.002$.

Competency #10: The competency to use research findings in the practice of nursing to improve client health was also rated higher by university faculty members (3.7 for beginning and 4.6 for ideal) than college respondents (3.6 for beginning and 4.2 for ideal). $F(1,248)=8.24$, $p <.004$.

Competency #13: The competency to provide theory-based nursing practice received a higher rating by college respondents (4.1 for beginning and 4.6 for ideal) than from university faculty members (3.5 for beginning and 4.4 for ideal). $F(1,248)=9.60$, $p<.002$.

Competency #14: The competency to act as a client's advocate was also rated higher by community college respondents (4.3 for beginning and 4.7 for ideal) than by university faculty respondents (4.0 for beginning and 4.6 for ideal). $F(1,248)=6.32$, $p <.01$.

Table 2

Univariate/Multivariate Analysis of Variance by Institution Type for Faculty practice Competencies

Variables Faculty Faculty	University			Comm.Col.			MANOVA			ANOVA		
	M	SD	N	M	SD	N	Wilks .85032	F* 2.75	df 5.234	F	df	p
COMP. #9 'b'	3.9	.84	59	3.4	1.17	191				9.78	1.248	.002
'i'	4.5	.77	59	4.0	1.08	191						
COMP. #10 'b'	3.7	.98	59	3.6	1.04	191				8.24	1,248	.004
'i'	4.6	.56	59	4.2	.83	191						
COMP. #13 'b'	3.5	1.07	59	4.1	.93	191				9.60	1,248	.002
'i'	4.6	.87	59	4.6	.61	191						
COMP. #14 'b'	4.0	1.12	59	4.3	.85	191				6.32	1,248	.01
'i'	4.6	.97	59	4.7	.69	191						

* This F indicates the result of all 15 variables; only 4 univariate significant variables are included in this table.

It is important to note that there was no statistically-significant difference in the ratings of the 11 remaining competencies. Analysis of the difference between the beginning and ideal measures on the repeated factor was significant for each variable: $F(15,234)=35.28$, $p<.000$. The difference between the "beginning" and the "ideal" was the same for university and college faculty.

Discussion

The results of the study indicate that both university and community college faculty considered all practice competencies to be desirable. Thus, there is a clear expectation that a "beginning" faculty member should have competencies that are at an advanced level. This suggests that some prior preparation, at least at the masters level, is needed for all new nurse educators.

Specialized clinical preparation at the masters level and research preparation preferably at the doctoral level are the norm in universities. As such, a higher rating by university faculty members for competency demonstrating an expertise in a specialized area of clinical nursing and using research findings in practice is not surprising. Advanced clinical preparation is not a requirement for college faculty. As such, despite the value they might place on these two competencies, their low rating is an indication of their own role-deficit. Also, because college faculty members are usually expected to teach in more than one clinical area, specialization in one area is problematic. However, if practice becomes a role expectation for college faculty members in response to a mandate from the profession, then it may be desirable that masters level preparation becomes a requirement for all beginning college faculty members. Those already teaching in colleges may, instead, be encouraged to receive extended clinical practice in a specific area.

In comparison, college faculty members gave a higher rating for competency in providing theory-based nursing practice and acting as client advocates. Nursing theories have been incorporated recently in the nursing programs of most community colleges. Their higher rating might indicate a heightened commitment to this aspect of the professional mandate.

The outcome of this study attests to the importance of faculty practice. Although there was a significant difference ($X^2=3.8$, $p<.04$), the respondents were of the opinion that teaching in nursing requires competence in practice as well as competence in teaching (86% university and 94% college responses). Respondents also felt that although they could improve clinical skills (85% of university and 88% college), they could not maintain clinical competence only through supervision of their students (62%). This view is

supported in the literature: "The more the teacher is away from the bedside, the greater the possibility that she will not gain knowledge of the patients required for teaching the kind of nursing she espouses" (Christy, 1980, p.497).

In spite of this, while 77 percent of university faculty members were teaching in the clinical area, only 59 percent were engaged in some form of clinical practice, regular or periodic. A larger percentage (88%) of community college faculty members were teaching in the clinical area, but a comparatively smaller number of them (51%) were practising regularly or periodically. A higher percentage of practice among university faculty members may possibly be attributed to joint clinical and academic appointments that are the norm in some university programs. As mentioned earlier, there is no such arrangement in the college system.

As documented in the literature, when faculty members teach through their practice, they facilitate the transition from the classroom to the clinical area. By being a role model, a faculty member shows students how to make critical clinical judgements, solve problems and demonstrate effective interpersonal skills. This aspect of the practice role was considered important by both groups of faculty (87% university and 90% college).

If practice is to become a viable part of the faculty role, the consensus in this study about the importance of practice could prove to be a unifying force. It should also have a compelling influence on educational and employing institutions to make faculty practice the norm.

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RÉSUMÉ

Compétences des professeurs dans l'exercice de la profession infirmière : perception des enseignants

On a demandé aux professeurs de sciences infirmières des universités et collèges universitaires d'Ontario d'évaluer les compétences professionnelles des enseignants et de donner leur opinion sur cet élément du rôle du professeur. Les deux groupes ont indiqué que toutes les compétences énumérées étaient importantes. Toutefois, une différence importante est apparue dans quatre des quinze aptitudes. Tandis que les professeurs d'université ont accordé davantage d'importance à l'expertise dans un domaine spécialisé des sciences infirmières et à l'application des observations de recherche à l'exercice de la profession, les professeurs de collège considéraient comme plus importante l'aptitude à dispenser des soins infirmiers fondés sur la théorie et à défendre la cause des clients. Les deux groupes ont indiqué qu'ils croyaient que l'enseignement des sciences infirmières nécessitait aussi bien des compétences professionnelles que pédagogiques. ê leur avis, les professeurs de sciences infirmières tout comme les autres professeurs qui exercent une autre profession doivent se consacrer à des activités professionnelles en plus de leurs activités d'enseignement et de recherche.

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The PhD in Nursing program prepares nurses for leadership roles in practice, education and research, as well as advancing nursing knowledge through identification of nursing phenomena and the development and testing of nursing theory. The number and types of courses included in the program will vary according to the individual needs of the student. Students are admitted in September and should have applications submitted by December 15 in order to be considered for scholarships. The faculty offers a variety of clinical, educational, and research resources. Graduate Assistantship opportunities are available for both MN and PhD students.

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PROCESSUS D'ADAPTATION A LA MALADIE CHEZ DES PERSONNES ATTEINTES DU SYNDROME D'IMMUNODÉFICIENCE ACQUISE

José K. Côté et M.-Fabienne Fortin

Le syndrome d'immunodéficience acquise (SIDA) constitue un problème de santé publique international d'une ampleur exceptionnelle. Il est en quelque sorte le fléau de cette fin du 20e siècle. Ce syndrome est la manifestation la plus évoluée et la plus sévère de l'infection par le virus de l'immunodéficience humaine (VIH). Il consiste en l'effondrement du système immunitaire, lequel se traduit cliniquement chez la personne atteinte par des infections opportunistes et souvent par des atteintes tumorales, notamment le sarcome de Kaposi. Outre ces manifestations physiques, le SIDA a des répercussions profondes sur l'équilibre psycho-social des personnes atteintes, d'où l'importance d'étudier leur processus d'adaptation à la maladie.

L'absence de traitement curatif et le sombre pronostic associé à cette maladie suscitent chez les personnes atteintes, des sentiments intenses d'anxiété, de peur, de colère, de tristesse, d'impuissance et de désespoir (Korniewicz, O'Brien & Larson, 1990; Nyamathi & Van Servellen, 1989). L'impact psychosocial de cette affection mortelle se caractérise surtout par des pertes catastrophiques pour la personne: perte de sa santé et de ses fonctions corporelles; atteintes des éléments inhérents à sa personnalité; destruction de son tissu social (relations, travail, ressources financières) (Clark, Curley, Hughes & James, 1988; Govoni, 1988; Korniewicz, O'Brien & Larson, 1990). Ces atteintes perturbent profondément l'intégrité psychologique de l'être éprouvé (Di Pasquale, 1990; Nyamathi & Van Servellen, 1989; Van Servellen, Nyamathi & Mannion, 1989). A cette détresse psychologique s'ajoute l'isolement de la personne (Flaskerud, 1987; McGough, 1990; Ross & Rosser, 1988). En effet, la peur incontrôlée et démesurée entretenue au

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sein de la société à l'égard du SIDA et la stigmatisation de différents groupes (homosexuels, toxicomanes, prostitués) contribuent à isoler les personnes atteintes du SIDA (Fuller, Geis & Rush, 1988; McGough, 1990).

Actuellement, si le diagnostic du SIDA appelle la mort biologique à plus ou moins brève échéance, il signifie, dans l'immédiat, une mort psychologique et émotionnelle pour les personnes qui en sont atteintes. Étant donné l'inexorabilité de la maladie, il semble essentiel de promouvoir le bien-être des personnes atteintes tout au long des stades évolutifs de la maladie. L'étude des facettes psychosociales présentée ici constitue un préalable au développement d'interventions de soins appropriés à cette clientèle.

Cadre théorique

Afin de cerner le processus d'adaptation à la maladie de personnes atteintes du SIDA, le modèle d'adaptation psychosociale de Craig et Edwards (1983) a été utilisé comme cadre de référence. Ces auteures (1983) se sont inspirées des travaux de Lazarus (1966, 1976) et de ses collaborateurs (Cohen & Lazarus, 1979, 1983; Lazarus & Folkman, 1984), portant sur le stress et le coping. La théorie de Lazarus (1966, 1976) concernant le processus cognitif et son influence sur la façon dont les personnes font face au stress, constitue l'élément central du modèle d'adaptation de Craig et Edwards (1983). Le choix de ce modèle repose sur les implications cliniques, propres au champ d'exercice de l'infirmière, qui en découlent.

D'après Craig et Edwards (1983), l'assaut et la progression de la maladie portent atteinte à l'intégrité psychosociale de la personne et font appel à une démarche d'adaptation. C'est au moyen des processus cognitifs d'appréciation et de réappréciation que la personne chemine vers l'atteinte d'un niveau d'adaptation. Lors de l'appréciation cognitive primaire, la personne porte un jugement quant à la sévérité des pertes subies, tandis qu'au niveau de l'appréciation cognitive secondaire, elle procède à l'estimation personnelle de ses stratégies adaptatives disponibles. Les stratégies utilisées pour composer avec les pertes éprouvées s'avèrent être un déterminant critique du bien-être psychologique de la personne.

L'infirmière agit comme facilitateur dans le processus d'adaptation à la maladie d'une personne et des interventions spécifiques relevant de ses compétences sont requises, notamment: (a) assister la personne dans la réalisation d'une appréciation cognitive primaire réaliste de la situation; (b) assister la personne dans l'identification de tâches adaptatives les plus appropriées; (c) faciliter le développement et l'utilisation de stratégies adaptatives.

Le modèle d'adaptation psycho-sociale de Craig et Edwards (1983) propose une structure logique et abstraite des concepts pertinents à l'étude du processus d'adaptation à la maladie des personnes atteintes du SIDA. Le schéma qui suit présente les variables de l'étude et leurs interrelations.

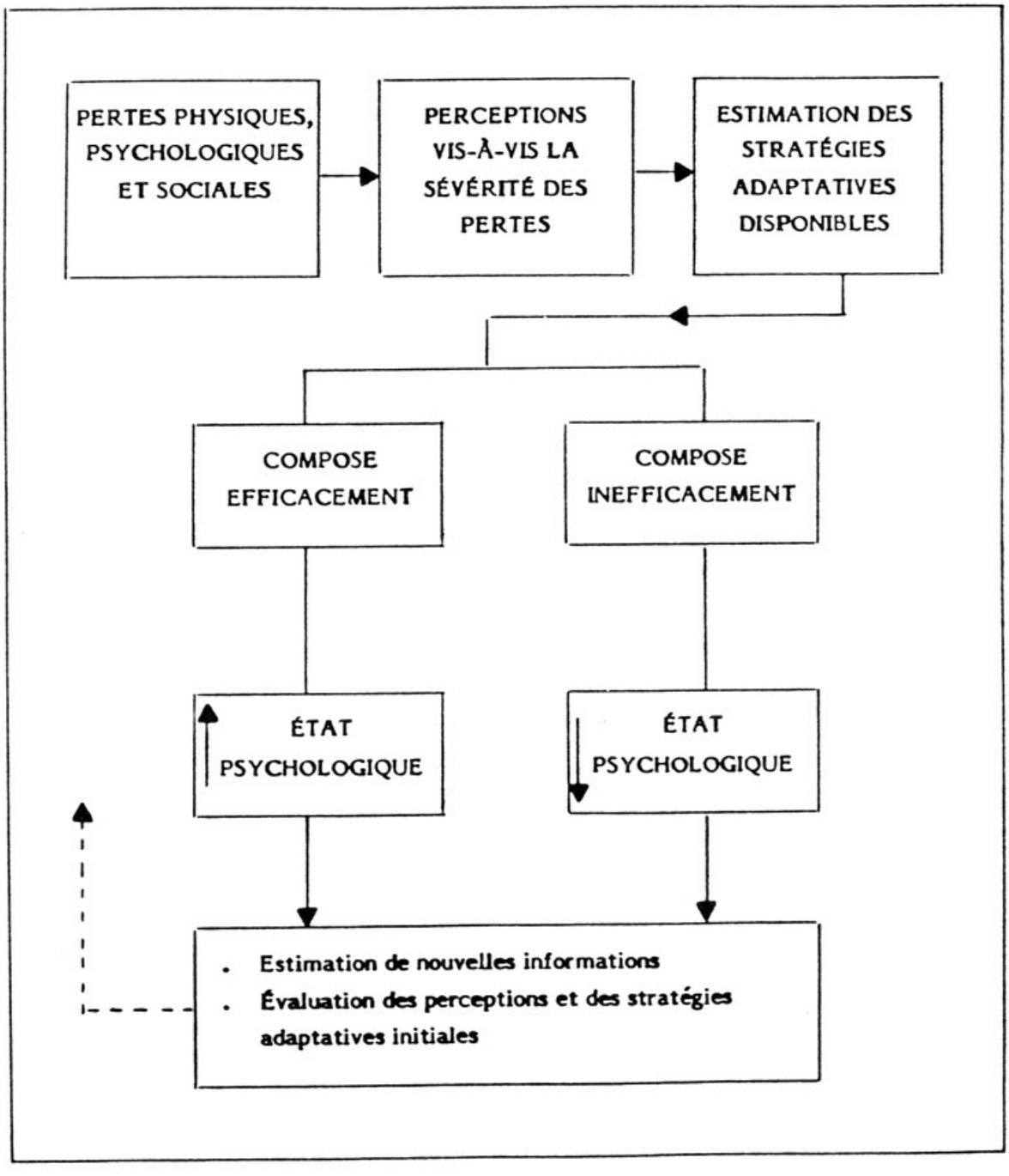

Figure 1
Schéma des variables

Questions de recherche

Quelles sont les perceptions de personnes atteintes du SIDA à l'égard de la sévérité des pertes éprouvées?

