NURSING PAPERS
PERSPECTIVES EN NURSING

Patterns of Concern in Hospitalized Chronically Ill Young Children

Client Care-Seeking Behaviours in a Community Setting and their Sources of Satisfaction with Nursing Care

Community Health Assessment

Growth and Development - for Elders
Reminiscence, an Underused Nursing Resource

Spring/Printemps 1982 **Volume 14, No. 1**

NURSING PAPERS
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NURSING PAPERS/PERSPECTIVES EN NURSING is published quarterly by the School of Nursing, McGill University. Letters regarding subscriptions, changes of address and other business matters should be sent to the Managing Editor, *Nursing Papers*, McGill University, 3506 University Street, Montreal, P.Q. H3A 2A7.

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A. Validité interne —

1. Le problème dont traite l'article est-il clairement défini?
2. La forme des recherches ou la structure de l'essai sont-elles appropriées à la question soulevée?
3. Les méthodes statistiques, logiques et les modalités de recherche sont-elles appropriées?
4. Les conclusions peuvent-elles être justifiées à l'aide des données présentées?
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Chaque auteur est avisé de la date de publication de son article à l'avance et deux exemplaires de la revue lui sont adressés à titre gracieux en même temps que la revue est expédiée à ses abonnés.

ERRATUM

In the Winter, 1981 issue of *Nursing Papers* (Vol. 13 No. 4), we incorrectly ascribed authorship of "Nursing Diagnosis: Differentiating Fear and Anxiety" to Phyllis Jones, with co-authorship by Dorothea Fox Jakob.

The article was, in fact, written by Dorothea Fox Jakob, in collaboration with Phyllis Jones.

The editor sincerely regrets the error.

Corrections to the author sequence have also been made in a revised index, which is being sent to subscribers as a supplement to this issue.

NURSING PAPERS
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Volume 14, No. 1
Spring/Printemps, 1982

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PATTERNS OF CONCERN IN HOSPITALIZED CHRONICALLY-ILL YOUNG CHILDREN: A PRELIMINARY REPORT

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INTRODUCTION

Advances in the medical management of chronic illness have resulted in a longer life expectancy for many children, but often necessitate frequent and prolonged periods of hospitalization for increasing numbers of these children.

While very few studies have examined the young child's response during these long term hospitalizations, the authors' own experiences with young children subjected to long stays in acute care hospitals confirm staff nurses' observations that these children do develop negative behavior patterns. Lack of information about response to long-term hospitalization makes it difficult for nurses to plan care which will prevent such behaviors.

This paper is a preliminary report of a study using play interviews to determine the dominant concerns of chronically ill two to five year old children in hospital and to compare their concerns with those of healthy children and children undergoing short-stay hospitalization. The study is the initial stage of a project to develop a means of examining the coping patterns of young chronically ill children in hospital and to measure the effect of nursing intervention designed to foster these children's adaptive capacity.

The study questions are:

1. What concerns consistently recur over a six week time period?
2. What changes in patterns occur over the same period?
3. Are there differences in the concerns of healthy children and those undergoing long-stay hospitalizations (more than 28 days), or short-stay hospitalizations (under 21 days)?
4. Do the concerns vary according to age, previous hospitalization, previous painful procedures, or parental visiting patterns?

REVIEW OF THE LITERATURE

References to chronic illness in this study are based upon Pless and Pinkerton's (1975) definiton:

> A physical, usually non-fatal condition which lasted longer than three months in a given year, or necessitated a period of continuous hospitalization of more than one month. (p. 90)

Surveys conducted in the United States and Great Britain indicate that 5 to 10% of children have a chronic physical illness (Pless & Pinkerton, 1975; Rutter, Tizard & Whitmore, 1970). The effects of chronic childhood disorders have been found to place the affected child at a higher risk of psychological maladjustment than healthy children of the same age (Mattsson, 1972; Pless, Roghmann & Haggerty, 1972). Higher incidences of psychiatric disturbances, reading difficulties, and problems in functioning socially have been reported in three populations of chronically ill children (Pless & Pinkerton, 1975).

It is also apparent from the literature that the difficulty the young child has in adapting to chronic illness, extends into later life. Pless, et al. (1972) determined that school-age children with chronic physical disorders had a 10 to 15% greater incidence of psychological maladjustment than their healthy controls and that the relative risk of maladjustment increased over time. Korsch, Fine, Grushkin & Negrete (1971) reported severe damage to self-esteem and poor scores on social adjustment in children surviving renal transplant for at least one year. However, Korsch also reported in a later report that most of these children and their families had "returned to pre-illness adaptation and family equilibrium". (Korsch, 1978, p. 347).

While the effects of short-term illness and hospitalization have been shown to vary with the child's developmental stage (with resultant differences in the child's interpretations), fears and reactions, and the effects of chronic illness have potential for interfering with the child's normal development and socialization across all developmental stages (Battle, 1974; Hughes, 1975; Pless & Pinkerton, 1975; Talbot & Howell, 1971). For chronically ill toddlers, the establishment of a sense of autonomy and progress through the stages of separation-individuation are made difficult if chronic illness results in maternal or familial over-control, limitation in self-expression and feelings of anxiety, helplessness and passivity (Maddison & Raphael, 1971; Magrab & Caleagno, 1978). In pre-schoolers, chronic illness threatens intellectual and social development by decreasing opportunities to explore

the environment, establish peer relationships and develop independence (Battle, 1974; Freeman, 1967; Hughes, 1975; Travis, 1976). Restrictions on mobility and play mechanisms for mastery of tension may result in increased anxiety and fantasy activity (Freeman, 1967; Maddison & Raphael, 1971; Mattsson & Gross, 1966).

A variety of emotional responses to chronic illness has been described. Stubblefield (1974), has noted that the child's reactions are seen in the psychological responses of anxiety, depression, somatic symptoms or antisocial behavior such as addiction and running away. While specific responses have been reported in particular types of illnesses, there are similarities in these reported reactions, namely exaggerated guilt, fantasies, anxiety about functioning and dissatisfaction with body image (Belfer, Harrison & Murray, 1979; Kagen-Goodheart, 1977; Korsch, et al., 1971; Korsch, 1978; Mattsson, 1975).

Few studies have described the adaptive mechanisms used by chronically ill children. Mattsson's experience with hemophilic children has convinced him that children and their parents are able to adapt so as to function within the limits of the disease (Mattsson, 1972). Such adaptation is reported to be accomplished through coping behaviors which include cognitive functioning (Geist, 1979; Korsch, 1978; Mattsson & Gross, 1966; Mattsson, 1972, 1975); motor activities (Mattsson, 1972, 1975); appropriate emotional expression of angry, sad and then hopeful feelings (Mattsson & Gross, 1966; Mattsson, 1972, 1975); the use of psychic defenses such as identification with the medical staff (Geist, 1979); and denial of an uncertain future (Geist, 1979; Mattsson, 1972, 1975).

The literature reveals findings on long-term adjustment to chronic illness and the impact of chronic illness on development. Most of the literature presents discussions from clinical practice. Few of these discussions examine young children and no studies were found on the adaptation of chronically ill young children to hospitalization.

METHODOLOGY

Setting

The study was conducted in a university teaching children's hospital and a large multi-setting day care centre, situated in the same metropolitan area. The research was ethically assessed and sanctioned by the Ethics Committee of the Faculty of Health Professions, by the hospital's Research Committee and by the Board of Directors of the day care centre.

Consent

Written consent was obtained from all parents whose child was to become a subject in the research.

A written proxy consent was obtained from the charge nurse or the head teacher before each play interview.

Sample

The sample reported in this paper consisted of 35 subjects: 10 healthy children and 25 hospitalized children. The healthy children were chosen at random from one unit of the preschool centre. They were judged by the teacher to be of normal cognitive development and had no history of severe emotional disturbance. The hospitalized children were chosen by a convenience sample based on the following criteria:

- normal cognitive development
- no history of severe emotional problems
- anticipated hospital stay of at least 8 to 10 days
- physical condition permitted an initial play interview within five days of admission
- physical condition could be expected to permit next play interviews within five to seven days of the first interview
- child not admitted to an isolation unit requiring sterilization of the toys following the interview.

There were three groups of hospitalized children; five children in a long-stay chronic illness group who were hospitalized a minimum of 28 days; 10 children in a short-stay illness group; and 10 children in a short-stay acute illness group. Both of the short-stay groups remained in hospital less than 21 days.

Description of Subjects

The subjects ranged in age from two to five years: 21 were four years and over, and 14 were under four years. The hospitalized children had a variety of medical and surgical conditions.

Counting the present hospital stay, 17 of the 35 subjects had more than one hospital experience. Twelve of the 15 subjects with a chronic illness had been in hospital more than once.

Twenty-four of the 25 hospitalized children had one parent living in or visiting most of the day. The high parental visiting pattern may be in part related to our data sample as it would have been difficult to discuss the study with them and get their written consent.