Quelles sont les stratégies adaptatives utilisées par les personnes atteintes du SIDA?

Existe-t-il une relation entre la sévérité des pertes éprouvées et les stratégies adaptatives utilisées?

Existe-t-il une relation entre les stratégies adaptatives utilisées et l'état psychologique de personnes atteintes du SIDA?

Existe-t-il une relation entre le stade d'évolution de la maladie et (a) la sévérité des pertes éprouvées, (b) les stratégies adaptatives utilisées et (c) l'état psychologique des sujets?

Méthodes

Un échantillonnage de convenance a été utilisé dans cette étude compte tenu du nombre restreint de personnes atteintes du SIDA. L'échantillon a été constitué de 50 hommes atteints du SIDA et présentant les manifestations du syndrome. La méthode d'échantillonnage a permis d'inclure dans l'étude des sujets hospitalisés (27) et des sujets fréquentant les cliniques externes (23) sans avoir a priori déterminé des proportions définies. Une catégorisation apparentée à celle élaborée par le groupe d'experts canadiens sur le SIDA (Degner et al., 1987) a permis de regrouper les personnes atteintes selon le stade spécifique d'évolution de la maladie. La moitié des sujets interrogés était au stade primitif de la maladie tandis que l'autre moitié était au stade progressif avancé. Le taux de participation à l'étude a été d'un peu plus de 90%.

Les instruments de mesure utilisés ont été: le questionnaire sur la sévérité des pertes éprouvées (élaboré par les auteures), la version française (Gagnon, 1988) de *Indices of Coping Responses* (Billings & Moos, 1984) et l'échelle de bien-être général (EBEG) (Kovess, Murphy, Tousignant & Fournier, 1985).

Le questionnaire "Sévérité des pertes éprouvées" visait à identifier les perceptions des personnes atteintes du SIDA quant à la sévérité des pertes éprouvées. Composé de 20 items, le questionnaire couvrait les dimensions physique, psychologique et sociale des pertes. Chaque item était mis en action au moyen de deux sous-questions; la première visait à connaître l'existence effective d'une perte et la seconde évaluait, en l'occurrence, l'intensité de la préoccupation concernant la perte éprouvée sur une échelle de Likert.

Avant d'être utilisé, le questionnaire a été vérifié par des experts au point de vue du contenu et de la pertinence des questions. Des prétests ont été

effectués auprès de personnes atteintes du SIDA présentant les mêmes caractéristiques que les sujets de l'étude. Une fois les questionnaires complétés, une analyse d'items a été effectuée afin d'établir le degré de consistance interne de chacune des sous-échelles de pertes. Il appert que l'ensemble des items, représentant les pertes physiques et les pertes psychologiques, démontre une homogénéité interne assez élevée, avec des coefficients alpha de 0,7138 et 0,6453. La sous-échelle de pertes sociales possède une consistance interne peu élevée (alpha = 0,1670). Pour cette sous-échelle, l'analyse d'items révèle l'existence de trois dimensions, soit les pertes sociales, familiales et amicales. Le nombre restreint d'items représentant chaque sous-échelle limite les analyses de consistance interne.

La version française (Gagnon, 1988) de *Indices of Coping Responses*, conçue par Billings et Moos (1984), a été utilisée pour la mesure des stratégies adaptatives. Cette échelle, composée de 32 items, a été conçue à partir d'une intégration des diverses perspectives du concept de *coping*. Ces items, représentant les réactions de coping, ont été classifiés dans un premier temps selon la méthode de coping et ensuite d'après le foyer de coping, lors de l'analyse des données. Billings et Moos (1981, 1984) se servent de la description faite par le sujet d'un événement qu'il juge stressant comme point de référence, afin de déterminer la fréquence des stratégies adaptatives utilisées. Pour les fins de cette étude, les auteures se réfèrent à la maladie, plus précisément aux pertes occasionnées par le SIDA, comme situation stressante.

En ce qui a trait à la version originale de l'échelle (1981), l'ensemble des items et les sous-catégories représentant les méthodes de coping démontrent une homogénéité interne modérée avec un coefficient alpha à 0,62. Pour ce qui est de la deuxième version de l'instrument (1984), les coefficients alpha illustrant les sous-catégories des foyers de coping sont modérés à bas (0,66 à 0,41). Selon les auteurs, le nombre restreint d'items représentant chaque catégorie expliquerait les coefficients obtenus.

Gagnon (1988) a traduit le Indices of Coping Responses en langue française et a procédé à une analyse factorielle. Cette analyse a révélé l'existence de deux principales dimensions, notamment les stratégies adaptatives générales et les stratégies adaptatives d'évitement qui expliquent respectivement 52.4% et 19% de la variance totale des items.

L'état psychologique du sujet a été mesuré au moyen de l'échelle de bien-être général (Kovess et al., 1985); celle-ci étant une adaptation du *General Well Being Schedule* élaborée par Dupuy (1969, 1973, 1974) et utilisée lors d'une enquête nationale aux États-Unis. L'échelle de bien-être général comporte sept paires de questions explorant le vécu subjectif des sujets. L'échelle de bien-être général (Kovess et al., 1985) a été utilisée auprès de 11 323 ménages lors de l'enquête Santé Québec 1987.

Résultats

Les caractéristiques personnelles des sujets, soit l'âge, l'ethnie, et la scolarité sont présentées au tableau 1. Le tableau 2 présente la répartition des sujets selon l'intensité de la préoccupation concernant les pertes d'ordre physique, psychologique et social.

Tableau 1

Distribution des sujets selon l'âge, l'ethnie et la scolarité (N=50)

Caractéristiques	n	%
Age		
21-30 ans	10	20
31-40 ans	20	40
41-50 ans	17	34
51-60 ans	3	6
Ethnie		
Canadiens	45	90
Haïtiens	4	8
Espagnols	1	2
Niveau de scolarité		
Secondaire	16	32
Collégial	13	26
Universitaire	16	32
Etudes graduées	5	10

A la question: Quelles sont les perceptions de personnes atteintes du SIDA à l'égard de la sévérité des pertes éprouvées?, un grand nombre de répondants ont exprimé la sévérité des pertes éprouvées en indiquant sur l'échelle de Likert qu'ils étaient modérément à excessivement préoccupés par une diminution de leurs capacités physiques (72%), par une perte de leur confort (70%) et par une perte de leurs fonctions corporelles (58%). Les résultats indiquent également que 64% des sujets ont subi un préjudice à leur apparence physique alors que 78% sont préoccupés de façon modérée à excessive par cette atteinte. Le SIDA entraîne chez 84% des sujets une diminution des activités sociales et communautaires, et 69% d'entre eux sont préoccupés de façon modérée à excessive par cette diminution. La perte de l'emploi est réelle pour 29 sujets, soit 58% de l'échantillon; parmi ceux-ci, 62% sont préoccupés de façon modérée à excessive par cet arrêt de travail.

Tableau 2

Distribution des sujets selon l'intensité de la préoccupation relative aux pertes physiques, psychologiques et sociales (N=50)

	Pertes d'ordre physique, psychologique et sociale							
Intensité de la préoccupation	Confort	Capacités physiques	Fonctions corporelles	Apparence physique	Activités sociales et communautaires	Emploi	Indépendance financière	Eloignement famille
Il n'existe pas de perte	8 (16%)	5 (10%)	12 (24%)	18 (36%)	7 (14%)	19 (38%)	30 (60%)	34 (68%0
Pas du tout préoccupé	2 (4%)	2 (4%)	3 (6%)	4 (8%)	6 (12%)	8 (16%)	4 (8%)	1 (2%0
Un peu préoccupé	5 (10%)	7 (14%)	6 (12%)	3 (6%)	7 (14%)	3 (6%)	4 (8%)	-
Modérément préoccupé	10 (20%)	8 (16%)	4 (8%)	13 (26%)	15 (30%)	6 (12%)	3 (6%)	-
Beaucoup préoccupé	19 (38%)	24 (48%)	20 (40%)	9 (18%)	12 (24%)	8 (16%)	5 (10%)	-
Excessivement préoccupé	6 (12%)	4 (8%)	5 (10%)	3 (6%)	2 (4%)	4 (8%)	4 (8%)	-
Autres	-	-	-	-	1 (2%)	2 (4%)	-	15 (30%)

Par ailleurs, 40% des sujets éprouvent une perte de l'indépendance financière. Une forte majorité de sujets (68%) ne sont pas affectés par l'éloignement d'un ou de plusieurs membres de la famille. Un fait intéressant à noter: 26% des sujets de l'échantillon n'ont pas révélé leur diagnostic aux membres de la famille.

Les types de stratégies adaptatives utilisées par les personnes atteintes du SIDA font l'objet de la deuxième question. A l'analyse des données les items (32), représentant les diverses façons de composer, ont été classifiés selon la méthode (3) de coping (active-cognitive; comportement-actif; évitement) et également selon le foyer (5) de coping (recherche d'information; analyse logique; résolution de problèmes; régulation affective; décharge émotionnelle).

La première méthode, active-cognitive, a été la plus utilisée par les sujets (X1=5,16); vient ensuite la deuxième méthode, comportement-actif (X2=3,74) et enfin la troisième méthode, celle de l'évitement (X3=1,48). L'analyse des données selon les foyers de coping démontrent que les stratégies adaptatives orientées vers la recherche d'information (X2=6,06) ont été les stratégies les plus souvent utilisées par les répondants, tandis que celles orientées vers la décharge émotionnelle (X5=1,90) ont été les moins utilisées.

Des analyses de régression et de corrélation ont été effectuées afin d'explorer l'existence et la force de relations possibles entre la sévérité des pertes éprouvées et les stratégies adaptatives utilisées selon les méthodes de coping et les foyers de coping (troisième question). Le seuil de signification statistique a été fixé à $p<,05$.

Un aperçu des relations possibles entre la sévérité des pertes éprouvées et les méthodes (3) de coping utilisées est présenté au tableau 3. L'analyse de régression a permis de constater que la sévérité des pertes physiques, psychologiques et sociales éprouvées est associée de façon statistiquement significative ($p=,019$, $r=,334$; $p=,049$, $r=,284$; $p=,011$, $r=,368$) à l'utilisation de stratégies d'évitement. De même, la sévérité des pertes amicales perçues est associée à l'utilisation de stratégies dites actives-cognitives ($p=,017$, $r=,332$).

Le tableau 4 fait état des associations possibles entre la sévérité des pertes éprouvées et les foyers (5) de coping utilisés. Le test de Fisher a fait ressortir une association statistiquement significative à $p=,018$ entre la sévérité des pertes physiques éprouvées et l'utilisation de stratégies adaptatives orientées vers la décharge émotionnelle ($r=,252$). Une association a aussi été constatée entre la sévérité des pertes sociales éprouvées et le recours à des stratégies de résolution de problèmes ($p=,013$, $r=-,235$).

Tableau 3

Analyse en régression des pertes selon les stratégies adaptatives (méthodes) (N=50)

Sous-échelles de pertes	Méthodes	B	Corrélation simple	p	
Physique	1	-0,208	-0,122	,200	
	2	0,127	0,054	,430	
	3	0,334	0,334	,019	**
	r^2=0,144	F=2,57	p=,065		
Psychologique	1	0,172	0,198	,296	
	2	0,020	0,137	,902	
	3	0,272	0,284	,049	**
	r^2=0,114	F=1,98	p=,131		
Social	1	-0,014	0,038	,932	
	2	0,058	0,088	,721	
	3	0,363	0,368	,011	**
	r^2=0,138	F=2,45	p=,075		
Amical	1	0,394	0,332	,017	**
	2	-0,136	0,083	,400	
	3	0,146	0,155	,295	
	r^2=0,142	F=2,54	p=,068		

Note: 1. Active-cognitive; 2. Comportement-actif; 3. Évitement

Afin de vérifier des associations possibles entre les stratégies adaptatives utilisées et l'état psychologique (quatrième question), des analyses statistiques non-paramétriques ont été effectuées à l'aide du test de Fisher. L'état psychologique des sujets avait été mesuré préalablement à l'aide de l'échelle de bien-être général de Kovess et al. (1985). Le tableau 5 présente les relations possibles entre les stratégies adaptatives utilisées et l'état psychologique. Les résultats ont montré une association entre l'état psychologique, tel que mesuré par l'EBEG et les méthodes de coping (p=,029, r=,420). En outre, un coefficient de régression (-0,335) a indiqué une relation négative entre l'état psychologique et les stratégies orientées vers l'évitement à p=,013. Enfin, il existe une association statistiquement significative à p=,048 entre l'état psychologique et l'utilisation de stratégies orientées vers l'analyse logique (r=,292).