Twenty of the 25 hospitalized children had more than three experiences with needles, including intravenous and immunization, prior to commencing the play interviews.

Fifteen of the 35 subjects had experienced surgical procedures. Eleven of these 15 subjects were children with a chronic illness.

Data Collection

Information about variables identified in the research questions was obtained through a questionnaire sent to parents of the healthy children, or a structured interview with parents of the hospitalized children. The data was collected by the researchers using the play interview procedure developed by Erickson (1958) and a suitcase containing both familiar toys and hospital equipment (Table 1).

Table 1
Contents of the Play Kit

Familiar Toys	Hospital Equipment
Bathtub	Adhesive tape
Car	Bandaids (4)
Chest of drawers	Cotton balls (4)
Crayons	Dropper bottle
Doll's bed and linen	Disposable enema bottle
Gun	Feeding tube
Kitchen sink	Gauze bandage
Nursing bottle	Gauze squares (2 - 4×4)
Refrigerator	Medicine bottle with 4 small candies
Spoon	Medicine cup
Stove	Nightshirts (2)
Tablet of paper	Plastic tape
Toilet	Rectal tube - red catheter
Family dolls: baby	Test tube
girl	Thermometer and holder
boy	Syringe and needle
mother	Venous catheter
father	Hospital dolls: doctor
	nurse

The initial interview with each child began with the researcher picking up and naming each object in the suitcase. The child was then told that he could play with the toys of his choice and the researcher "would do some writing". Questions were answered with minimal direction. For example, if a child asked, "What's this?", the researcher responded, "It can be whatever you want it to be". Any request to participate in the play was declined except on a few occasions when, at the insistence of the child, the researcher became more involved in the play. In such instances, the child indicated a need to perform certain actions on a live person rather than a doll. The researcher was a passive participant and took direction from the child. Play interviews lasted up to 45 minutes and the child was free to refuse to play or terminate the interview at any time.

The play interviews were done every 5-7 days up to a maximum of six interviews for the long-stay chronic illness and healthy groups. The interviews were held in a private room. When this was not possible in the hospital setting, the curtains were pulled around the hospital bed. At times, parents of hospitalized children were present during the play interview.

The child's verbal and non-verbal activities were recorded in writing by the researchers. To provide interobserver reliability in the recorded play interviews, the researchers were trained in observing and recording, using videotaped play interviews. An interobserver agreement of 86% was achieved by the three researchers.

A total of 100 play interviews were done. In the short-stay acute illness group, there were one to two play interviews with most subjects. In the short-stay chronic illness group, two to three play interviews were done with each subject. All long-stay subjects had five play interviews. The healthy subjects had between two and six play interviews.

Analysis of Data

The narrative recordings of the interviews were subjected to content analysis. The data was divided into units of behavior. Units of behavior were any acts of the subject which were in the form of vocalization or verbal or non-verbal behavior. The units of behavior were then categorized according to the type of object the child handled in the play activity and the type of concern expressed in the play. A unit of behavior was categorized as one of four type of objects, and as one of ten major concerns (Table 2). All behaviors were considered meaningful and reflective of a concern. A concern was defined as a matter in which a child invests some interest or energy in the course of development or in particular situations. The categories of concerns

were based on the published reports of concerns of this age group in relation to hospitalization and normal developmental concerns. To assure an exhaustive system of categories, the final decisions in the development of the categories were derived from actual content analysis of the narrative recordings. This content analysis of the narrative recordings yielded frequency counts of numbers of behaviors in each of the categories.

To assure uniformity in coding units of behavior and categorizing the units, the researchers underwent extensive training in the content analysis procedure prior to the actual coding of data. Coding was not begun until the three researchers achieved a minimum percentage of agreement of 70%. The interjudge percentage of agreement achieved in each area of coding was:

Units of behavior	88.4%
Types of objects played with	87.5%
Categories of concerns	71.8%

The preliminary analysis of the data was designed to examine differences in the proportion of concerns expressed between groups and over time. The average proportions of play behaviors classified as particular concerns were calculated for each of the four groups on each interview. This calculation demonstrated which concerns dominated the children's play. The frequency counts of classified play behaviors for each individual interview also comprised the raw data for statistical analysis. The differences in proportions of concerns expressed were analysed using the statistical package GLIM (Royal Statistical Society, 1977).

Table 2
Categories for Analysis of Data

Types of Objects	Types of Concerns Expressed
Hospital	Autonomy
Familiar	Body Integrity
Both	Caretaking
Neither	Exploration
	Interpersonal Communication
	Intrusion
	Mobility
	Punishment
	Separation
	Violence

FINDINGS

Descriptive Analysis of Concerns Expressed

Play behaviors classified as Autonomy or Exploration consistently occurred in high proportions in all groups but dominated the interviews with healthy children and the short-stay acute illness group. These behaviors always occurred in the highest proportion and ranked first or second in all interviews with the healthy and short-stay acute illness groups. However, in the long-stay chronic illness group, expressions of concerns about Intrusion challenged the dominant position of Autonomy and Exploration. For the long-stay chronic illness group, behaviors classified as Intrusion occurred in either the highest or second highest proportion in four of the five interviews.

Play behaviors classified as mobility, interpersonal communication, punishment, and separation each accounted for 5%, or considerably less, of the play behaviors in all interviews in all groups. Only those concerns accounting for a higher proportion of behavior will be presented here.

Autonomy and Exploration. Play behaviors which demonstrated concern with independent function or pride in ability to accomplish a task (Autonomy) or which demonstrated efforts to identify or describe an object (Exploration) occurred most frequently in the interviews with both the healthy children and the short-stay acute illness group. Tables 3 and 4 demonstrate that Autonomy and Exploration combined, accounted for 70 - 80% of the play in each interview with the healthy children. In contrast, Autonomy and Exploration combined, accounted for only 41 - 48% of the play on the long-stay chronic illness group on all interviews except the fourth.

Table 3
Percentage of Behaviors Expressing
Concerns About Autonomy

	GROUP			
WEEK	Short Stay Acute	Short Stay Chronic	Long Stay Chronic	Healthy
1	34.7	22.7	17.6	30.6
2	23.6	18.4	22.5	37.9
3		35.4	22.3	26.4
4			33.3	36.8
5			16.6	36.8
6				39.9

Table 4
Percentage of Behaviors Expressing
Concerns About Exploration

	GROUP			
WEEK	Short Stay Acute	Short Stay Chronic	Long Stay Chronic	Healthy
1	33.1	31.6	30.3	45.5
2	43.8	36.7	18.6	31.6
3		29.3	24.3	47.4
4			25.9	39.9
5			29.7	35.5
6				40.2

Table 5
Percentage of Behaviors Expressing
Concerns About Intrusion

	GROUP			
WEEK	Short Stay Acute	Short Stay Chronic	Long Stay Chronic	Healthy
1	6.5	7.2	21.0	2.9
2	7.2	16.7	30.9	6.4
3		18.6	32.9	3.6
4			23.4	1.2
5			27.1	9.7
6				2.8

Intrusion. Play behaviors which demonstrated concerns about any entry into the body boundaries, including injections, tests, treatments, etc., occurred in the highest proportion in both groups of chronically ill children. In the long-stay chronic illness group, Intrusion accounted for 21 - 33% of the play and occurred in either the highest or second highest proportion on all but one interview. In the short-stay chronic illness group, Intrusion accounted for 16.7% and 18.6% of the play in the second and third interviews. In contrast, Table 5 shows that Intrusion always accounted for considerably less than 10% of play behaviors of children in the healthy and short-stay acute illness groups.

Body Integrity. Behaviors which demonstrated concerns about intactness or mutilation, health, illness, or reason for hospitalization, etc., occurred least frequently in the short-stay acute illness and short-stay chronic illness groups. Body Integrity comprised 5.6% - 11.5% of the play of healthy children and consistently ranked third or fourth on all of their interviews. Body Integrity concerns accounted for 2.8% -8% of the play behaviors of the long-stay chronic illness group on all interviews except the fifth interview when the proportion rose to 15.1%.

Caretaking. Behaviors which demonstrated activities of daily living which involve providing for another person, usually occurred in fairly small proportions and ranked fourth, fifth or sixth except in the short-stay acute illness group. In that group, Caretaking accounted for nearly 10% of the play and ranked third in each of the first two interviews. Only in the long-stay chronic illness group did the proportion of Caretaking concerns reach similar levels, accounting for 11.1% of play in the second interview and 9.3% of play in the fifth interview.

Violence. Play behaviors demonstrating aggressive acts or concerns about such acts occurred most often in the first interviews with all groups. However, violence accounted for 24.5% of the play of the short-stay chronic illness group and 11.95% of the play of the long-stay chronic illness group in the first interview. In contrast, in the short-stay acute illness and healthy children groups, Violence accounted for 6.0% and 7.9% of the behaviors on the first interview.

Statistical Analysis of Concerns Expressed

The preliminary statistical analysis used a logistic linear model to examine differences in the proportion of concerns expressed over time, and to determine whether there was a group x time interaction. For each of the ten categories of concern, there was a highly significant interaction of group x time with chi-square values, ranging from 17.5 -115.1 for eight degrees of freedom. Because of the group x time interaction, it is not possible to test statistically for differences between groups. Therefore, the statistical analysis of the full data set will test whether the differences in proportion of concerns expressed are explained by age, previous hospital experience, or experience with painful procedures.

DISCUSSION

It is impossible at this stage of analysis to draw conclusions about differing patterns of concerns in the four groups of children. There are, however, important overall patterns revealed in this preliminary analysis which have implications for nursing practice.

The expression of concerns related to Autonomy and Exploration accounted for a large number of the play behaviors in all interviews with the lowest rate of occurrence being 41% and the highest, 80.1%. This consistency across groups of high proportions of behaviors which demonstrate the child's efforts to do things for himself, pride in accomplishing tasks, or exploration of the nature and function of objects seems to indicate that such activities are important developmental concerns and remain a primary element in the lives of hospitalized children. However, the somewhat lower proportion of these concerns in the chronically ill children (41 - 48%) may reflect decreased curiosity and less push toward independence in these children because of obstacles created by their illness or the hospital environment. If these children are to achieve their developmental tasks (Erikson, 1963), nursing personnel must create situations which permit extensive assertion of autonomy and the exploration of a safe environment.

The preliminary analysis also makes clear that healthy children have fewer concerns related to Intrusion than chronically-ill children. However, the healthy children's relatively high ranking of concerns related to Body Integrity seems to reflect that such concerns about intactness of the body are, in reality, a developmental rather than a hospital-related concern. In contrast, Intrusion is at least as dominant a concern as Autonomy and Exploration for the long-stay chronic illness group. This pattern reflects the multitude of diagnostic and therapeutic procedures to which these children are subjected. Their play demonstrated dramatic re-enactments of these events and of the behavior expected of patients during these events. Nurses caring for these children should provide opportunities for such play and recognize that experience does not appear to decrease the chronically-ill child's concern about Intrusion.

The patterns of concerns relating to Caretaking and Violence are more difficult to interpret. The higher proportion of behaviors relating to Caretaking in the acute illness group may be a failure of this group's lack of experience with illness and hospitalization and resulting concerns about who will meet their needs. In contrast, the high proportion of concerns relating to Violence in both chronic illness groups may reflect these children's previous experience in hospital and resulting anger at re-admission.

If the patterns demonstrated in the preliminary analysis are also demonstrated in the analysis of the full data set, the study to examine the young child's coping pattern during long hospital stays must include observations during situations of normal developmental concern; that is, those stimulating efforts to explore or assert autonomy, as well as situations which evoke concern about body integrity and intrusion.

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RÉSUMÉ

Soucis des jeunes enfants hospitalisés atteints d'une maladie chronique

Cet article tient lieu de compte rendu préliminaire à une étude basée sur des entrevues visant à déterminer les soucis principaux d'enfants âgés de deux à cinq ans atteints d'une maladie chronique et hospitalisés et à les comparer aux soucis d'enfants sains de corps et d'enfants hospitalisés à court terme. Cette étude constitue la première étape d'un projet dont le but est de trouver des moyens d'examiner les façons dont s'y prennent les jeunes enfants atteints d'une maladie chronique et de mesurer l'effet des interventions d'infirmiers et infirmières visant à renforcer la capacité d'adaptation de ces enfants. Trente-cinq enfants (dix enfants sains de corps; dix enfants atteints d'une maladie très grave; dix enfants atteints d'une maladie chronique et hospitalisés à court terme; et cinq enfants atteints d'une maladie chronique et hospitalisés à long terme) ont été interviewés toutes les semaines pendant un maximum de six semaines. Les observations notées au cours de 100 entrevues ont été analysées selon le type de soucis manifesté. Les comportements de jeu classifiés comme souci d'autonomie ou d'exploration se sont produits avec une grande régularité mais ont néanmoins dominé les entrevues d'enfants sains de corps et d'enfants atteints d'une maladie très grave et hospitalisés à court terme. Dans le groupe d'enfants hospitalisés à long terme et atteints d'une maladie chronique, les soucis d'intrusion ont occupé la première place et prévalu sur les soucis d'autonomie et d'exploration. Les conséquences de cette analyse préliminaire sont ensuite discutées.

CLIENT CARE-SEEKING BEHAVIOURS IN A COMMUNITY SETTING AND THEIR SOURCES OF SATISFACTION WITH NURSING CARE

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INTRODUCTION

Only a few studies have focused on the client's responses to nursing care and those have tended to examine selected aspects of an interaction. Factors that influenced patient behaviour in the hospital were studied by Tagliocozzo (1965). Two other studies by Becker (1978) and Christiansen (1978) have examined client compliance and non-compliance with prescribed care. Factors in hospitalization and illness which increased anxiety levels were the focus of a study by Wilson-Barnett (1978). A search of the literature failed to reveal any studies on the characteristics and processes inherent in a client-nurse interaction. Why do clients seek care? What do they expect when they seek care? What are the outcomes from their point of view? In examining some data collected as part of a larger study of nurses and clients, the answer to some of these questions appeared to be present in interviews that had been conducted with the clients. The availability of the data thus provided the impetus for this study.

PURPOSES OF THE STUDY

The purposes of the study were (1) to identify the characteristics and processes inherent in client care-seeking behaviour in a community health setting; and (2) to identify the sources of client satisfaction and dissatisfaction with the process of receiving nursing care.

DEFINITIONS

Category:	A class or dimension in a scheme of classification.
Characteristic:	A distinguishing trait or property.
Phase:	A sequence in a series of related events.
Stage:	Related segments that together make up a phase.
Dimension:	The range or degree over which a particular characteristic extends.
Interaction:	Mutual or reciprocal action between at least two people.
Activity:	A generalized behaviour utilized by the nurse as a response to client need (e.g., support).
Action:	A specific act utilized by the nurse which constitutes one element of an activity (e.g. listening).
Self-referred:	Clients who made the initial contact with the workshop themselves.
Other-referred:	Clients whose contact with the agency was made by other persons on their behalf.

DESIGN AND PROCEDURES

The study was exploratory in nature. It utilized precollected interviews and the transcripts of the interviews formed the unit of analysis. A grounded theory approach, using a constant comparative method of analysis, was used to generate categories. Utilizing the categories, a model of care-seeking was constructed.

POPULATION AND DATA COLLECTION

The population consisted of 35 clients who had been in contact with one or more nurses from a community agency, "The Health Workshop," a facility staffed entirely by nurses. The clients were interviewed by one or two interviewers, between the 2nd of May and the 25th of August, 1978. All clients interviewed were adult, and usually only one member of a family took part in the interview. The clients were seen by eight different nurses. One nurse saw only one client, one saw nine clients while the mode was five.

The number of visits that clients had made to nurses at the time of the recorded interview ranged from one to 100, with a mode of four. In 17 cases the identified problem centered on a female, in three on a male and in 15 cases more than one member of a family was involved. Fifteen clients had been visited in their own homes and 20 in the workshop. Twenty-seven clients were self-referred.

LIMITATIONS OF THE STUDY

1. Time constraints prevented construct validation of the characteristics.
2. Negative findings in some small sub-groups were only partially explained due to the small numbers of cases involved.
3. Data were pre-collected so weak areas could not be supplemented by the addition of more cases.
4. Problem dimensions were not mutually exclusive based on the results of the reliability check.

ANALYSIS OF THE DATA

The constant comparative method used to examine the data employs joint coding and analysis to generate theory. Such theory is integrated, consistent, plausible, close to the data and in a form clear enough to be readily, if only partially, operationalized for testing in quantitative research (Glaser, 1969).

In conducting the analysis, the first step was to read all the interviews to identify some broad categories in the data. Once tentative categories were identified, interviews were reanalysed and the categories examined for common characteristics. The interviews were examined in sets of five. After the second set of five interviews were analysed, they were compared with the first set of five and the categories and characteristics revised as necessary. Subsequently each batch of interviews were compared with the initial batch. Exceptions were noted and reasons for the differences examined. The data were then examined for processes related to the characteristics. The next stage was re-examination of the categories, characteristics and processes in an attempt to delimit the theory.

Validity

Validity of categories was established by a panel of three judges (all nurse educators). Each judge analysed one interview (selected by use of a random number table) using the provided categories. Following discussion there was a revision of the data initially assigned by the researcher to these categories and some readjustment of the original titles. The panel then evaluated one further interview using the revised categories and agreement was reached on their appropriateness for analysis. Validity of the types of problem and types of care was also established but the properties and relationships were not validated by the panel.

Reliability

One graduate student accepted the task of analysing three interviews utilising the revised coding scheme following the validation procedure. A reliability of .73 was established between the student (S) and researcher (R). The reliability index was constructed as follows:

$$I = \frac{R - S}{R + S}$$

R = Researcher Frequency

S = Student Frequency

Validity and Reliability of the Interviews

The quality of the interviews with clients varied somewhat. There was consistency in the information obtained by the two interviewers involved but in later interviews less probing questions were asked and for the purpose of this analysis, the data were less rich than in the earlier interviews.