Tableau 4

Analyse en régression des pertes selon les stratégies adaptatives (foyers) (N=50)

Sous-échelles de pertes	Foyers	B	Corrélation simple	p	
Physique	1	-0,241	-0,129	,129	
	2	-0,195	-0,068	,224	
	3	0,008	-0,035	,960	
	4	-0,004	0,067	,978	
	5	0,419	0,252	,018	**
	r^2=0,149	F=1,54	p=,196		
Psychologique	1	0,024	0,095	,882	
	2	0,052	0,137	,752	
	3	-0,108	-0,002	,513	
	4	0,070	0,159	,674	
	5	0,231	0,263	,198	
	r^2=0,082	F=0,78	p=,569		
Social	1	0,019	0,024	,899	
	2	0,143	0,155	,355	
	3	-0,394	-0,235	,013	**
	4	0,162	0,185	,299	
	5	0,219	0,253	,191	
	r^2=0,201	F=2,21	p=,070		
Amical	1	0,157	0,266	,323	
	2	-0,112	0,048	,487	
	3	0,273	0,317	,092	
	4	-0,002	0,126	,989	
	5	0,094	0,174	,583	
	r^2=0,139	F=1,42	p=,235		

Note: 1. Analyse logique; 2. Recherche d'information; 3. Résolution de problèmes; 4. Régulation affective; 5. Décharge émotionnelle

Tableau 5

Analyse en régression de l'état psychologique (EBEG) selon les stratégies adaptatives (méthodes et foyers) (N=50)

État psychologique	Stratégies adaptatives	B	Corrélation simple	p	
EBEG	Méthode 1	0,271	0,232	,090	
	Méthode 2	-0,036	0,070	,821	
	Méthode 3	-0,347	-0,335	,013	**
	r^2=0,177	F=3,29	p=,029 **		
	r=0,420				
EBEG	Foyer 1	0,323	0,292	,048	**
	Foyer 2	-0,023	-0,0001	,886	
	Foyer 3	0,112	0,169	,488	
	Foyer 4	-0,020	0,009	,903	
	Foyer 5	-0,173	-0,048	,320	
	r^2=0,121	F=1,21	p=,319		

Note: Méthode 1: Active-cognitive; Méthode 2: Comportement-actif; Méthode 3: Évitement; Foyer 1: Analyse logique; Foyer 2: Recherche d'information; Foyer 3: Résolution de problèmes; Foyer 4: Régulation affective; Foyer 5: Décharge émotionnelle

Les résultats obtenus à l'aide d'analyses de variance univariée indiquent que la sévérité des pertes sociales éprouvées est associée de façon statistiquement significative (p=,044) au stade d'évolution de la maladie (cinquième question). Les sujets au stade progressif avancé de la maladie (X=4,44) ont perçu plus sévèrement les pertes d'ordre social que ceux au stade primitif (X=2,92). Par ailleurs, une association se dégage entre les stratégies adaptatives dites d'analyse logique et le stade d'évolution de la maladie (p=,018). L'utilisation des stratégies adaptatives orientées vers l'analyse logique est plus marquée au stade primitif de la maladie (X=4,87) qu'au stade progressif avancé (X=3,20).

Discussion

L'échantillon de l'étude a été constitué d'adultes masculins dont la moyenne d'âge est de 39,8 ans. Selon les données du Centre fédéral sur le SIDA (1992, juillet), il s'avère que 94,7% des cas dénombrés au Canada sont des adultes masculins et une forte proportion (44%) d'entre eux sont âgés entre 30 et 39 ans. Il convient de souligner qu'il n'y a pas de distorsion majeure concernant l'âge et le sexe entre la population étudiée et les cas de SIDA notifiés par l'organisme canadien de surveillance épidémiologique. Cependant les résultats présentés ne peuvent être généralisés à l'ensemble des personnes atteintes du SIDA étant donné le nombre restreint de sujets (50) choisis de façon non aléatoire.

Les résultats de l'étude indiquent que les sujets qui ont obtenu des scores faibles sur l'échelle de bien-être général utilisent davantage des stratégies dites d'évitement. Les études de Billings et Moos (1981), ainsi que celles de Pearlin et Schooler (1978), effectuées au sein de la communauté, démontrent que l'utilisation de stratégies adaptatives centrées sur l'évitement et la décharge émotionnelle est associée à un taux supérieur de dépressions comparativement à celles orientées vers le problème. L'étude ultérieure de Billings et Moos (1984), réalisée auprès des sujets dépressifs, confirme ces données préliminaires à l'effet que les stratégies orientées vers l'évitement et la décharge émotionnelle seraient associées à des dysfonctions plus sévères. Ces résultats confirment les prédictions théoriques de plusieurs auteurs (Abramson, Seligman & Teasdale, 1978; Coyne, 1976; Lavelle, Metalsky & Coyne, 1979).

Toutefois, les observations cliniques effectuées auprès de personnes atteintes du SIDA (Menenberg, 1987; Nyamathi & Van Servellen, 1989; Ross & Rosser, 1988; Rundell, Wise & Ursano, 1986) révèlent que le déni est un mécanisme fort utile et fréquemment employé par cette clientèle. Il permet aux personnes atteintes du SIDA de mobiliser et de regrouper leurs forces, car sans le déni, ces personnes seraient facilement écrasées sous le poids des événements (Bohm, 1987; Nyamathi & Van Servellen, 1989). Par contre, l'usage abusif de déni, de la part du sidatique, peut nuire à son processus d'adaptation à la maladie et interférer à la thérapeutique proposée (Menenberg, 1987; Nyamathi & Van Servellen, 1989).

De l'avis de Cohen et Lazarus (1979), le jugement global sur la valeur d'une stratégie adaptative doit être porté avec prudence et vigilance. Ces auteurs soutiennent que cette évaluation fort complexe dépend de plusieurs facteurs, notamment du contexte, du temps, des valeurs et des perspectives. En effet, des stratégies telles que le déni et l'évitement peuvent être très efficaces ou totalement nuisibles dépendant de la durée et du moment de leur utilisation. Ces stratégies ont été associées à une diminution du taux de mortalité suite à une chirurgie coronarienne (Hackett, Cassem & Wishnie, 1968) mais elles ont été aussi associées à une diminution importante de l'assiduité au traitement médical un an plus tard compromettant ainsi sérieusement l'état de santé de ces malades (Croog, Shapiro & Levine, 1971).

Il est apparu fort important pour de nombreux auteurs et chercheurs (Andreasen & Norris, 1972; Antonovosky, 1979; Averill & Rosen, 1972; Billings & Moos, 1981; Carson, 1969; Cohen & Lazarus, 1979; Lipowski, 1970) de se pencher sur l'étude du coping comme médiateur dans la relation entre le stress de la vie quotidienne et le bien-être physique, psychologique et social. L'infirmière qui facilite le cheminement de la personne vers son adaptation à la maladie se préoccupe de la valeur des efforts déployés en vue

de composer avec la situation stressante. Cependant, il s'avère difficile d'évaluer l'efficacité d'une stratégie adaptative. Les travaux récents de Benner et Wrubel (1989) critiquent l'approche purement cartésienne utilisée jusqu'à présent pour l'étude du concept coping. Elles préconisent une approche phénoménologique afin d'explorer la signification profonde du coping au moyen des perceptions communiquées par les personnes.

Les résultats de l'étude démontrent que les sujets ont utilisé davantage des stratégies orientées vers la recherche d'information plutôt que celles centrées sur la décharge émotionnelle pour composer avec les pertes accablantes éprouvées. Chez les patients atteints de cancer, la recherche d'information est l'une des stratégies susceptibles d'alléger les sentiments d'anxiété et d'impuissance (Silberfarb & Greer, 1982) et permet, selon Hopkins (1986), de réévaluer la situation menaçante. Jusqu'à présent, peu de chercheurs se sont intéressés à l'étude de ce type de stratégie; il s'avère donc difficile d'apporter des éléments de comparaison.

Il ressort de l'étude que les sujets qui perçoivent sévèrement les pertes physiques, psychologiques et sociales entraînées par le SIDA, utilisent davantage les stratégies dites d'évitement (méthode de coping). De même, l'analyse des stratégies selon les foyers de coping démontrent que les sujets qui sont préoccupés de façon importante par les pertes d'ordre physique ont recours à des stratégies orientées vers la décharge émotionnelle. A ce sujet, Folkman et Lazarus (1984) mentionnent que la notion d'évaluation joue un rôle prépondérant; il semble que le facteur sentiment de contrôle influence grandement les réactions de coping déployées. Les épisodes de stress suscités par des problèmes de santé sont alors évalués comme étant des conditions non modifiables par la personne et devant être acceptées. Ces données sont congruentes avec celles obtenues par Cohen et Lazarus (1979), Lipowski (1970) et Moos et Tsu (1977) qui démontrent que les épisodes de stress occasionnés par des problèmes de santé étaient associés à une augmentation de stratégies orientées vers l'émotion.

Relativement aux pertes d'ordre social, les résultats de l'étude démontrent que 26% de l'échantillon n'ont pas révélé leur diagnostic aux membres de leur famille. Cette donnée est fort indicative en regard du soutien social. D'ailleurs, Lazarus et Folkman (1984) notent que les individus auront une meilleure adaptation s'ils reçoivent du soutien adéquat.

Finalement, les résultats de l'étude supportent les travaux de Craig et Edwards (1983) à l'effet que le cheminement de la personne vers son adaptation revêt un caractère cyclique et continu au cours duquel se fait une appréciation et une réappréciation constante de la situation. Les pertes entraînées par la maladie se présentent de façon subséquente, déclenchant alors une démarche d'adaptation qui se traduit par l'évaluation personnelle

de la sévérité de ces nouvelles pertes et l'estimation de nouvelles stratégies adaptatives disponibles. Ce processus a été qualifié de la façon suivante par une personne atteinte: "Les montagnes russes du SIDA". En effet, il ressort des résultats que les sujets au stade progressif-avancé de la maladie perçoivent plus sévèrement les pertes d'ordre social que ceux au stade primitif. Ces pertes relatives aux fonctions individuelles, sociales, communautaires, à l'indépendance financière et à la dépendance vis-à-vis les services de santé, sont vécues dans une phase plus avancée de la maladie où les manifestations physiques importantes du syndrome contraignent la personne à diminuer ses activités.

Quant à l'utilisation des stratégies adaptatives par les répondants, celles orientées vers l'analyse logique sont plus marquées au stade primitif de la maladie qu'au stade progressif-avancé. L'annonce d'un diagnostic relativement récent de SIDA et l'apparition d'une première infection opportuniste caractérisent le stade primitif de la maladie. A ce stade, les personnes cherchent alors à comprendre la situation, à prendre du recul face à cette situation et à examiner des éléments de solutions possibles.

Le champ des connaissances relatif au processus d'adaptation à la maladie s'enrichit par les résultats de l'étude. Les concepts de perte, de *coping*, de bien-être et d'appréciation constituent des variables clés dans l'étude de ce processus. Les auteures croient que l'ajout de variables telles que l'espoir et le soutien formel et informel permettrait une compréhension plus globale et approfondie du processus d'adaptation à la maladie.

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RÉSUMÉ

The Process of Adaptation to Acquired Immunodeficiency Syndrome

This study was conducted to describe the adaptation process to illness. The study subjects were 50 AIDS patients. The study variables and tools of measurement were chosen according to the Psychosocial Adaptation Model of Craig and Edwards (1983).

It was found that throughout the disease process an appraisal-reappraisal of the situation is continuous. The sick person constantly evaluated the severity of his losses and the availability of the coping strategies at his disposal.

The study results demonstrated that persons afflicted with AIDS suffer considerable amount of physical and psychosocial prejudice. It was apparent that the patients who suffered severe physical, psychological and social losses used avoidance strategies. Those preoccupied with the physical losses had a tendency to use the strategy of emotional discharge. Otherwise the study subjects sought information rather than emotional discharge to come to terms with their losses.

In addition, the use of logical analysis strategies was associated with an increase in psychological well-being. In contrast, the strategy of avoidance was associated with a decrease in well-being. Finally, the subjects with the advanced disease experienced more severe losses of a social nature and made less use of logical analysis strategies than did subjects in the early phases of the disease.

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CONCEPTUAL ISSUES RELATED TO MEASUREMENT IN FAMILY RESEARCH

Linda J. Kristjanson

Scholars from a number of disciplines are directing more attention to epistemological, conceptual and methodological issues associated with family research. These issues include concerns about theoretical and operational definitions of family variables (Feetham, 1984; Gilliss, 1983), debates about technical aspects of measurement and analysis (Hudson & Murphy, 1984; Schumm, Milliken, Poresky, Bollman, & Jurich, 1983; Schumm, Barnes, Bollman, Jurich, & Milliken, 1985), and fundamental questions regarding the appropriateness of the logical-positivistic tradition of scientific inquiry as the pathway to knowledge about the family (Becvar & Becvar, 1988; Bednar, Burlingame, & Masters, 1988). Approaches to method and measurement follow conceptual decisions. Therefore, the purpose of this paper is to identify some core conceptual concerns related to measurement in family research and to pose questions and make suggestions to those interested in clarifying some of the associated problems. Among the problems are the following.

1. Confusion and inaccuracies in the research literature related to definitions of the term "family". These include problems with how to measure the "whole", the propensity to rely on singular informants, the importance of context and external versus internal definitions of the family.
2. Incongruencies in use of conceptual definitions, operational definitions, design and analysis methods that threaten the validity of research findings.
3. Incongruence between the logical-positivistic methods currently used and accepted by the research community and family systems principles.
4. A lack of respect for qualitative research methods resulting in theory and measurement gaps as a consequence of poorly defined constructs and processes.

Definitions of the family

The family has been described as a complex unit with distinct attributes of its own (Gilliss, 1983). It contains individuals who are unique and who inter-

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act in various ways with other individuals, subgroups within the family and the family as a whole. Questions about who to study, which parts to examine and how to measure the whole are concerns of family researchers. One of the most troublesome problems encountered has been the difficulty in obtaining accurate information *from* the family *about* the family. Part of this problem comes from confusion and errors about conceptualizations of the family in the literature. Close examination of family literature reveals that the concept of family is often not defined nor is the family a basic unit of analysis in the research (Feetham, 1984).