FINDINGS

Phases of Care-Seeking

Three definite phases of care-seeking were identified: a preactive, an interactive, and a postactive phase. These phases formed the framework for the analysis. The dimensions, the behaviours and the activities relating to each phase were examined and the processes of care-seeking were identified (Figure 1).

Preactive Phase

The preactive phase consisted of three stages: (1) a situation which precipitated care-seeking behaviour; (2) the identification of a problem by the client; and (3) the initiation of care-seeking behaviours.

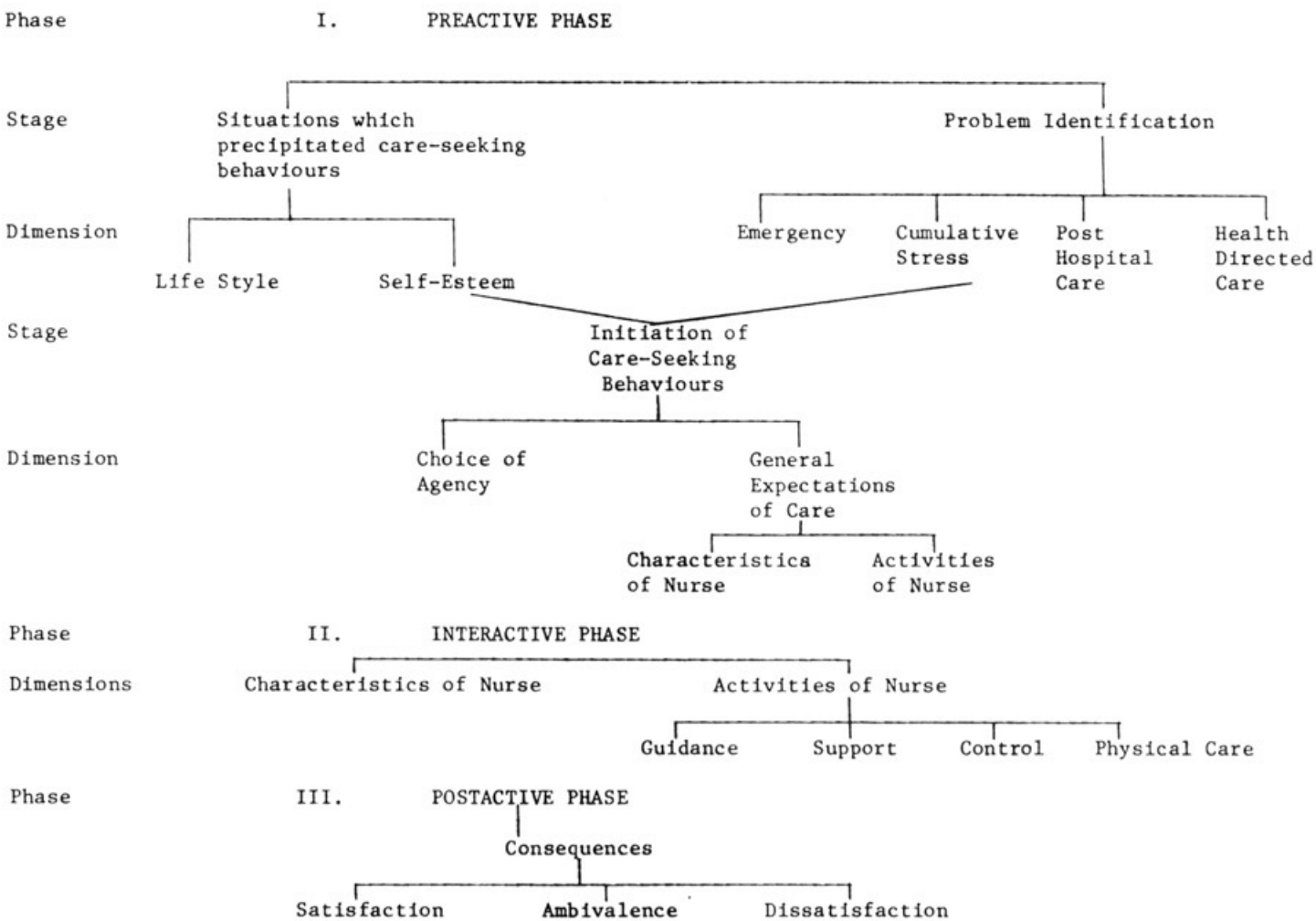

Figure 1. The Model of Care-Seeking Utilised for Analysing the Client-Nurse Interaction.

Stage 1: Factors which Precipitated Care-Seeking Behaviours

Among self-referred clients, a preactive phase occurred before contact was made with the workshop and some common dimensions were identified related to the interaction of factors in the clients' lifestyles and the clients' self-esteem. Self-esteem was used to denote the ways in which the client viewed his own capabilities and body image. Lifestyle was a factor in the environment which affected the individual as he went about his daily activities.

Table I

Preactive Phase: Situations Which Precipitated Care-Seeking Behaviours

Situation	Threat to Lifestyle	Effect on Self-Esteem
Chronic pain	Malfunctioning support system	Psychological threat to self-image
Discharge after hospitalization	Unstable support system	Dependence/independence conflict. Threat to self as independent individual
Divorce, move to new area	No support system	Threat to psychological and social image
Chronic obesity	Social consequences	Threat to body-image
Negative experience with previous health care	Forced into dependence on health workers	Feeling of helplessness deprivation of independence

Table I demonstrates some of the lifestyle and self-esteem factors that made the clients identify a need for care. Some clients already had stresses and strains in their life while others sought care because they wanted to prevent problems by improving their lifestyle; for example, a "good mother" produces a "healthy baby."

From the data, the following processes related to care-seeking emerged:

1) When factors in the individual's lifestyle exerted sufficient force on his self-esteem so that he perceived himself as helpless to resolve the problem unaided, care-seeking behaviour was initiated.
2) When an individual perceived that a change in lifestyle would be beneficial to his health but did not believe he had adequate resources to create this change, care-seeking behaviour was initiated.

Stage 2: Problem Identification

The dimensions of the problems presented by clients were limited to four major categories: emergencies, cumulative stress, post hospital (self-referred), and health promotion.

Emergencies were situations where the clients perceived that their problems required immediate input and when the purpose of seeking care was to get attention at that time only. Cumulative stress was identified when clients presented evidence of multiple problems or one problem that had built up over time. Post hospital care was the term used to identify those clients who referred themselves following discharge from hospital. Generally these clients found they had difficulty accepting independence and responsibility following a period of dependence. Health promotion was the term used to identify clients who came to the workshop seeking health measures that would change their lifestyle. They could be seeking to decrease the effect of chronic disease (diabetes, asthma) or might be looking toward a new direction in their life (pregnancy, family planning). The client might also be seeking measures to decrease illness potential (weight reduction).

Processes involved in problem identification (and presentation) were:

1) Having perceived a need for help, the individual identified a problem or goal with which to approach a health care agent or agency.
2) A dominant problem was selected but the presenting problem might be only one symptom of a more complex situation.
3) Clients who went through an inter-agency or inter-agent referral process might not have an identified problem or goal.

Stage 3: Initiation of Care-Seeking Behaviours

After a client had identified a problem, care-seeking behaviour began. Care-seeking behaviour involved both identification of an agency or agent able to provide help in the solution of an identified

problem or goal and the development of an expectation of care. For some clients, expediency was an important dimension of care-seeking. They looked for a facility which was close to home and where they would receive prompt service. All clients classified as emergencies were concerned with expediency. Similar behaviour was identified by Ingram (1978) who found that in an emergency, clients utilized the nearest service whether or not the facility was appropriate.

The role of a stimulus in directing a client's attention to a service once a problem had been identified, appeared to be another important dimension of care-seeking. Friends and neighbours provided information, as did nurses who spoke to groups. Friends' information was sometimes gained from attendance at an "Open House" at the Workshop. Verbal stimuli appeared to be most important; however clients frequently gained additional information from brochures and advertisements after their attention had been focused on the Workshop as an available service.

A third dimension of care-seeking was the client's previous experience with health care agencies. Several clients who came to the Workshop were looking for an alternative service because they felt that they were not receiving adequate help from health care agents and/or agencies with whom they were already involved. These clients expressed negative feelings about previous contacts with the health care system.

General Expectations of Care

Interactions were apparent between problem identification, selection of an agency and the development of an expectation of care. In reality, these are interdependent activities rather than separated in time. It was also apparent that clients did approach the agency with an expectation of the care they would receive, and the personality and characteristics they expected of the individual who would give that care.

Clients frequently made contact with the Workshop because they sought increased knowledge of a self identified problem or condition. However, clients saw themselves as able to manage their own problems but needed information and support from a nurse. The nurse was expected to be sympathetic to their problems. The expected prototype of this nurse for most clients appeared to be a knowledgeable individual, skilled in giving care, who would be reliable and respect confidentiality.