There is considerable confusion about how to measure the aggregate and its component parts (Feetham, 1984; Gilliss, 1983; Jacob & Tennenbaum, 1988). Family members may provide responses about themselves, about others in the family or about their relationships with subunits or the family as a whole. As well, subgroups within the family can provide perspectives on these components and, finally, the family as a whole may produce a response to a variety of research questions. The information obtained about and from these various sources provides different data that must be analyzed and interpreted in a way that is consistent with the conceptualization of the family constructs.

A review of the literature on family theory and measurement revealed that there are four considerations that must be made explicit when the term "family" is used: the level of inquiry (i.e., individual, dyad, triad, whole unit), the context within which the family is viewed (i.e., dependent or independent variable), source of definition (i.e., internal versus external), and properties and attributes of the different levels of inquiry.

Level of inquiry

According to systems theory, the whole is greater than the sum of its parts (Bertalanffy, 1968). At present, a tool that quantitatively captures the family does not exist. One reason for the absence of such a tool may be that questions remain about how to conceptualize the family as a whole. Gilliss (1983) has struggled with this conceptual and measurement issue for years. For example, she has been concerned with the measurement of subjective stress in the family unit, using a minimum of two adult members from each family as data sources. When the mean stress scores of individual family members were compared to a family unit score, which the family group reported, no differences were found (Gilliss, 1981). Dobbins (1982) replicated this work with similar results. Is there no difference between the sum of individuals and the group? How much does the process of arriving at a group consensus measure influence the outcome? Or does the instrumentation fail to capture the aspect of the family that is greater than the sum of its parts? At this time, even the multivariate analysis techniques are additive (Gilliss, 1983).

Despite the theoretical underpinnings of family systems theory which imply that the sum of the variables studied is more than the sum of the parts, seldom is this whole measured in family research. Wakefield, Allen and Washchuck (1979) reviewed reports of federally-funded research and found that most of the studies tended not to examine the family as a unit, but studied family members as individuals. More recently, Jacob and Tennenbaum (1988) reviewed 19 journals of family research between the years 1980 and 1985. They concluded that instruments specifically designed for the assessment of family system properties, although sometimes found in the literature, are relatively few in number and are still in an early stage of development.

The family is usually defined as individuals bonded by a biological or legal relationship. In other studies, families are defined as those persons having a "functional" relationship with one another. Families may be described as nuclear, intergenerational or extended. They may or may not cohabitate with each other. An implicit assumption in much of the research related to families is that these definitions are comparable and that specifying a social role relationship or legal or biological bond conveys an understanding regarding the commonality of feelings, perceptions, behaviours and identity of those individuals as a unit.

Some researchers have used one member as the "family" and make inferences based on this person's response to other family members. In most instances, this individual is the mother in the family and much of this research involves family health behaviours or family development (Bokemeier & Monroe, 1983). The use of this singular informant results in an obvious threat to the construct in question. For example, mothers of schizophrenic children reveal their own reality when they provide a history of the child (Gilliss, 1983). Gathering information from only one informant is valid when the researcher's theoretical framework emphasizes the importance of the individual's perception of the family experience, as does symbolic interaction theory (Uphold & Harper, 1986). However, interpretations and definitions in the research may result in these data being used to describe and predict family views.

Lobo (1982) used the mother or wife to report the daily well-being of each family member and family unit. Using a multiple regression and correlational technique, Lobo identified which individual member's well- being was the greatest contributor to family well-being. This source of data collection may be legitimate, if the research question is only interested in mother's perceptions. However, the extent to which individuals themselves would define their own health similarly was not explored.

Olson and Portner (1983) used the FACES II (Olson, Sprenkle & Russell, 1979) to measure family cohesion and adaptability. The tool was designed to

be administered to individual family members in order to gain information about the family as a unit. Olson and Portner (1983) reported lack of agreement among family members in the scores on FACES II. This raises the question of which member's report is most useful for what purpose. As well, it demonstrates the importance of obtaining scores from as many family members as possible to gain a more complete picture of the family system (Jacob & Tennenbaum, 1988). Schless and Mendels (1978) have also demonstrated that interviewing additional informants provides significantly more data about the family.

Many of the epidemiological studies of family have also used individual family members as sources of data about other family members and the family as a collective (Gillis, 1983). The underlying issue in these studies is construct validity. Does the measure truly assess the construct in question?

Context

Although there is controversy about the sources of data and the information these data provide in the research of families, there is agreement regarding the effect of context on family data. It is recognized that the same question asked of a person individually may result in different data than when asked of the same person within the context of other family members (Feetham, 1991). Therefore, context becomes an important variable in the conceptualization of family research questions.

The family itself may be conceptualized as the environment or context within which individual behaviour is studied. For example, the family may be viewed as the context within which the individual develops. Barnard (1984) studied family structure as an independent variable predicting child performance. In other instances, the family may be defined as the dependent variable studied in relation to behaviour of individual members. The individual's behaviour is then defined as the context within which to understand family functioning. For instance, the Feetham Family Function Inventory was developed to measure the family's adaptation to a child with a chronic health problem (Roberts & Feetham, 1982).

It is interesting to note that in studies of pathological families the focus is on the ill family member as the independent variable, implying a direct causality of the presence of the ill family member to the family outcomes. In contrast, investigations examining families described as healthy tend to use a measure of the healthy family as the independent variable and outcomes related to individual family members as the dependent variable (Feetham, 1991).

Whether or not family is an independent, dependent or intervening variable is not a concern. Of importance is the clarity with which the family is

defined and the consistency of the theoretical definition of the family with the operational definition and the subsequent design.

Definition source

Although the family may be viewed as an open system interacting with other systems, the definition of the family is usually an externally imposed one. Punctuation of the family system boundaries is necessary, particularly for purposes of defining family membership for comparison. However, it is important for researchers to acknowledge this external definition as an artificial delineation that may not represent boundaries that the family would view as meaningful.

Qualitative research methods that use the family as a definer of its membership may be beneficial for some research questions. This work may result in a richer understanding of "functional" families. For example, in research related to families of the terminally ill, patients were asked to identify the individuals who they considered to be family members involved in or affected by the illness (Kristjanson, 1986). One patient who was a practising nun identified her "spiritual family" because these people provided daily care and contact. In this same study, subjects identified neighbours or close friends who were "like family" because of frequent contact time or because of their close emotional bond to the patient. Understanding who constitutes these "functional families" may be a particularly relevant area of research in itself.

Properties and attributes

A number of scholars have attempted to clarify and identify qualities of families by developing organizing frameworks for family phenomena. Straus (1964) was one of the earliest to suggest the notion of analytical, structural and global indicators as they relate to families. Analytical indicators are measures of attributes or behaviours of the individuals who constitute the family unit. For example, age or alcohol consumption of individual family members might be measured within this category. Structural indicators are those that provide information about the relatedness of family members to one another and the interaction of the members with one another (Gilliss, 1983). These are the most process oriented and permit a view of function and interdependence (Straus, 1964). This category might include self-report methods of data collection or observational techniques. Global indicators are those that describe the unit as a collective. Some examples might be socio-economic status of the family or income of the family unit (Gilliss, 1983). This framework is helpful in clarifying components of the family.

Fisher (1982) distinguishes between *family research* and *family-related research*. He describes *family-related research* as relational and family

research as transactional. Relational data are data collected from two or more family members about family constructs. The scores from individuals are combined and the analysis results in a descriptive level statement regarding the sum or average of family members' perceptions of family events, history or attributes (Fisher, Kokes, Ransom, Phillips, & Rudd, 1985).

Family research does not measure independent elements because of the level of complexity of the interactions and the fact that relationships among variables are not linear (Fisher, 1982). The data are not indicators from individual family members, but are derived from the functioning of the entire family unit (Feetham, 1991). Data collection of this type requires naturalistic observation and contingent, structured interaction (Bavelas, 1984; Fisher et al., 1985). This transactional view of the family suggests that research questions and designs must allow examination of sequences or patterns of family behaviours (Feetham, 1991).

Unfortunately, much of the empirical work done in the area lacks explicit theoretical or conceptual frameworks. This creates problems in evaluating the choice of instruments used in the studies and clouds interpretation of findings.

In summary, it is apparent that there is no one agreed upon conceptualization of the family. This is not feasible nor is it recommended. Rather, the operational definition of the family selected for the study and the procedures used to obtain the data must be congruent with the theoretical framework used to guide the research. In particular, research questions that address the family as a unit must be conceptually, procedurally and analytically appropriate to the aggregate (Gilliss, 1983).

Loyalty of Research Methods to Systems Theory

In the preceding section of the paper, the underlying principles of systems theory have been alluded to as an issue related to measurement of family phenomena. The importance of conceptual clarity as a basis for measurement decisions necessitates a more detailed examination of some of the underpinnings at the heart of family systems theory. As well, it is pertinent to question the match between the research paradigm used to study family phenomena and family systems theory.

The Logical-Positivistic tradition

The notion of "good science" that pervades the present day scientific community is nestled quite solidly and comfortably in the logical-positivistic tradition. "Since the seventeenth century, physics has been the shining example of an 'exact' science, and has served as the model for all other sciences"

(Capra, 1983, p. 42). This view began with the work of scholars such as Descartes and Newton who presented a mechanistic world view of scientific inquiry that emphasized objectivity, reductionistic principles and the belief that science deals in certainty (Becvar & Becvar, 1988). An assumption underlying this approach is a belief in ultimate causality (Steinglass, 1987).

Social scientists today have relaxed some of the rigidly held reductionistic views and accept that there may be multiple causes associated with a problem and claims of certainty have given way to statements of probability. Subjectivity itself, in the form of cognition and beliefs, is now a legitimate topic for systematic, controlled observation and study. However, the basic assumptions of this scientific paradigm remain, and the methodology still advocated involves hypothesis testing of a priori theories that purport to be accurate maps of the world (Becvar & Becvar, 1988).

During the first half of the twentieth century psychology was also dominated by mechanistic reductionistic theories of the stimulus-response variety. The advent of family therapy revealed the inadequacies of these theories. Those who treated families as nothing more than the sum of their individual members soon discovered that they were missing something (Nichols, 1984). Both the new physics and systems theory challenged fundamental assumptions in the logical-positivist, empirical science (Becvar & Becvar, 1988).

Family therapists also began to examine basic assumptions about causality. Initially, troubled families were treated as a collection of disturbed individuals. Later, families were viewed as mutually causative systems, whose complementary behaviour reinforces and perpetuates the nature of their interactions. A major theoretical shift occurred: from mechanical to systems theory with an associated shift from linear to circular causality (Nichols, 1984).

Systems theory

As early as 1928, Ludwig von Bertalanffy first introduced a systemic perspective to provide a basis for an "organismic" approach to biology (Steinglass, 1987). He claimed that understanding biological phenomena could be improved by examining processes that lead to the increasing complexity of organization. This theory has been widely applied as general systems theory to other fields, such as community health, engineering, computer science and family studies. Systems theory suggests a universe that constitutes one organism. In the purest sense of this perspective, we would not see parts or subsets of the whole (Becvar & Becvar, 1988). This view is captured in the deceptively simple axiom: "The whole is greater than the sum of its parts." Von Bertalanffy (1968) also believed that living organisms were essentially open systems, maintaining themselves with continuous

inputs from, and outputs to, the environment. He emphasized living systems as wholes, in contrast to previous analytic and summative approaches; he substituted a dynamic conception of life for previous static and machine analogies; and he attributed primary activity to living organisms, rather than primary reactivity. From a family perspective, this means that the family system is best understood as a product of its organizational characteristics, which implies a different view of causality and, therefore, of defining pathology. The focus becomes organizational patterns with attention to interactional behaviour, structural organization and balance or stability of the system as a whole. Thus, the key concepts introduced in systems theory are wholeness, organization and relationships (Steinglass, 1987).

The dilemma

Despite the popularity of the systemic perspective among many scholars today, the primary legitimate science remains a logical-positivistic one. The traditional quantitative reductionistic methods fall short of capturing the depth and wholeness that is represented in family systems theory. Nevertheless, the lures of simplicity, clarity and unidirectionality seem too appealing to abandon and have indeed produced valuable scientific knowledge. And family researchers represent a scientific group caught in the crossroads of two perspectives.

Arguments for continuing the practice of logical-positivistic research methods to study family systems concepts are based on a belief that it may be difficult to obtain support and credibility for family research that is not based on the traditionally accepted logical-positivistic method (Becvar & Becvar, 1988). Kniskern (1983) argues that the reductionistic perspective is most accepted and, therefore, empirical findings researched and presented in this tradition are more respectable and will, therefore, help to advance the field. To do so, however, may serve to reinforce this model and thus detract from the potential usefulness of helping society evolve another paradigm that might become the accepted view.

Kuhn (1970) suggests that the emergence of a new paradigm, such as the systemic perspective, implies the need for a method logically consistent with the paradigm. Gurman (1983) extends this requirement further by arguing that it is unethical to evaluate family therapy with a method that implies more certainty than is warranted. As well, the validity of such findings is suspect, given the mismatch between constructs and methods. Another "ethical imperative" might be to seek to be logically consistent within ourselves and our paradigm, and to let research methods evolve, be used, and be published even in the face of the inhospitable charges of our research as inferior.

The notion of objectivity characteristic of the logical-positivistic tradition is also inconsistent with systems theory (Becvar & Becvar, 1988). The whole

idea of a scientific experiment rests on the assumption that the observer can be separate from the experimental apparatus and that the experimental apparatus "tests" the theory (Briggs & Peat, 1984). In contrast, Becvar and Becvar (1988) argue that what we observe is a function of the means we use to measure the phenomena of interest and of our theories that suggest what might be "out there". According to Capra (1983), observer and observed influence each other and the activity of scientific study changes what is being measured. Subjectivity, or the values and biases of the researcher, can no longer be treated as error because the paradox is that we study ourselves (Becvar & Becvar, 1988).