Three major activities clients expected the nurse to perform were physical care, support and guidance. Clients who identified their own primary problem as a need for help with physical care also expected support and guidance if they were self-referred. However, clients who were referred by hospital personnel either were unable to define expectations or did not identify support and guidance as nursing activities. The nursing actions identified by clients as providing support included listening and reassurance. Reassurance included reinforcement of the client's own observations and decisions. The most important nursing action in relation to guidance was provision of information. Expected nursing actions relating to physical care were weighing, blood pressure, taking a pulse, bathing and wound dressing.

A small group of clients (seven) showed a lack of external control in their own lifestyle and expected the nurse to impose controls within which they would have to function. This group showed a parallel between their lack of self control in lifestyle behaviour and their expectation that the nurse would set limits for them.

The Interactive Phase

The second phase, designated as the interactive phase in this study, consisted of the clients' perceptions of their visit with a nurse. In the interview, clients described their perception of the characteristics and behaviour of the nurse during the interaction. In most instances, clients described nursing activities that were related to guidance and support, which were also the behaviours most commonly expected by the clients when they sought help. Clients described the nurse as knowledgeable, caring, gentle, skilled, reliable, concerned and easy to talk to, putting one at ease.

Supportive activities were those that sustained clients in endeavours so they were more likely to succeed in solving their problem or reaching their perceived goal. Guidance activities were those activities which provided direction so individuals could select their own course of action. The activities described included sharing information, acting as sounding board for the client's ideas and providing alternative resources when the client lacked information. The nurse was perceived as helping clients make their own decisions and not making decisions for them.

Among the clients referred by other agencies or agents, there were a small group who did not identify a need for guidance and support. While they described actions related to such activities, they did not see

them as relevant to their needs. When physical care was given by the nurses, the activities involved were congruent with the expectations of the clients. The clients who were referred from hospital and who had no clear expectations of care suffered role-confusion when physical care was not provided by the nurse.

Processes involved in the client-nurse interaction were:

1) Provision of supportive activities resulted in reduction of tension enabling clients to resume some or all of their normal coping behaviours;
2) Provision of guidance allowed the clients to select a course of action and to move toward the solution of problems or the establishment of new goals;
3) The provision of guidance and support to families whose problems were of a long-term nature resulted in a sense of security which appeared related to the perception that they had acquired a functional support system; and,
4) Clients who did not have a clearly defined goal or purpose did not see nursing activities as relevant even when they were addressed to the problem identified by the referring agency.

The Postactive Phase: Consequences of Care-Seeking

In the postactive phase, clients looked back on the interaction with a nurse and assessed that feeling of satisfaction, dissatisfaction or ambivalence with the process.

Clients who were satisfied either (1) saw a resolution of the problems; or (2) had identified new goals; or (3) perceived their tension to be reduced so they could independently resume problem solving; or, (4) perceived they were making progress toward their goals.

Ambivalence or dissatisfaction were present: (1) if the client's expectation of care did not coincide with his perception of the care given; and, (2) if the client did not perceive the care as necessary, that is if he had no identified problem and generally no expectations of the care that he needed from a nurse.

Client Satisfaction with Nursing Care

Clients who expressed satisfaction with their care identified some common elements in describing the reasons for their response. These included reduction of tension (reassurance and relief were terms used by clients); finding someone who would listen to them; and finding someone who could provide them with information, enabling them to understand or solve their own problems.

While some clients identified progress in resolving their presenting problems, others expressed satisfaction if they perceived the nursing interaction to provide support even if progress toward solving their problems was not achieved. For example, one client whose husband had suffered a stroke realised that he would not recover, and that her goal for him was not feasible, but did show a positive response to the nurse's visit, as she felt someone was sharing her responsibilities with her.

Even when the nurse did not identify a client's covert problem (her fear of battering her child); when the nurse behaved in a way congruent with the client's expectations, the outcome was satisfactory from the client's viewpoint. In this instance, the nurse had listened to the concern about her son's temper tantrums and given advice on child behaviour. This client had perceived her need as having someone to listen to her and give advice, and felt that the nurse had met this need.

Ambivalence or Dissatisfaction with Nursing Care

Out of 35 clients, 7 were ambivalent or dissatisfied with nursing care. These clients came from two groups: (1) those whose primary goal was weight reduction; (2) those who were referred from other agencies. The mechanism which created a lack of satisfaction appeared to differ in the two groups.

Seven clients contacted the clinic with a primary goal of weight reduction. Of these, four were satisfied with their care, two were ambivalent and one clearly dissatisfied. The nurse's action in each case was clearly related to the goal. However, in looking at the client's expectation of nursing action and the perceived action of the nurse in the situation, there was a lack of congruence between expected and perceived actions in the case of the three who were not satisfied with their care.

There were eight clients referred from other agencies. Of these, four did not understand the reason for their referral; they did not have a clearly identified purpose in seeing the nurse or a clear expectation of her role. These four were all ambivalent about the care given.

Processes involved in consequences of care-seeking were:

1) When the client perceived progress toward solution of a problem, or achievement of a goal, satisfaction with the interaction ensued;
2) When expectations were not congruent with the perceived interaction, ambivalence or dissatisfaction with care resulted; and,

3) When a client had not defined a problem and/or if he had no expectation of care, the result was ambivalence or dissatisfaction with the intervention.

PROPOSITIONS

Based on the findings of this study, five tentative propositions relating to nursing intervention were formulated and can be tested in future studies. Validation in a variety of settings, both hospital and community, would support or rule out their generalisability.

The propositions formulated were as follows:

1) Clients who perceived themselves as having inner control over their daily activities will expect guidance and support from the nurse in response to their initiation of an interaction.
2) Clients who lack inner control over their daily activities will expect the nurse to act as an authoritatian figure who exerts external control.
3) Clients who received nursing care congruent with their expectations will feel satisfied with the nursing intervention, whether or not their problem has been solved.
4) Clients who receive nursing care that is perceived as divergent from their general expectations will be ambivalent or dissatisfied with their care even when progress toward their goal has been achieved.
5) Clients who cannot identify their problems or who have no definite expectations of the care they will receive from the nurse will be ambivalent or dissatisfied with the care given.

DISCUSSION

The majority in this study decided on their own initiative to seek health care at the Workshop. For some clients, the effect of cumulative problems had created a level of stress with which they could no longer cope. Generally clients saw themselves as independent and able to solve their own problems on a day-to-day basis, but at the time they contacted the Workshop, they felt they had lost control over the situation. This supports LeFeourt's (1966) contention that:

> If the locus of control is external, unrelated to one's own behaviours in certain situations and beyond personal control, he will perceive the situation to be more stressful (p. 207).

When these clients believed they had obtained information that allowed them to resume control of the situation, their stress level was reduced and they felt able to cope with the situation again. This suggest that it is important for the nurse to identify the areas perceived by

the client to be strengths and to work with these. At the same time, the nurse must avoid behaviour which indicates to the client that external control of the situation is being imposed by the nurse.

There was an atypical group of clients who requested external control of the situation by the nurse. These individuals exhibited lifestyle behaviours demonstrating a generalised lack of control over their own affairs; they did not perceive themselves as able to solve their own problems and sought an authoritarian approach from the nurse. When this was not given, they expressed themselves as less than satisfied with the client-nurse interaction. This suggests that, at least at the initial encounter, nurses must be alert to the type of expectations that a client has of the health professional.

The way in which a client's expectations of the role and function of the nurse were met was of more importance in this study than was progress toward a stated goal. If a client recently discharged from hospital holds the expectation that the nurse will take his pulse and check his blood pressure, it may be important that she accepts these functions at the initial visit, even when the stated purpose is to support the client in an attempt to decrease an observed high anxiety level.

One critical function of the nurse was to listen to the client's feelings, fears and ideas. The nurse was an informed listener and it was this knowledge base that differentiated her role from that of a neighbour. Clients could view the nurse as a friend but this did not detract from their image of her as a "professional" person. While the nurse was expected to be knowledgeable, she was not expected to have an immediate answer to a problem. The important thing was that she was able to identify the resources she would utilise before the next contact with the client.

It is important for nurses to be alert to those clients who have had previous negative experiences with the health care system. While the number in this study was small, it would appear that one of their major concerns was that they felt that in previous encounters with health care personnel, they had lost their control over the situation. They did not understand the doctor's orders, or the explanation given related to their illness, so frequently the stress they experienced was severe. For these clients, the establishment of a trusting relationship was critical, particularly when the client was afraid that no-one would give him information. This is where the use of books and reference materials may be useful as the client can read the information for himself and then discuss areas not understood with the nurse.

Some clients who were referred by other agencies seemed to have difficulty in understanding the purpose of the nurse's visit. The nurse must be alert to the expectations of clients who have been referred by others. If the client has no clear expectations of the care the nurse will give, it is necessary to explore mutual goals and identify the nurse's role before nursing intervention commences.

This study demonstrated the need for the nurse and client to establish congruent goals. It also showed that for nursing care to be effective, the nurse must be sensitive to the client's expectations of the nurse's role and activities in the nurse-client interaction.

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RÉSUMÉ

Comportements des clients cherchant à se faire soigner dans une localité et satisfaction que leur procurent les soins infirmiers

Le objectifs de cette étude étaient de déterminer les caractéristiques et les méthodes inhérentes au comportement des clients cherchant à se faire soigner ainsi qu'à déterminer les sources de satisfaction des clients bénéficiant de soins infirmiers. Cette étude était de nature exploratoire, et l'on a utilisé une méthode d'analyse comparative constante pour aboutir à certains résultats. La population étudiée comprenait 35 clients qui ont assisté à *l'atelier à votre santé*. On a déterminé trois phases définitives dans la quête des soins. Il s'agit de la phase pré-active, de la phase inter-active et de la phase post-active. Dans la première, les clients déterminaient un problème, choisisaient un organisme et fondaient certains espoirs. Dans la seconde, le client interagissait avec l'infirmier ou l'infirmière. Dans la phase post-active, le client examinait ses interactions et évaluait ses sentiments de satisfaction ou d'insatisfaction face aux soins reçus. On a noté une certaine ambivalence ou insatisfaction chaque fois que les espoirs du client ne coïncidaient pas avec sa perception des soins donnés ou chaque fois que le client ne percevait pas les soins comme indispensables.

COMMUNITY HEALTH ASSESSMENT: A SYSTEMATIC APPROACH

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INTRODUCTION

Nurses are continually being told to become more familiar with the health care delivery system in which they function. Their traditional tasks have been to prevent and intervene in illness, and to promote and maintain the health of individuals and families. Accordingly, when community health nurses are asked to identify and meet the needs of a more complex client — the community — they are frequently overwhelmed. The proliferation of survey approaches available (Bell and Newby, 1974; Poplin, 1979) does not make the task easier.

As one of three nurse investigators asked to develop a comprehensive baseline study of a particular community's health needs, I found that a systematic approach to assessment was uniquely beneficial.

This article focuses on the use of general systems theory (Von Bertalanffy, 1968) as a framework for community analysis. It provides an overview of the systems theory terminology relevant to community assessment and briefly describes the community involved. It also outlines the inherent advantages and disadvantages of the approach.

THEORETICAL FRAMEWORK AND REVIEW OF THE LITERATURE

Systems theory terminology used in this article includes:

(1) the *system*, a set of interdependent components, objects, or elements interacting and interrelating
(2) the *subsystem*, the component parts, units, or elements of the total system
(3) the *boundary*, an arbitrary line that encircles these parts, producing parameters, limits, and a filtration medium for the system
(4) the *environment*, those factors external to the system's boundary, including ones that affect and are affected by the system (McKay, 1969; Hazzard, 1971; Chadwick, 1972; Archer and Fleshman, 1975).

If the human body was used as an example of a system, the organs could be identified as subsystems, the skin as the boundary, and clothing as the environment.

Systems can be *closed* or *open*, according to whether they communicate with the environment (Hazzard, 1971; Chadwick, 1972). Closed systems do not interact with their environment, but depend on their internal resources for survival. Open systems, on the other hand, freely exchange matter, energy, and information with their environment. They are self-regulating, adapting according to environmental feedback. Although open systems retain resources for their own survival, their dynamic exchange of materials, energy and information with their surroundings stimulates internal growth.

According to this definition, then, individuals, families, and communities can be classified as open, living systems (McKay, 1969; Leighton, 1971; Hall and Weaver, 1977). The goal of nursing assessment and intervention should be to promote optimum functioning, adjustment, maintenance, organization, adaptation, and growth (Archer and Fleshman, 1975; Putt, 1978).

THE COMMUNITY AS A SYSTEM

A community is a social system encompassing the physiological, psychological, and social facets of individuals and families (Report of the PAHO/WHO Committee on Textbook Programs, 1976). Further, it includes the organizations and institutions that carry out diverse functions including stratification, control, socialization, production, and communication (Anderson and Carter, 1974; Moe, 1977). As an open system, it is thought to be unique in its ability to meet the individual's needs (Harmston and Lund, 1967; Bruhn, 1975; Poplin, 1979; Roberts, 1979).

The basic resource of a community system is its human *energy*. Its health depends on the ability of individuals and groups to direct the flow of energy by working toward common goals (Hanchett, 1979).

The community as a client, then, must be assessed comprehensively as an interdependent unit of complicated social relationships (Wilson, 1970; Bell and Newby, 1971; Leighton, 1971). Health care, as one subsystem, is an integral part of the whole community system. Like any other subsystem, it should not be considered on its own (Wilson, 1970; Braden and Herban, 1976).

To analyze the community system as a whole, outside influences of government organizations, other comunities, and society at large must also be considered (Hall and Weaver, 1977). Psychosocial as well as biophysical aspects of the environment must be determined when evaluating a community's health. Health workers recognize, for example, that fumes from a neighboring steel plant can pollute the community's air; that sewage from a town upstream can poison the drinking water; and that illegal drug trafficking can infiltrate into the community from a metropolitan center. The community depends on the inflow of products and human energy from the environment (Braden and Herban, 1976; Roberts, 1979). If the rate, quality, and quantity of the input and output (matter, energy and information) are controlled, an ideal *steady* or *homeostatic* state of self-regulation is achieved (McKay, 1969).

Community changes are therefore complex, and must be made within a framework that ensures they agree with the goals of each subsystem and of the community as a whole. A change in one part of the community produces change in other parts and change in one community can create change in another (Roberts, 1979). Planning for only one dimension of health ignores the fact that this dimension is part of a larger system. All community sectors affect health and all sectors can be substituted for the health subsystem in improving the health status of the population. Furthermore, acceptance of a holistic approach to health care planning involves moving from incremental systems improvement to creative systems design (Dever, 1980).

General systems theory implies a unique method of planning and decision-making that focuses on each subsystem individually without losing sight of the totality. The emphasis is on complex relationships and interdependencies, rather than on constant attributes as in a community survey or descriptive study; this ensures comprehensive analysis and conceptualization.

Systems analysis reveals community patterns used historically to meet needs as well as current resources and variables influencing planned change (Braden and Herben, 1976). It predicts the effect of new external forces and indicates intervention points. Like the concept of *system linkage*, systems analysis assumes that communities are not discrete self-contained groups but are connected to other communities and to the wider societal *suprasystem* (Roberts, 1979).

Systems theory analyses have been applied to urban metropolitan communities, primarily by economists interested in public investment planning (Jonassen and Peres, 1960; Harmston and Lund, 1967;

Steinitz and Rogers, 1970; Chadwick, 1972; Bourne, 1975). In contrast, Cardoza et al. (1975) and Raeburn and Seymour (1977) developed non-mathematical systems for assessing community mental health services and needs.

A systems theory-based approach to community health assessment is notably absent from nursing research literature (Highriter, 1977). Nurse educators and practitioners have advocated the use of nursing process (Knight, 1974), epidemiology (Ruybal et al., 1975) and survey listing (Wagner, 1976). Putt (1978) and Helvie (1979, a and b) used either systems theory or adaptations of it to analyze the individual and family. McKay (1969) stated that the taxonomic development of the subsystems of large systems such as communities should precede the study of functional relationships. When systems theory was applied to discussions of community health (Braden and Herban, 1976; Hall and Weaver, 1977), community subsystems and elements were not clearly identified although Hanchett (1979) has developed a relevant conceptual tool kit approach. Our study of a suburban community presented a unique opportunity to develop a *model* for systematic community health assessment.

THE COMMUNITY

A Nova Scotian suburban community, located 24 kilometers outside a major metropolitan center, had experienced a remarkable six-fold population growth from 6,000 to 30,000 in less than a decade, although it had been in existence for over 200 years. The community was created artificially; government financial assistance had precipitated rapid land acquisition and cooperative housing construction in the area.

As in many middle-class suburban towns, most of the residents were young married couples with two children. In the community, 75 percent were 44 years of age or younger; only five percent were over 60. The majority worked outside the community: many of the male wage earners were in the military service and away from home for extended periods. These factors, as well as inadequate public transportation and a congestion of cooperative and mobile homes, contributed to increased social and emotional health problems. The economic pressures of owning a home, as well as personal bankruptcy, marital discord, parenting problems, juvenile delinquency, depression, and loneliness concerned the citizens. Development of recreational, social, educational, and other health-related services had "reportedly" not kept pace with the structural growth of the community.

Surveys in that community indicated that isolation, family breakdown, and financial difficulties were the most pressing problems affecting the population.