An issue related to the scientific paradigm within which family research is conducted is the notion of *purpose*. In the traditional reductionistic view, the aim of knowledge is to control and predict. From a systemic perspective causality does not exist, therefore, control is not a logical outcome.

If one accepts the belief that the observer is the observed, and that reality is not a constant, absolute, static phenomenon waiting to be measured, then efforts to control and predict are futile. The outcome of this type of scientific inquiry is description. This outcome is no small feat. And despite the disclaimers in most "good" research that sample sizes are too small and that findings cannot be generalized, consumers of research read, internalize (to varying degrees) and "know" this information after incorporating it with their own values and world views. The clinician uses knowledge generated from research to help provide a probable context within which the individual family or client is understood. The error occurs when this empirically generated "general" understanding is accepted as complete. Therefore, even qualitative descriptive research is generalized, at least cognitively, by clinicians. And the claims of objectivity made by reductionistic scientists are likely untrue.

Reconciling two paradigms

How does the family research community reconcile the opposing perspectives of these two world views? Although the logical-positivistic tradition may at some future time evolve into a more systemic research paradigm, family science is in need of research and conceptual clarity today. To abandon the reductionistic method of inquiry appears unwise. It has produced some fruitful information and is *one* approach to knowledge. However, family researchers who use this paradigm must clarify the limitations of their work more explicitly and acknowledge that the phenomenon studied is not the way it was before it was studied. It is different by the very act of observation (Becvar & Becvar, 1988).

It is also practical and inevitable that family research will continue to include examination of parts. For this type of research a reductionistic

quantitative method appears less worrisome. For example, some data analytic tools, such as path analysis, may provide useful ways of examining non-recursive interactions among family parts (Alwin & Hauser, 1975; Godwin, 1985, 1986; Lehrer, 1986; Schumm, Southerly & Figley, 1980). The emphasis in this research should be on patterns of interaction, sequences of exchange, direct and indirect interaction effects and on understanding the functions of the relationships among variables.

Simulated laboratory techniques may be useful in allowing observation and measurement of family phenomena, however, their approximation to real life is questionable and issues of coder reliability are a concern (Gilliss, 1983). If attention is given to training raters and findings are not over-interpreted, then this work has merit as a source of theory development that may be tested later in natural settings.

Exploratory analysis (Ferketich & Verran, 1986; Verran & Ferketich, 1987) is also a tool that may be particularly applicable to the analysis of family data. Noting patterns of distributions of scores across family members is useful for detecting outliers and may help guide decisions about the appropriateness of sum or mean scores (Appelbaum & McCall, 1983).

As well, there is a need for further work with dyadic relationships in families, in particular, more knowledge is required about processes and interactions among siblings (Jacob & Tennenbaum, 1988). For this type of study, "partial" quantitative methods hold merit. The use of different quantitative statistical methods may be a fruitful way of understanding complex family phenomena. For example, Schumm et al. (1985) describe the use of multivariate multiple regression, typological analysis and repeated measures designs as ways of capturing complexities of family data. At this time, however, for the reductionistic data analytic approaches, the elusive "whole" still remains a measurement enigma.

Depending on the research purpose, the place of qualitative inquiry methods may be more appropriate and consistent with systemic principles. Lewis (1950) advocated living-in with families as a means of providing structure and access to meanings. Kristjanson (1986) used qualitative interviews to identify health professional behaviours important to families of terminally-ill cancer patients. This work was later used to develop a tool to measure family satisfaction with advanced cancer care (Kristjanson, 1989; in press). Participant observation was also used by Hansen (1981) and Henry (1973) to observe family patterns with normal and mentally-ill families. Steinglass,Davis and Beerenson (1977) studied alcoholics and their family members in a laboratory setting. The patient and family members were hospitalized and the patient was permitted to become intoxicated. This work resulted in insight into the relationship between drinking behaviour and fam-

ily interaction. Haley (1962) pointed out that, in contrast to experiments with individuals in which the interpersonal factor is controlled, family experiments seek to measure that interpersonal factor. From these qualitative works emerge theoretical formulations that can be tested experimentally.

Although the qualitative methods have enjoyed a long and rich tradition in sociology and anthropology (Duffy, 1987), these methods are frequently criticized by other disciplines for not meeting standards of scientific adequacy.

One reason for reservations about qualitative research arises from the persistent tendency to evaluate those methods against criteria that are appropriate to quantitative research. Morgan (1983) argues that applying the criteria of one research tradition to another is nothing more than self-justification, because these criteria inevitably favour the research tradition that generated them. A number of scholars have proposed criteria of rigor more appropriate to evaluation of qualitative research (Aamodt, 1983; Cobb & Hagemaster, 1987; Glaser & Strauss, 1966; Guba & Lincoln, 1981). These include credibility of the findings, applicability, consistency and confirmability (Sandelowski, 1986). As well, specific strategies have been developed to address these criteria, such as use of an "audit trail" or triangulation of data sources.

The qualitative approaches to research are more consistent with family research and are worthy of further attention. This work can be fundamental to theory building, as constructs relevant to family research are identified and described.

According to Bednar et al. (1988), the success of any method of inquiry is directly related to the clarity with which the central conceptual elements in the field are defined and measured. These authors recommend a five-step process to scientific maturation: punctilious observation (which can range from the informal methods that often precede creative hunches, to structured case-study methods, to the observational techniques of qualitative inquiry, to the rigorous quantification of theoretical constructs); development of descriptive taxonomies that define, describe, differentiate and order crucial variables; refinement in the measurement of central variables; establishment of empirical relationships between and among the variables; and finally, development of theories based on empirical data.

A number of other authors agree that description and measurement are prerequisites to rigorous experimentation (Cook & Campbell, 1979; Shontz & Rosenak, 1985). Bednar et al. (1988) argue that the research efforts of family studies are out of harmony with what would normally be expected from such a young discipline, and they have moved too quickly to experimental studies

examining relationships among variables in the field. They suggest that family research is in desperate need of more fundamental descriptive information before proceeding with this more advanced undertaking.

Some would argue that the traditional positivistic (quantitative) method and the qualitative methods are two irreconcilable opposites. For the purposes of conceptual clarity and analysis, this discussion has polarized these world views. However, as Gould (1984, p. 7) states: "Dichotomy is the usual pathway to vulgarization. We take a complex set of arguments and divide it into two polarized positions - them against us. We then portray 'them' as foolish caricature of extremes in order to put 'us' in a better light." The issue is not which method is "correct" but that each contributes a portion of the truth and that one may be more useful than the other in guiding human affairs (Harman, 1977).

Given that reductionistic, quantitative methods will produce data that are incomplete and do not capture the density and complexity of family systems theory, it appears that some discord is inevitable. As well, qualitative methods of research may be helpful in revealing properties and processes related to the family as a unit and may elucidate important theoretical constructs and contextual variables.

Conclusion

Conceptual and methodological problems are intertwined in current family research. Greater conceptual refinement will help sharpen some of the blurring of family dimensions and will permit more precise measurement decisions. At a higher conceptual level, attention to the research paradigm most appropriate to the research question and constructs of interest is warranted. The place for qualitative research must be recognized.

However, it would be inaccurate to assume that qualitative research can replace quantitative knowing. Quantitative researches have to trust and build upon qualitative knowledge with the aim of achieving an integrated epistemology. This integration does not imply a blur of methods that are indistinct and unrecognizable. Rather, researchers must be systematic and precise about the level of the research questions addressed, the focus of inquiry (individuals, subunits, family), and the research method that will provide the most conceptually valid and meaningful results.

In summary, approaches to measurement issues associated with family research should include the following.

1. Use of more qualitative methods to delineate family constructs and capture the "whole" more accurately.

2. Qualifiers associated with reductionistic research that specify the effects of the observer on the phenomena and the uncertainty of the findings (Becvar & Becvar, 1988)

3. Clarity in conceptualizing which parts (or wholes) of the family are studied in an effort to match methods with conceptualizations.

4. Acknowledgement of the gap that exists between data generated from a logical-positivistic method and family systems theory.

5. Development of innovative ways to combine methods of inquiry to more completely access family systems constructs.

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RÉSUMÉ

Concepts de mesure en recherche sur la famille

Le présent document constitue une analyse des questions conceptuelles clés relatives à la notion de mesures dans le domaine de la recherche sur la famille et présente des recommandations sur la façon d'envisager ces problèmes. On y traite notamment : a) de la mesure de l'unité familiale, b) de la précision des définitions familiales, c) des problèmes de validité conceptuelle, d) de la pertinence des principes de la théorie des systèmes familiaux par rapport à la recherche positiviste logique traditionnelle et e) de l'apport relatif des méthodes de recherche qualitative et quantitative. On y souligne les points forts et les points faibles des méthodes de mesure spécifiques.

L'auteur prône un plus grand raffinement des concepts, afin d'apporter un éclaircissement aux dimensions des familles visées par les recherches et de permettre de prendre des décisions plus réfléchies et plus précises quant à ces mesures. A un niveau conceptuel supérieur, tenir compte du modèle de recherche le mieux approprié à la question expérimentale est justifié.

PRECEPTOR SELECTION CRITERIA IN CANADIAN BASIC BACCALAUREATE SCHOOLS OF NURSING - A SURVEY

Florence Myrick and Celeste Barrett

In 1982, a resolution that the baccalaureate degree become the minimal educational preparation for entry into the nursing profession by the year 2000 was endorsed by the Canadian Nurses' Association (CNA). This endorsement presents significant ramifications for the nursing profession in this country and in particular for nursing education. Conceivably, within the next 10 years, university nursing faculty may acquire the exclusive role of preparing registered nurses in Canada. Presently, it is acknowledged that existing university programs do not possess the resources with which to adequately accommodate the anticipated increased enrollments that would be precipitated by the realization of this resolution (CNA, 1982; French, 1984). Faculty in university schools of nursing continue to be faced with the dilemma of new graduates feeling inadequately prepared for the practice setting (Myrick, 1988; Shamian & Inhaber, 1985). Escalation of the student-faculty ratio will generate an even greater strain on clinical teaching. In light of these developments, the onus is on nursing education to examine alternative clinical teaching strategies that will assist in dealing with these difficulties. One strategy being advocated is preceptorship.

Preceptorship may be defined as "an individualized teaching/learning method in which each student is assigned to a particular preceptor...so she can experience day-to-day practice with a role model and resource person immediately available within the clinical setting" (Chickerella & Lutz, 1981, p. 107).

Review of the Literature

Traditionally, the major responsibility for clinical teaching of nursing students has been maintained directly under the auspices of nursing education (Limon, Spencer & Walters, 1981). The professional growth and development of the student has been guided directly by the clinical instructor who has been a member of the nursing faculty. In this method of clinical teach-

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ing, the faculty-student ratio varies between ten and fifteen students per instructor (Registered Nurses Association Ontario, 1982; Stuart-Siddell, 1983). Unlike this traditional approach, preceptorship is an individualized teaching-learning method in which each student is assigned to a specific preceptor who is usually selected from among hospital staff nurses (Chickerella & Lutz; Myrick, 1988; Shamian & Inhaber, 1985).

Since the 1960's, preceptorship has been used increasingly as a clinical teaching method by many nurse educators. Specifically, in Canada and in the United States, faculty in university schools of nursing are utilizing preceptorship for the clinical teaching of their nursing students. In 1975, in the United States, a total of 58 preceptorships were reported for nursing students (Spears, 1986). By 1985, that number had escalated to 109 in generic programs with faculty in diploma and associate degree programs also reporting the use of preceptorship experiences for their students (Spears, 1986).

A variety of studies have been conducted on the use of preceptorship in nursing education. These studies have focused primarily on the effects of preceptorship on the clinical competency and self-perception of the preceptee. Huber (1981) examined the impact of preceptorship on graduate nurse performance and found that preceptorship did not significantly contribute to their clinical performance. Olson, Gresley and Heater (1984) completed an investigation to determine the effect of preceptorship on student self-concept and self-perception vis a vis clinical competence and found no significant differences in those students who had been preceptored. A further study by Shamian and Lemieux (1984) evaluated two teaching methods - the preceptor teaching model and the formal teaching model. Results of this study revealed that the preceptorship model, when compared to the formal or traditional method, produced superior results in the areas of knowledge attainment, assessment skills and educational program attendance. Unlike the previous studies, this study used a heterogenous sample of registered nurses and nursing assistants. In 1988, Myrick reported a study in which she examined the effect of preceptorship on the clinical competency of fourth year basic baccalaureate nursing students. The findings of this study indicated that there was no significant difference in the clinical competency of the preceptored and non-preceptored students.

It has been acknowledged in the literature that the role of the clinical preceptor is a crucial one (Chickerella & Lutz, 1981; Crancer, Fournier & Maury-Hess, 1975; Huber, 1981; Limon, Bargagliotti & Spencer, 1982; Scheetz, 1989). The staff nurse who assumes this role acts as resource person and role model, as well as teacher, counsellor and evaluator to the preceptee or student nurse. Although the literature is replete with articles concerning preceptorship and research regarding the impact of preceptorship on student self-perception and performance, to date, no research exists that addresses

preceptor selection criteria. If the role of the clinical preceptor is as crucial as is purported, then surely specific selection criteria are critical to the preceptorship process. Yet could the absence of such research in this area suggest otherwise? Ultimately, lack of such criteria may have an impact upon preceptee clinical competency and self-perception. Given the inconsistencies already evident in the literature related to the use of preceptorship for clinical teaching and, in light of the absence of research regarding preceptor selection criteria, this study is timely.

Conceptual Framework

The Dreyfus Model of Skill Acquisition has been applied to nursing by Benner (1984) and provides a useful method for understanding clinical performance. In applying this model to nursing, Benner considers advancement in skilled performance, based upon experience as well as education, clinical knowledge development and career progression in clinical nursing. Benner's application of the Dreyfus Model, *From Novice to Expert*, is used as the framework for this study.

During the process of acquiring and developing a skill, a nurse progresses through five levels of proficiency. These include: "novice, advanced beginner, competent, proficient and expert" (Benner, 1984, p. 14). These different levels represent changes in three general areas of nursing performance: progression from a dependence on abstract theory to the use of previous actual experience as a framework; advancement by the student from perceiving a situation as a fragmented whole to viewing the situation in its entirety in which only certain factors are relevent; and transition from observer to performer. Through the utilization of Benner's model, it is possible to describe the performance characteristics of each level of the nurse's development and to identify, in general terms, the teaching and learning needs specific to each level. In accordance with this framework, the nursing students or preceptees may be classified at the level of novice, advanced beginner, competent or proficient while the clinical preceptor would be categorized as expert. At the expert level, the performer does not depend on an analytical rule to comprehend the situation (Benner, 1982, 1984). Based on a vast background of experience, the expert nurse has acquired an instinctive understanding of the situation that permits her or him to disregard unnecessary components and focus directly on the problem situation. The expert functions from a deep understanding of the total situation.

Purpose

The purpose of this study was to determine the presence of selection criteria for clinical preceptors in Canadian baccalaureate schools of nursing, and, the commonalities and discrepancies that exist regarding those criteria.

Research Questions

1. Are there any structured preceptorship programs presently in existence in Canadian basic baccalaureate schools of nursing? If so, what factors influence the decision to select preceptors and in what practice settings are they utilized?
2. What are the criteria used to select clinical preceptors in these programs?
3. Are there commonalities and discrepancies in the structured preceptorship programs?
4. What are the criteria used to evaluate the performance of clinical preceptors?

Definition of terms

Structured programs: The delineation of specific expectations concerning the function of preceptorship and the roles of clinical preceptor and preceptee.

Preceptorship: An individualized teaching and learning strategy. The baccalaureate student nurse is assigned to one specific preceptor for a specified period of time in the clinical setting so that she or he can experience the day-to-day practice with a resource person immediately available within the clinical setting (Chickerella & Lutz, 1981).

Clinical preceptor: A registered nurse who is knowledgeable in her or his particular clinical area (Gardiner & Martin, 1985). She or he is a staff nurse who assumes the responsibility for teaching, counselling, acting as role model and resource person and supporting the growth and development of a baccalaureate student in her or his designated clinical experience.

Preceptee: A basic baccalaureate student nurse who is involved in clinical practice. She or he is responsible for providing professional nursing care to assigned clients under the supervision of an experienced and prepared registered nurse preceptor.

Instrument

The instrument used in this study is a questionnaire entitled, *Survey of Preceptor Selection Criteria in Canadian Basic Baccalaureate Nursing Programs*. It is a self-administered, three-part questionnaire requiring approximately 20 minutes for completion.

Part A, entitled "General Information" is composed of ten questions. These consist of nine forced-choice and one open ended question. Based on a

thorough review of the literature together with previous nursing education experience and knowledge, these questions were developed by the researchers. Part B, entitled "Specific Criteria", is composed of eight questions numbered from 11 to 19. This section consists of factors specific to the selection of clinical preceptors in basic programs in Canadian university schools of nursing. Seven forced-choice and one rank order question are included in this section. These questions were developed by the researchers. Part C, entitled "Evaluation", was designed by the researchers. It requests data concerning the evaluation process related to the performance appraisals of the clinical preceptors.

To achieve content validity, a "panel of experts" reviewed the questionnaire to ascertain if the items represented adequately the possible range of topics to be included in the selection criteria for clinical preceptors. This panel of experts comprised three faculty from a university school of nursing and the coordinator of a preceptorship program in a university teaching hospital. Ambiguous questions were reworded. The question concerned with selection criteria was expanded from 14 items to 15 items. This expansion included "effective conflict management skills". The question referring to the clinical areas in which preceptors are used was expanded from six items to eight items. This expansion included "care of the child" and "community health care".

In order to assess the instrument's stability, reliability was determined by subjecting the questionnaire to pre-testing. Prior to the onset of the study, three nurse educators with experience in the use of clinical preceptors, pretested the instrument entitled "Survey of Preceptor Selection Criteria". These participants were not included in the actual survey. The participants completed the pre-test questionnaire in early March, 1990 and three weeks later they completed the post-test. A Spearman rank-order correlation was obtained for the preceptorship data at $r = .66$.

Method

This survey study employed an exploratory, descriptive design using qualitative and quantitative data. Sieber (1973) states that quantitative and qualitative data from the same organization can be used in combination to provide more powerful analyses than can be acquired from either single approach. This method may disclose unique sources of variation that otherwise may not be obtainable.

The study was designed to examine the criteria used in the selection of candidates for the role of clinical preceptor in Canadian baccalaureate schools of nursing. A mailed survey was used because of its cost effectiveness and time-saving advantages, accessibility to the subjects within the

selected setting and because of its usefulness for qualitative and quantitative data analysis (Dillman, 1978).

Sample

The sample for this study consisted of 25 out of the 31 basic baccalaureate nursing programs in Canada. Eligibility for participation in this study was based on the existence of preceptorship programs in their respective schools of nursing and the willingness of the Deans and Directors to participate.

Procedure

Written correspondence was forwarded to the Directors and Deans of 25 Canadian baccalaureate schools of nursing to obtain their consent to participate in this study and to arrange for the distribution of the questionnaire to the appropriate faculty. A proposal of the study was also included to explain the purpose of the study.

Once consent was obtained, questionnaires and a cover letter were prepared with self-addressed stamped envelopes. Each envelope was coded according to the name of the university, in order to insure follow-up. A research assistant, independent from the study, opened the envelopes so that the universities were not indentified by the investigators. As a reminder of the deadline date for the study, a follow-up letter was sent at a one month interval following the initial mailing of questionnaires to the participating university schools of nursing. The Directors or Deans were requested either to complete and return their questionnaires in the self-addressed stamped envelopes provided or to direct the questionnaires for completion to those faculty involved in the use of preceptorship. Results of the study have been made available to all participants.

Results

To date, there is a total of 31 Canadian university schools of nursing in which both basic and post-RN programs are offered (CNA, 1988). The one basic baccalaureate school of nursing that participated in the pre- and post-testing of the questionnaire was excluded. Twenty-five Canadian baccalaureate schools of nursing received instruments. Of this number, 20 (80%) returned completed questionnaires. Three incomplete questionnaires were returned because these schools administer post-RN programmes only and therefore did not qualify for participation in this study. Two schools did not return the quesionnaire. One of the returned questionnaires was completed by a school of nursing with a post-RN programme only and the data were included in this study because this school had indicated that they had interpreted basic to mean post-RN.

Research Question 1

Are there any structured preceptorship programs presently in existence in Canadian baccalaureate basic schools of nursing? If so, what factors influence the decision to select clinical preceptors and in what practice settings are they utilized?

Currently, of the 20 Canadian basic baccalaureate schools of nursing that participated in this study, 70% (n=14) indicated that they employ clinical preceptors for the teaching of their students in the practice setting. Factors that are identified as directly influencing their decision to use clinical preceptors are outlined in Table 1.

Table 1

Factors Influencing The Decision To Select Clinical Preceptors (N=20)

Factor	(n)	%
Congruent with faculty philosophy	9	45%
Lack of nursing faculty for clinical teaching	8	40%
Congruent with agency policy	4	20%
Availability of qualified preceptors	3	15%
Other	3	15%

Reasons cited in the category "other" include: "preceptorship is perceived to be an ideal teaching strategy with which to assist students in the process of synthesis in the clinical setting", 5% (n=1); "preceptorship is reported to provide an enriched experience for students especially those in year IV", 5% (n=1); and 5% (n=1) indicate that "preceptorship enables the use of clinical placements that would be otherwise unavailable due to distance and that the preceptors are the experts in practice." Of the 20% (n=4) that indicate that they do not use clinical preceptors, 15% (n=3) report their reason to be related to the "unavailability of qualified preceptors" and 5% (n=1) state that such a program would be "incongruent with faculty philosophy".

Of these existing structured preceptorship programs, 65% (n=13) of the respondents report using preceptorships in Year IV; 45% (n=9) in Year III; 5% (n=1) in Year II; and 5% (n=1) in Year I. Time allotted for the use of preceptors in clinical teaching is reported by the Deans or Directors to be on average 211.38 hours S.D.(178.6) annually.

Specific practice areas in which clinical preceptors are used are presented in Table 2.

Table 2

Utilization of Clinical Preceptors in Practice Settings, (N=20)

Practice settings	(n)	%
Care of the Adult	12	60%
Care of the Child	11	55%
Community Health Care	11	55%
Care of the Newborn	9	45%
Care of the New Mother	9	45%
Care of the Elderly	8	40%
Mental Health Care	8	40%
Other	6	30%
Care of the Family	5	25%

Areas indicated in the "other" category include: all clinical areas in the hospital setting inclusive of, ICU 15% (n=3); northern medical services settings, 5% (n=1); long-term care/rehabilitation/palliative care, 5% (n=1); and area of choice selected by student, 5% (n=1).

Research Question 2

What are the criteria used to select preceptors in these programs? Forty-five percent (n=9) defined specific criteria for the selection of their clinical preceptors.

Fifteen percent (n=3) did not define specific criteria and 15% (n=3) were in the planning phase about the development of selection criteria. When questioned about who is responsible for defining the selection criteria for clinical preceptors, 35% (n=7) indicated that it is carried out collaboratively between the school of nursing and the agency and 20% (n=4) by the faculty of the school of nursing only.

The minimal educational qualifications for clinical preceptor selection are reported as: baccalaureate degree in nursing 40% (n=8); diploma in nursing 30% (n=6); baccalaureate in nursing preferred but diploma prepared RN's with excellent clinical experience, skill and decision-making abilities, 5% (n=1). The minimal clinical nursing practice experience required of clinical preceptors is: two years, 30% (n=6); one year, 10% (n=2); three to five years, 10% (n=2). Of the 20% (n=4) who indicate the category "other", the following were identified: "recommendation of supervisor or agency carries

more weight than length of experience", 5% (n=1); "do not identify as agency selects preceptors", 5% (n=1); "not specifically indicated", 5% (n=1); and length of experience preferred is one year, which is not always possible in certain areas. However, priority is given to knowledge and skills, 5% (n=1). Minimal clinical teaching experience required of clinical preceptors are that no experience is necessary 65% (n=13) or are not identified because preceptors are selected by agency 5% (n=1). Forty percent (n=8) agree that their preceptor selection criteria are clearly defined while 30% (n=6) do not agree. Thirty percent (n=6) of the respondents always use preceptor selection criteria; and 30% (n=6) do not use the criteria. The criteria used to select clinical preceptors are outlined in Table 3.

Table 3

Median Rank Scores For Criteria Used To Select Clinical Preceptors, (N=20)

Criteria	Median rank scores
Clinical Competence	1.0
Commitment to the Preceptor Role	2.0
Effective Communication Skills	3.0
Skilled Use of the Nursing Process	4.0
Professional Conduct	4.0
Other	6.0
Active Involvement in Own Professional Development	6.5
Ability to Complete Performance Evaluation	7.0
Ability to deal with Conflict	7.0
Knowlege in the use of Nursing Research in Clinical Practice	8.0

Those who responded to the "other" category identified the following additional criteria: availability, 5% (n=1); ability to teach others, 5% (n=1). Forty percent (n=8) indicated that they specifically matched the preceptor with the preceptee and 35% (n=7) stated that they did not match. Of the 40% (n=8) who did match, 15% (n=3) matched on personality, 5% (n=1) matched on age and 35% (n=7) matched on: student preference, 5% (n=1), learning needs of students, 25% (n=5) and experience as preceptor, 5% (n=1).

Research Question 3

Are there commonalities and discrepancies in the structured preceptorship programs?

Sixty-five percent (n=13) of the schools reported that they provide an orientation for clinical preceptors, while only 10% (n=2) do not. Of those who do provide orientation, 70% (n=14) stated that the faculty of the school of nursing provides the orientation. Fifteen percent (n=3) who answered "other" indicated that the orientation is provided through a collaborative effort among community college, university or agency. Five percent (n=1) stated that the hospital participates only if the clinical area is new to the preceptor. Five percent (n=1) indicated that the head nurse, who holds a joint appointment with the school of nursing, works together with faculty to develop an orientation and to monitor the course and student performance. Ten percent (n=2) stated that the head nurse at the agency provides the orientation. The common content areas included in the orientation of clinical preceptors are presented in Table 4.

Table 4

Orientation Content for Clinical Preceptors, (N=20)

Orientation content	(n)	%
General orientation to the program	11	55%
Student performance evaluation methods	11	55%
Clinical teaching strategies	10	50%
Objectives of the basic baccalaureate program	9	45%
Instructor accountability	9	45%
Philosophy of the basic baccalaureate program	8	40%
Other	7	35%
Conflict management	5	25%
Principles of adult learning	4	20%
Principles of communication	4	20%

Research Question 4

What are the criteria used to evaluate the performance of clinical preceptors?

Only 30% (n=6) stated that they completed a performance evaluation on the clinical preceptors. Of those, 10% (n=2) indicated that the head nurse and the preceptee completed the evaluation. University faculty and the preceptee carried out the evaluation in 10% (n=2). The evaluation was completed by the university faculty only in 10% (n=2); and 10% (n=2) stated that the preceptee only completed the evaluation. Thirty-five percent (n=7) indicated that they did not complete a performance evaluation, while 10% (n=2) stated that they were uncertain. The 30% (n=6) who completed the performance evaluation on the clinical preceptors included the evaluation criteria outlined in Table 5.

Table 5

Criteria Used To Evaluate The Performance Of Clinical Preceptors, (N=20)

Criteria	(n)	%
Interpersonal communication skills	7	35%
Clinical competence	6	30%
Commitment to preceptor role	6	30%
Selection of appropriate clinical assignments for the level of the learner	5	25%
Evaluation skills	4	20%
Skilled use of the Nursing Process	4	20%
Ability to deal with conflict	2	10%
Use of nursing research in clinical practice	1	5%
Other	1	4%

Those who answer "other" indicate areas of strength, areas of improvement and suggestions for improvement. The 35% (n=7) who indicated that they do not complete performance evaluation on the clinical preceptors, cited the following: lack of adequate time and lack of an appropriate evaluation tool, 20% (n=4). Other reasons included by 15% (n=3) are: informal evaluations completed by 10% (n=2), and 5% (n=1) stated that, because of the limited number of available qualified preceptors, they are unable to reject applicants and therefore have not developed formal evaluation criteria.