COMMUNITY ASSESSMENT: METHODOLOGICAL APPROACH

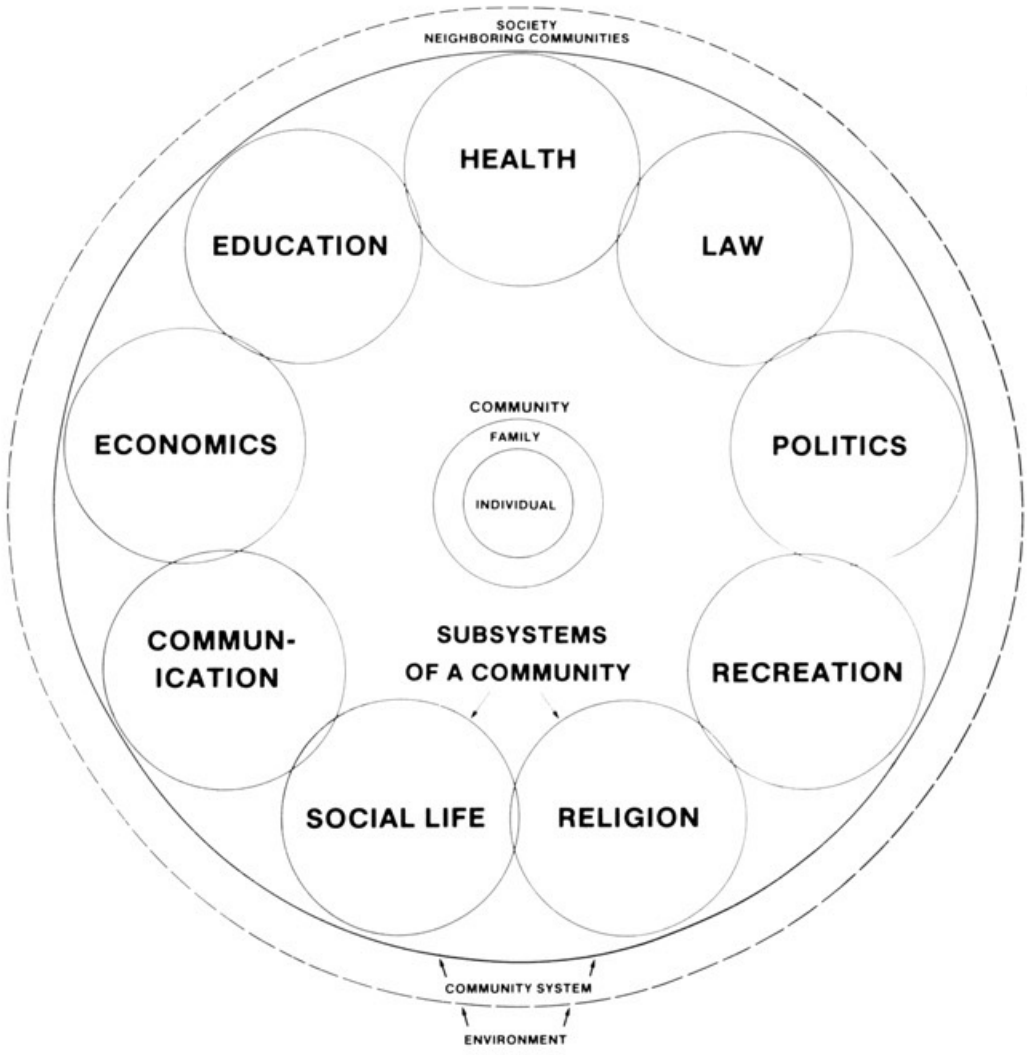
To describe the community from a systems theory perspective, we first arbitrarily defined the community's boundary along geopolitical lines. These lines encompassed two provincial districts, distinguishing the community from its environment and, in particular, from the neighboring metropolitan center. This arbitrary line could have been drawn around emotional ties, ecological problems, identifiable needs, organizations, kinship groups, power structures, social classes, and special interests (Archer and Fleshman, 1975).

Once we determined the boundary, we then considered the dynamics of the community based on the premise that each subsystem is likely to have independent goals which, when combined, support community-wide goals. To do this, we identified for analysis not only the health subsystem, but also the subsystems of communication, economy, education, law, politics, recreation, religion, and social life (Figure 1). Subsystems were derived from the review of the literature (Wilson, 1968; Bruhn, 1975, Cardoza et al., 1975; Wagner, 1976), from consultation with experts in community study, and from a preliminary survey of community components.

To understand the changing nature of the community, we examined the historical as well as current influences on each subsystem. Proposed services and anticipated needs were also identified.

We gathered data on the community system and its environment from census tracts, bylaws, government documents and reports, implemented or proposed research projects within the community and vicinity, minutes of community meetings, newspapers, program pamphlets, slides, maps, and historical books. The primary source of information, however, was the citizens.

Interviews were primarily semi-structured and tailored to the person or agency representative being interviewed. Sixty community leaders or decision-makers were identified, using the reputational technique discussed by Bell and Newby (1974), Cardoza et al. (1975), and Poplin (1979). That is, many people who were interviewed suggested other influential, knowledgeable community residents. The list of potential interviewees, as well as relevant written sources of data, thus expanded very quickly. Observation of the layout of the community was only a minor part of the study.


SOCIETY
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ICATION
SUBSYSTEMS
OF A COMMUNITY
RECREATION
SOCIAL LIFE
RELIGION
COMMUNITY SYSTEM
ENVIRONMENT

FIGURE 1

Quantitative and qualitative data were compiled for each subsystem. Statistics on population characteristics, personnel, facilities, services, programs, and caseloads of health-related agencies were gathered as well as information on issues, perceived problems and proposed solutions. All information was then classified according to positive and negative influences on health, and compiled into a summary statement. This statement formed the basis for the model of community assessment presented in this article.

MODEL OF COMMUNITY SYSTEM AND FINDINGS

Health

To accurately assess health in a community, the life expectancy, population growth, health status, nutritional status, health services, resource allocation and utilization, and level of social functioning should be considered in addition to more traditional disease-oriented measures of mortality, morbidity and disability (Hulka, 1978; Mooney and Rives, 1978). Basic information should be gathered on the community's health care facilities including the foci of clinical programs and the age groups served. Ambulance and sanitation services need to be identified. Data on the number, type, and routine caseloads of health professionals such as community health nurses, public health inspectors, nutritionists, dental hygienists, family physicians, and specialists should be compiled, as well as information on paraprofessionals and consumer participation in community health programs (Thompson, 1980).

Information on customary sources of health knowledge and prevalent health concepts is also important but more difficult to define. Telephone books often provide residents with data on formal agencies and available services, although only the grapevine reveals informal health-related resources (Hanchett, 1979). Levels of immunization among children; the value the population places on health; the view residents have of their own health status; the geographic, economic and cultural accessibility to health services; lifestyle data including rationale for seeking health care and risk taking; and the environmental condition of air, water and soil all reflect the physical and emotional health of community members (Dever, 1980). The interrelationship and interplay of the subsystems of communication, economy, education and social life with health become evident.

Sanitation reports indicated that this Canadian community was almost totally serviced, although many residents were concerned about the intermittent pollution of the lakes and the site of a garbage dump. Depression was prevalent, judging by "Helpline" statistics; mental health visits constituted a considerable portion of public health nursing caseloads as did prenatal classes and newborn visits. The fact that there was no hospital meant that residents in need of acute care had to travel to the nearby metropolitan center. Most clinics, such as those for child guidance and family planning, operated on a "satellite" part-time basis from the neighboring city. Ambulance services were duplicated by the fire department's emergency rescue truck and a private company.

At the time of the study, ten general practitioners, four specialists, six dentists, four public health nurses, two public health inspectors, and one nutritionist worked in the community. When surveyed, health services rated high among requested improvements in community services. Community debate focused on whether the community should have an emergency care facility or a broader-based community health center.

Communication

The health of a community depends on the ability of individuals and groups to work towards common goals. They cannot work together unless they exchange ideas and feelings. Informal internal exchanges between local subsystems — horizontal patterns — and formal external exchanges between the system and the environment — vertical ties — enhance the system's in/through/output of matter, energy, and information (Hall and Weaver, 1977; Hanchett, 1979). There must be a reaction to feedback if people are to remain satisfied with the community system and if the system is to survive. A public forum for individuals and groups to express their views is one source of feedback for the community (Roberts, 1979). Others include telephone services, mass media and roadways. Although roads are the most visible system network, telephones and mass media also provide system linkage. Telephones promote communication among residents while newspapers provide a steady flow of information on community activities. Finally, transportation can greatly influence physical access to health care in a community system. Access to recreational, educational, and other facilities also indirectly affects health.

Internal roads and external highways linking the community studied with the nearby city were inadequate, although improvements were planned. Public transportation was virtually nonexistent. Residents believed that such transportation was essential as most families were one-car owners and taxis were financially inaccessible for the average citizen. Both factors contributed to feelings of isolation and alienation. These feelings were voiced by female residents in particular. The local newspaper did, however, promote a sense of community identity, and telephone services were considered adequate. Annual "Community Action Days" and periodic public meetings provided a forum for citizen debate.