Discussion and Implications

While the results of this study indicate that clinical preceptors are utilized in 70% of Canadian university schools of nursing surveyed, 45% actually define specific criteria for the selection of their clinical preceptors. Of that number, only 30% always use those criteria when selecting the preceptors. The lack of selection criteria evident in 55% of those schools using clinical preceptors may be related to the fact that there are insufficient qualified preceptors available in the practice setting who actually meet such criteria. Under these circumstances, it may be counter-productive for those schools to delineate specific criteria when such criteria could not be met. The lack of criteria may also be related to the low priority designated to clinical teaching in the university setting (Karuhije, 1986). In light of the already onerous workloads of university nursing faculty, it may also be a reflection of the shortage of time that faculty have in which to develop and implement such criteria (Myrick, 1988). Such criteria may also be seen to be irrelevant because of the perception that the staff nurse possesses the clinical expertise and is an appropriate role model and teacher in the practice setting. Benner (1984) states that expertise results from the process of experiencing different clinical situations. Moreover, the expert is one who possesses a profound understanding of clinical situations vis-à-vis the complexities and realities that only experience can provide. Of interest is the fact that 40% of the respondents state that their reason for using preceptors results from the lack of nursing faculty who are available for clinical teaching. Despite the fact that only 15% indicate that qualified preceptors are available, clinical preceptors are employed because it is consistent with the philosophies of the nursing faculty and the agency. The academic must rely on the practitioner for clinical knowledge development and the determination of questions that theorizing does not necessarily address (Benner, 1984). The unavailability of nursing faculty for clinical teaching may be related to: emphasis of the university infrastructure on scholarly activities and the low priority afforded clinical teaching; increased and complex workloads of university nursing faculty; and, lack of clinical practice of the faculty themselves.

Sixty-five percent of those schools using clinical preceptors do not require previous teaching experience. According to Benner and Benner (1979), nursing service professionals demonstrate lower ideal expectations of new nurses than do nurse educators. Can this not result in ambiguity and role confusion on the part of the student? While orientation is provided to the clinical preceptors in 65% of the schools, prinicples of adult learning are included by only 20%. Interestingly, principles of effective communication are also included by only 20%. This may be related to the fact that registered nurses are generally regarded as effectual communicators. According to Benner and Benner (1979), all too frequently, the expert's difficulty in accurately communicating all that they know is misunderstood by the beginner. One may

speculate that if the expert is provided with principles of adult learning theory, would this not improve or facilitate their communication of that knowledge?

Performance evaluation of the clinical preceptors is completed in only 30% of those schools that use preceptorship. There is considerable disparity in these schools about who actually completes such evaluations. Moreover, it seems that there is no formal evaluative mechanism for feedback on the clinical teaching performance of the preceptors, despite the fact that minimal teaching experience is required. Given the fact that these preceptors are increasingly becoming more and more directly responsible for preparing the future practitioners of the nursing profession, one would assume that the evaluation of such a role would be of major priority to nursing faculty.

In ranking the factors that influence the selection of clinical preceptors, clinical competence ranks the highest while commitment to the role of preceptor is second highest. Knowledge of the use of nursing research in the clinical setting ranks the lowest. It is widely accepted in the nursing profession that research is considered to be the basis for the generation of scientific knowledge and the promotion of the profession as a research based discipline (Burns & Grove, 1987). Therefore, it is indeed surprising that knowledge in the use of research in clinical practice does not receive a higher ranking by the university programs that participated in this study.

Limitations

1. The instrument was new and when pre-tested resulted in a low Spearman Rank Correlation Coefficient. This has implications for the reliability of the instrument.
2. Several questions in the questionnaire were not answered. This may be attributed to the ambuiguity of those questions.
3. The survey was limited to the basic baccalaureate nursing programs. No attempt was made to include post-RN programs.
4. One school interpreted basic to mean post-RN which may indicate that the definition of "basic" is not clearly delineated.

Conclusions and Recommendations

The majority of Canadian baccalaureate schools of nursing have indicated that they use clinical preceptors or are in the process of implementing the use of such a method for the clinical teaching of their students. However, only a small percentage (45%) actually define specific criteria for the selection of their preceptors and 30% of those schools that use preceptorship complete a performance evaluation of their clinical preceptors, despite the fact than many (65%) do not require any previous clinical teaching experience.

Twenty percent of the respondents stating that they do not evaluate their clinical preceptors do not do so because of the non-existence of an appropriate evaluation tool, as well as lack of time. Factors that influence the selection of clinical preceptors include: clinical competence, which ranked as highest; commitment to the preceptor role, ranked second highest; and knowledge of nursing research in clinical practice ranked the lowest.

In light of the findings in this study, the authors recommend that an evaluation tool for the performance appraisal of clinical preceptors be developed and that additional emphasis be placed on the clinical teaching ability of clinical preceptors. Consistent use of specific criteria should be promoted when selecting clinical preceptors, especially to counteract the "warm body" syndrome. It is also recommended that a follow-up study be conducted after two years to determine the percentage of Canadian baccalaureate schools of nursing in which specific criteria are used in the selection of clinical preceptors.

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RÉSUMÉ

Critères de sélection des conseillers cliniques dans les écoles canadiennes de sciences infirmières

Ce sondage vise à examiner les critères utilisés actuellement dans la sélection des candidats au rôle de conseiller clinique dans les écoles canadiennes de sciences infirmières qui offrent le baccalauréat. Le sondage effectué par courrier comprenait des données qualitatives et quantitatives, dans un concept descriptif et prospectif. Vingt-cinq des 31 écoles canadiennes de sciences infirmières qui offrent le baccalauréat ont été visées par le sondage. Le taux de réponse a été de 80% (N=20). On a effectué une analyse des données en se servant des fréquences, des pourcentages et du coefficient de corrélation des rangs de Spearman. Les observations découlant de l'étude indiquent que 70% des écoles universitaires canadiennes de sciences infirmières qui ont répondu au sondage se prévalent des services de conseillers cliniques. Parmi elles, 45% ont effectivement des critères spécifiques de sélection. Parmi les facteurs qui influencent le choix des conseillers cliniques, mentionnons la compétence clinique qui est le critère le plus important, l'engagement du candidat dans ses fonctions de conseiller vient en deuxième lieu et au dernier rang, l'aptitude à appliquer les recherches en sciences infirmières à l'exercice clinique. La période allouée à l'utilisation des conseillers dans l'enseignement clinique est d'en moyenne 211,28 heures (écart-type) (178,6). Nous traitons de ces conséquences dans l'enseignement des sciences infirmières.

LIFE ON HOLD: THE EXPERIENCE OF THE SUPPORT PERSON INVOLVED IN A LUNG TRANSPLANT PROGRAM

Marcy E. Saxe-Braithwaite and Jacqueline S. Chapman

Lung transplantation, which includes heart-lung, single lung and double lung, has been available as a therapeutic option for some patients afflicted with end stage irreversible pulmonary disease for only a short period of time (Griffith & Zenati, 1990; Morrison, Maurer & Grossman, 1990).

One centre which offers lung transplantation has developed an intensive pre-operative assessment that applies stringent patient selection criteria. One of these requirements is the identification of a support person who is willing to accompany and commit him- or herself to the potential transplant candidate 24 hours per day for an indeterminate period. Because the transplant candidates are often disabled to a significant degree, this support person is mandatory. In most cases, the support person is a family member, but, any individual who has the trust of the patient and is prepared to fulfil the necessary commitment is eligible. The identification and selection of such a support person is unique and not known to be mandatory in other health care programs.

The investigators explored the family and transplantation literature to see what previous investigations had been carried out vis-à-vis the role of the support person in transplantation. While there is considerable evidence in the literature regarding the social and psychological impact of cardiac and cardiopulmonary transplantation on the recipients themselves (Cardin & Clark, 1985; Covner & Shinn, 1983; Hyler, Corley & McMahon, 1985; Lahde, 1981; Lough, Lindsey, Shinn & Stotts, 1985; McAleer, Copeland, Fuller & Copeland, 1985; O'Brien, 1985; Santamaria & Smith, 1985; Shinn, 1984), if the family members of these recipients are mentioned, it is only in passing (Covner & Shinn, 1983; Hyler et al., 1985; Lough et al., 1985; McAleer et al., 1985; O'Brien, 1985; Santamaria & Smith, 1985; Shinn, 1984). The one exception is the study by Mishel and Murdaugh (1987) study of family adjustment to heart transplantation. This study explored the processes used

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by the family members to manage the unpredictability elicited by the need for and receipt of a heart transplant. "Redesigning the dream" was the main theme that described how family members gradually modified their beliefs about organ transplantation, and developed attitudes and beliefs to live with the continual unpredictability that they encountered.

The existing literature on lung transplantation describes mostly the surgical technique, patient selection criteria, pulmonary donors, and postoperative complications (Bonser & Jamieson, 1990; Boychuk & Patterson, 1988; Cooper, 1986; deLeval et al., 1991; Egan & Cooper, 1990; Emery et al., 1991; Gluckman & Cooper, 1987; Griffith & Zenati, 1990; Mauer, 1990; Morrison et al., 1990; Nelems et al., 1980; Novick et al., 1991; Patterson, 1990; Patterson et al., 1991; SerVaas, 1985; The Toronto Lung Transplant Group 1985, 1986, 1987; Todd, 1990; Veith, 1978; Williams, Grossman & Maurer, 1990).

The literature alluded to the importance of a supportive network in other populations such as with cardiac and liver transplant recipients (Craven, Bright & Lougheed-Dear, 1990) but no research has examined the effect of the transplant process on a support person in a lung transplant program. Because of this gap in the literature, we addressed the following question:

"What is the experience of the support person involved in a lung transplant program?"

Method

Design

The grounded theory method which involves simultaneous collection, coding, and analysis of data (Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990) was selected for this study. Grounded theory allowed the study of complex areas of behaviour where salient variables had not been identified (Stern, 1980) and discover basic social processes as the subjects experience them, rather than have the investigators assume what is occurring. Therefore the subject is the expert and the theory is inductively derived from the interview data.

Sample

During the time of data collection there were ten possible candidates awaiting a lung transplant. Only five of the ten subjects approached by the clinical nurse specialist of the transplant team, who assisted in subject procurement, met the selection criteria; i.e., they spoke and understood English, were available to be interviewed weekly and bimonthly, and were interested in participating in a research study. Of the five subjects who did not meet the

selection criteria, two were unavailable for weekly or bimonthly interviews, one did not speak English very well, one was a paid homemaker obliged to accompany her employer to the transplant program and the last support person did not wish to be involved in a research study. Of the five subjects who did agree to participate, all were provided with an explanation of the study and signed a consent form. No one withdrew from the study. In the group of five, there was one mother, one son, one husband and two wives. Their ages ranged from 22-73. Prior to accepting the commitment to be a support person each subject had a life of his or her own. Three were employed full time and had to leave their jobs. Once was a university student who requested an extended leave of absence. The last was a full time mother since giving birth to a high-risk infant. Among the five subjects, three had permanent homes in another city and had to relocate. During the four-month period of data collection, two of the transplant candidates received lung transplants; one a single lung, the other a double lung transplant. Therefore their support persons' data contained both prospective and retrospective perspectives. However, one limitation of this study was that the sample was able to be interviewed only as long as the patient was hospitalized or undergoing the rehabilitative phase of the program because the majority lived in other cities. Another limitation of this study is that the ideas generated from this small sample can only be restricted to support persons in this transplant program.

The Grounded Theory method

In keeping with the grounded theory method, empirical data were collected by one of the two investigators, through unstructured informal interviews and participant observation. This involved one investigator's daily on-site interactions with the subjects as well as attendance at the weekly support group meetings for patients and their support persons.

Over a four-month period of data collection, 34 private interviews were held, with each support person being interviewed a minimum of six and a maximum of nine times. The interviews were conducted weekly or every other week, depending on the support person's schedule. Duration of the tape recorded interviews was usually 30-45 minutes.

In keeping with the process of constant comparative analysis (Glaser 1978, Glaser & Strauss, 1967; Strauss, 1987) data from each interview, observation and interaction were transcribed verbatim analyzed line by line, coded (usually by each word or phrase), and compared to excerpts from previous interviews, observations and interactions. From the transcribed interviews and field notes, substantive codes were derived and analyzed prior to the investigator re-entering the field. Next, the initial substantive codes were clustered to create categories. Data were collected until categories were saturated, i.e. no new conceptual information was being added (Chenitz &

Swanson, 1986; Glaser & Strauss, 1987; Hutchinson, 1986, p. 125). From the major categories, theoretical codes were derived that contributed theoretical meaning and scope to the substantive theory (Glaser, 1978, p. 70).

Credibility of the data

The criteria of truth value, applicability, neutrality and consistency for ascertaining credibility in qualitative research suggested by Woods and Catanzano (1988) were applied in this study. Truth value refers to "adequate representation of multiple constructions of reality". Some of the ways truth value was established was through prolonged engagement with the subjects in the field setting to ensure sufficient time to build a trusting relationship with them and through persistent observation to provide depth to the findings.

Applicability refers to "fittingness", which means describing the data in detail and generating working hypotheses to enable someone to consider the possibility of verifying the hypotheses in another context (Woods & Catanzano, 1988). The analytic scheme generated was submitted to an expert whose research concerns families with chronic illness. She confirmed the suitability of the fit of the analytic framework generated for this study for other chronic populations in other contexts.

Neutrality depends on the existence of truth value and applicability (Woods & Cantanzo, 1988).

Consistency is the process by which other researchers can follow the method used in this study and are able to find similar concepts, not contradictory ones, if they were to have access to the investigator's data (Woods & Cantanzo, 1988). This criterion is similar to reliability in quantitative research. In this study, 28 of the 34 interviews (82%) were independently coded by the two investigators. Consensus on substantive codes, categories and theoretical codes was achieved.

Findings

The core variable which best explained the experience of the support persons was *Life on Hold*. Life on Hold begins when the support person and the patient make the initial decision to apply to a lung transplant program and continues to an unknown period post transplantation. This is a process with five phases.

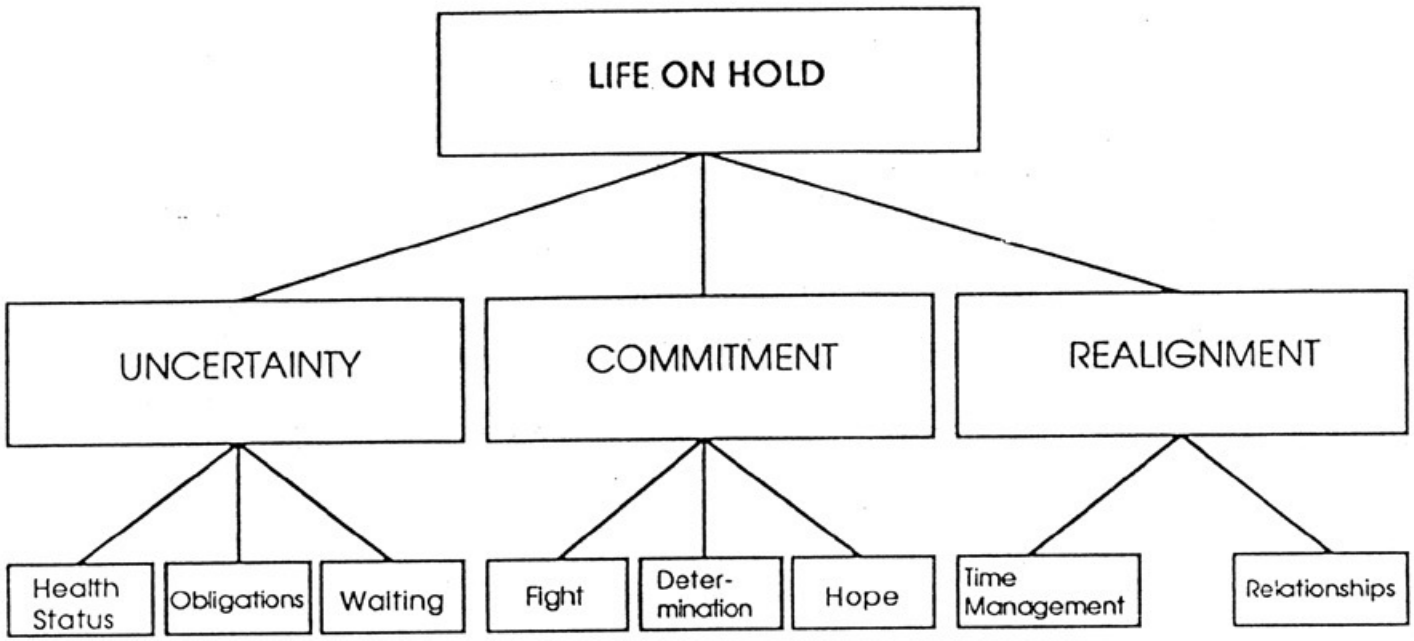

Figure 1
The analytic scheme for the life experiences of the support person of a lung transplant recipient

In this study, the phases paralleled the five stages of the lung transplant program, i.e., Pre-acceptance, Assessment, Pre-Transplant, Transplant and Convalescence. The process of Life on Hold is composed of three interrelated concepts -- *Uncertainty, Commitment* and *Realignment.* (See Figure 1). Each concept is evident during all phases of the transplant process, but changes in its intensity and character depending upon the demands and issues confronting the support person, as well as on the circumstances arising from each particular phase of the transplant process.

Uncertainty

Uncertainty prevails through all of the support person's experiences, but in varying degrees. Initially there is uncertainty about whether or not one should become the "designated support person" and how long one would have to maintain that role. The support person is also uncertain whether their family member will be considered an eligible candidate and hence allowed to undergo the initial assessment. Once the support person becomes involved with the lung transplant program, there is uncertainty with respect to the patient's *health status,* their own *obligations* and the *continual waiting.*

Initially, the patient's *health status* is stable enough to meet the criteria for eligibility into the program but, as time passes, a physical and mental deterioration often takes place. As explained by two of the support persons: "Her quality of life isn't very good. She never feels wells. Her quality of life is not worth not doing the transplant," and, "We are going the expected route, we obviously are not getting any better."

It is at this time that the support persons become uncertain as to their *obligations* towards the patient. What does the transplant program expect from them? What are their roles? For many, they will take on new roles, unthought of prior to being accepted into the transplant program. Others will carry on with their normal roles, but with more dedication now as they await "a chance" at a transplant. As the support persons become more involved with the patients, their obligations become more complex. Prior to transplant they become the primary caretaker of the patient: they are responsible for assisting the patient with their health maintenance needs, carrying out the domestic chores and chauffeuring or accompanying the patient to and from the hospital for pre-transplant physiotherapy. One support person commented, "One thing I had to quickly get over was the fact that I had to bathe my father. My God, my father. I had to help him get from the bed to the wheelchair, I had to help him get dressed. I made him breakfast, filled his oxygen tanks and took him for walks in his wheelchair". At all times, the support persons were obligated to manifest strength for the pair. "You need a bit of time away to recoup your own strength every once in a while."

The support person's obligations change remarkably during the transplant and convalescent stages. During these phases the health care professionals abruptly take over most of the care of the patient. No longer are the support persons the primary caretakers or considered knowledgeable consultants, as they were in the earlier three phases. They are treated just like a relative of any surgical patient in the fifth phase (convalescence) until the transplant recipient is discharged from the hospital. Once home, there is less strain imposed upon the support persons and more opportunity to spend quality time with the family member. They start to feel relief and great pleasure at watching the convalescing patient's progress.

In addition to being uncertain with respect to the patient's health status and the support persons' obligations, there is much uncertainty with regard to the *waiting* that goes on. There is always waiting to be done. Initially, in the pre-acceptance phase the support person and patient wait to hear from the program about whether they are eligible for assessment, a wait that can vary from three to nine months. Next they wait for the assessment, and then for a decision to be made about whether or not they are accepted into the program. Typical comments expressed by the support persons were: "The assessment is very trying on your relationship. Your life is in an uproar. You don't know where you are headed and what direction you are going in. You need to demonstrate some tough love." Another subject stated that: "We had no idea what we were in for at all, not at all."

Once accepted into the program the waiting for a donor organ is potentially one of the longest phases of the entire transplant process. There is little that the support persons or the patients can do to increase organ availability. As they wait for "the call" for a transplant, the patient's health status starts to deteriorate further. During the waiting, the support persons are faced with the reality that the patient may not live long enough to be given "the chance" at the transplant surgery.

At the time of the transplant surgery, the support persons encounter a different kind of waiting. There is more uncertainty as they wait to hear whether or not the patient survived the transplant surgery: "I was thinking how relieved I was that it was over and he had survived." After hearing whether the patient has survived or not the support persons encounter another kind of waiting, one of restricted visiting hours in the intensive care unit. Family members could only visit the patient for ten minutes on the hour, every hour, provided that the health care professionals were not too busy with the patient. Even though the support persons are less uncertain about the patient's health status, for many it is difficult to visit on such a restricted schedule. "I found myself doing a lot of waiting and walking." After all, the support persons have been with the patient 24 hours a day for months and now must abide by a designated visiting schedule. This waiting

for infrequent visiting carries on into the hospital convalescence phase in which almost all of the patient's waking hours can be accounted for by a rehabilitation program. As expressed by one support person, "It was stressful dealing with his schedule which restricted you to an hour here or there to visit." The transition of family members visiting the patient for a total of two to three hours per day from previous 24 hours per day took some time to adjust to.

Commitment

The second major concept evident in the process of placing one's Life on Hold is the *commitment* made by the support persons. This commitment to the patient's welfare begins when the support persons make the decision to become the "designated support person" and accompany the patient to the transplant program. At this time, they free themselves from all prior commitments. This commitment is very encompassing. As one support person stated, "I gave up everything to come here with my husband." The support person will be responsible for the patient, and confined with the him or her 24 hours a day. The support person's commitment to the patient is demonstrated through their ability to *fight*, their *determination* and their *hope*.

Once the decision is made to apply to the transplant program, the support persons *fight* with and for the patients to get into the program for "a chance" at an assessment. Then the pair fights to keep the patients alive and stable long enough to be able to undergo the transplant surgery. Underlying the support persons' commitment to the patient is their ability to fight at all phases for the patient's survival. "Once he made the decision, I just supported what he wanted to do....It was a fairly heavy duty commitment and once I made it there was no backing out."

As other support persons commented: "The people you are supporting are physically sick and mentally tired, they are tired of waiting and as their support person you have to fight for them. It would be nice to know the ground rules before you got in there and put up your dukes with the transplant team."

As the support persons fight for the patients, they also become *determined* to attain their major goal -- a transplant for their family member. The fight is more patient-oriented, whereas the determination is more support person oriented. Once committed to being in the support person's role, the support persons are determined to carry on as expected and help the patients in any way that they are capable of, in order to have the transplant surgery. As one support person explained, "You have to be determined. If you are not determined and not dedicated, you are not going to make it through the transplant program at all."

At all times, from the initial decision to apply to the program until after the transplant, an element of *hope* prevails. The transplant is viewed as the last source of hope at improving the patient's quality of life. Hope keeps the support persons going. Without hope, they would not be as committed and without the accompanying determination they would not fight as hard to keep the patient going, to achieve their goal of a transplant.

Realignment

In addition to uncertainty and commitment, there is also a *realignment* of the support person's *time management* and *relationships*. To accompany the eligible transplant candidate means realigning the support person's personal life. The support persons realign their lives with the hope that the situation is only temporary.

The support persons now learn to *manage time* differently. Some spend the majority of their time caring for the patient. Some spend their free time (what little there is of it) by continuing with familiar activities and hobbies. Others manage the waiting by taking up new interests. But most become involved in some way with the activities offered by the transplant program.

All of these support persons were limited in their *relationships* with other people outside of the lung transplant program. It is as if they are on the inside of "a shell" and have minimal relationships outside their shells. Their relationships with others are based on their common interest -- receiving a lung transplant. The support persons neither have the time nor the energy to invest or carry on with relationships with other family and friends who are far away. Restricted visiting can disrupt the previous continuity in the support persons' relationship with the patients. During all phases of the process of placing one's Life on Hold there is a continual realignment of the support persons' time management and relationships.

Questions Arising from the Study

The identification of the theoretical analytic scheme of Life on Hold is a beginning step to realizing the psycho-social needs of the support persons involved in a lung transplant program. The ease, enthusiasm and eagerness with which the support persons responded to participation in the present study indicated that the support persons must be provided with regular opportunities where they can be encouraged to discuss their experiences, thoughts and feelings with a receptive listener.

Why is it that the program requires each candidate to be accompanied by a support person, but does not provide reinforcement of that role as they do for the patient's role? Why does it appear that the role of the support person is

not valued as much in the transplant and convalescent phases as in the earlier phases?

The support persons may need just as much caring and support as does the transplant candidate but in a different mode. What would happen if the lung transplant program did not require each candidate to be accompanied by a support person? Would the natural supportive network of each patient unfold? Would more than one family member or friend volunteer to be the so called "designated support person"? Would they be as committed throughout the entire transplant process? Could the program offer a support group solely for the support persons themselves? Health care professionals should be cognizant of the commitment of the support person on the patient's behalf. If not for the support persons, where would the patients be? Each support persons has placed their Life on Hold for their family members to be provided with the chance to have a lung transplant as the last viable option for extending their life expectancy and their lives together.

Recommendations

The findings from this study should be expanded upon in future studies within the lung transplant population and among other transplant groups. We also advocate the use of qualitative research designs with more extensive theoretical sampling. Theoretical sampling using this framework also could be used to explore the long term trajectory after successful transplantation. Such studies could assist in increasing the health care professional's knowledge of the demands and expectations placed upon those who provide support to transplant recipients.

In this study we have taken the first step towards increasing the health care professional's insight into the experience of the support persons involved in a lung transplant program. With the use of grounded theory methods, the emergent substantive theory of *Life On Hold* accounted for most of the support person's behaviour in the social scene under study. During each of the five phases of the transplant process, the support persons experience uncertainty, commitment and a realignment of their lives.

The findings from this study have some similarities to Mishel and Murdaugh's (1987) study of family adjustment to heart transplantation. In both studies there is much uncertainty with respect to whether or not the patient will live to receive a transplant and, if they do, whether they will survive the surgery. If they survive, both the patient and family presumably undergo a number of role changes and assume a new lifestyle. As yet data are unavailable to track this process over time.

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RÉSUMÉ

La vie en suspens : l'expérience des personnes-ressources participant à un programme de greffe pulmonaire

On décrit dans la présente étude qualitative l'expérience des personnes-ressources participant à un programme de greffe pulmonaire. Nous servant d'une théorie à base empirique, nous avons recueilli des données auprès de cinq personnes-ressources (tous des membres d'une famille). Les données font ressortir un processus social de base dans lequel les personnes-ressources doivent mettre leur vie en suspens pour une période indéfinie allant souvent jusqu'à deux ans. Ce processus est dicté par les cinq étapes du programme de transplantation : présélection, évaluation, prétransplantation, transplantation et convalescence. ê chacune des cinq étapes, la personne-ressource fait l'expérience a) de l'incertitude liée à l'état de santé du malade, à ses responsabilités en tant que personne-ressource et à l'attente prolongée; b) d'un engagement envers le malade, exprimé par une aptitude à se battre pour obtenir une greffe du poumon, par une détermination à voir le malade s'en sortir et par l'espoir; et c) du rajustement de sa vie sur le plan de la gestion de son temps et de ses relations interpersonnelles.

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