Economy

The economic health of the community affects the physical and emotional health of its members. For example, the ability to function, one indicator of community health, can be assessed by the percentage of residents employed or attending school (Hanchett, 1979). If a town has a high unemployment rate, social health problems are frequently widespread. While any assessment should identify a community's occupational health programs and industries, the occupations, income levels, and employment status of its residents as well as the quality and types of housing available should also be considered. Consumer education and manpower development also reflect the effectiveness of the system's throughput mechanism (Dever, 1980). In surburban "bedroom" communities, a subtantial portion of human energy is exported to large urban centers where the residents hold jobs. Communities that export more resources than they attract in the form of people and products such as goods, services, goals and values may risk decay or "entropy" (Anderson and Carter, 1974; Hanchett, 1979). Conversely, if a community's commercial and industrial base is strong, the financial support available for health, educational and recreational services is generally substantial.

In the community studied, businesses were primarily of a supportive nature. They determined which products were available for human consumption and so influenced the lifestyle of the citizens. Residents thought that commercial growth would augment the community's tax base. The Chamber of Commerce was actively trying to recruit new industry, home buyers, tourists and customers for local businesses to retrieve the "energy" lost by residents working outside the community. The racetrack was a major tourist attraction. Unemployment was negligible. Eighty percent of the workers were labelled "central"; that is, they earned reasonable wages and had

stable jobs. Not surprisingly, 59.2% of the population had lived in the community less than five years, having moved from the nearby metropolitan area. A high degree of cooperative ownership meant that the majority of residents occupied private dwellings. The largest percentage of mobile homes in the province was concentrated in seven trailer courts within the community. This rapid development of concentrated housing to fulfill the demand for inexpensive accommodation had reduced individual privacy. Credit counselling was considered to be a health-related need as more and more residents incurred heavy debts.

Education

A community whose major energies are expended on law enforcement and economic concerns achieves a lower level of development than one whose energies are directed to education, social and cultural activities (Hanchett, 1979). Schools are responsible for promoting intellectual development and socialization of a community's youth into the community's values (Dever, 1980). Although school health facilities and personnel are important, quality lunch programs, gymnasia, extra-curricular activities, libraries, and counselling services may contribute to a student's physical, emotional and social health. These factors may be particularly significant at the high school level, when many teenagers make major decisions concerning lifestyle and face family pressures. Furthermore, adult literacy and continuing education programs can affect community development. Therefore, duration and quality of education of residents is significant information (Dever, 1980).

High school dropout rates, teenage pregnancies, vandalism, drug abuse, alcohol consumption, poor academic achievement and minimal parental involvement in the schools (less than half of the schools had parent-teacher associations) reflected individual and family health problems in this community. A moratorium on school construction as well as cutbacks in teaching staff were perceived as potential problems by the citizens. Adjunct services of resource teachers for the physically handicapped and mentally disabled were being developed, however, and clergy consultants and community volunteers were being sought. Some evening extension classes were conducted at the local high school. The majority of adult residents were English, originating from the British Isles, and had attained an educational level of Grade 11 or higher.

Law

The caseloads of a community's police force and lawyers often define the social health problems of its residents. Domestic quarrels, shoplifting, child abuse, vandalism, drug addiction, alcoholism and

other forms of adult and juvenile crime all indicate underlying problems and unhappiness. Community order, social organization and safety are indicated by family breakdown, crime and delinquency (Dever, 1980). Thus, the safety and security of a community's citizens must be considered and steps taken to overcome and prevent identified problems.

Fifty percent of the RCMP caseload concerned shoplifters, not serious offenders. The nearest police detachment was based in a neighboring town. No aid was available to people unable to finance legal counselling. Citizens of this community felt threatened by transients and juvenile deliquents. The juvenile delinquency problem indicated a need for community youth diversion programs; the majority of teenagers frequented shopping malls. Female residents were worried about the presence of a nearby minimum security correction center, although some volunteers visited the prisoners weekly for periods of sports and crafts. (According to Hanchett (1979), the flexibility of institutional boundaries is a major indication of health of a community system.)

Politics

Political jurisdictions identify the formal boundaries of many of the community's subsystems, such as school, health, and police districts. Furthermore, formal political channels can be the focus of legitimate authority (Poplin, 1979). Legislative or municipal hearings provide a medium to present issues concerning resource allocation. Thus the ability to control the direction of health dollar "energy" may lie with the politicians and not with the consumers (Hanchett, 1979). However, community development rarely occurs without participatory democracy (Roberts, 1979). Community political issues may focus on health concerns. The average election turnout can indicate the extent of citizen involvement and community cohesiveness. Political leaders and those involved in the formal and informal power base may be perceived as the most influential people in community activities. It is important, then, to identify the respective responsibilities of local and other governments for all other community subsystem services. Decision-making structures and organizations can include community councils, health and welfare councils, and housing authorities. The characteristic community patterns of decision-making and problem solving are more difficult to ascertain.

The site of sanitary landfill was a source of political conflict in the community studied. A community council was formed for two purposes: 1) to identify the needs of the area, and 2) to open avenues through which necessary resources could be provided for the community. A health committee of this local community council was a lobby for health-related services. Community politicians were trying to determine the focus of a proposed health center: whether it should maintain the quality of health in the community, restore individual health levels, or prevent health problems. Only two regional councillors represented the concerns of the community. This indicated that there was an urgent need for local government, and for the community to become incorporated as a town or city. The rapid growth of this municipally-governed community had surged ahead of its political evolution.

Recreation

A community's sports fields, playgrounds, arenas, camps, libraries, art galleries, museums, and theatres provide physical exercise, intellectual stimulation and an emotional outlet (Hanchett, 1979; Dever,1980). The availability and location of inexpensive recreational services for all age groups should be assessed. The human energy directed to recreational activities can provide information about a community system's goals (Hanchett, 1979). It is also necessary to identify the participation levels in fitness-oriented groups; the use made of schools and vacant buildings for informal and formal recreational activities; and the existing number of family-centered programs.

In our study, we found that there were few developed playgrounds and sports fields, and that there was no pool. The one arena in the community was constantly in use. Free activities were rare. A recently-hired community recreational director, however, recognized the need for inexpensive fitness classes for housebound women and programs for senior citizens. A local recreation association was also trying to match recreational services and facilities with the rapid growth in housing. The county and community were reportedly reluctant to take responsibility for developing and maintaining playgrounds and parks. Residents met informally for recreation when more formal avenues were lacking or did not encompass individual preferences. Lack of leisure time can adversely affect mental health (Hanchett, 1979), but a large number of people who worked outside this community indicated that they did have minimal time available for social and recreational activities.

Religion

A traditional function of the church is to provide support to the individual and family in time of crisis. Religious associations focus on the spiritual health needs of the individual, regardless of age, sex, race, education or social class. Involvement in religious organizations can also help the individual develop spiritually and morally and cope with the shifting values of a technological era (Hrycak, 1980).

One of the unique services available in this community was a church program called *Family Clusters.* This program emphasized the growth of individuals within a Christian family, and so addressed the growing problem of family breakdown. While the community relfected the widely-recognized changing role of the church from social control to service, it had an unusual plan for a "church campus". Although it was purely an economic move, the campus concept involved cooperative sharing of facilities by six denominations and emphasized coordination of internal and community outreach efforts. This was a good example of system *synergy,* energy resulting from combined efforts from the member churches. There was a great potential for input by health workers in such a setting.

Social Life

While it is important to assess the predominant social classes, language, guiding values, child-rearing practices, racial and ethnic make-up of a community, its social committees, clubs and social organizations should not be ignored. These groups can promote cohesiveness and affiliation among citizens of all ages. Financial assistance, emotional support, psychological identification, counselling and rehabilitation of the handicapped are but a few of the services offered by social associations and clubs. Such groups may range from formal government agencies to informal primary friendship groups. Participation in community social activities can reflect social belonging (Dever, 1980). Socially isolated elements do not gain support from the community system and the system does not gain from their information and experience (Hanchett, 1979). Hence, internal exchange of energy and information is decreased. The percentage of people who belong to some established primary face-to-face group or are engaged in volunteer activities are indicators of community health. The community's culture and values affect its health and its ability to incorporate input from the environment. Community health requires that values adjust to changing needs yet retain sufficient stability to maintain system integrity and homeostasis (Hanchett, 1979).

The need for financial counselling, day care facilities and family-centered activities was predominant in this "instant" community, where separation and divorce rates were steadily increasing. Associations for the mentally retarded and for learning disabilities, as well as Alcoholics Anonymous, Parent Crisis, Senior Citizens, Kinsmen, Jaycees, Brownies and Cubs were only a few of the groups that were being developed to meet the community's social health needs. Neighborhood card clubs provided informal face-to-face contact for some residents.

EVALUATION

In this suburban community, the overlapping patterns of energy indicated that a network, or set of linkages, needed to be developed between the health subsystem and the other community subsystems to ensure dynamic interchange. The assessment of this community culminated in a proposal that a multi-service center be designed to coordinate the broad health services offered in the different subsystems: one that could meet the specific health and welfare needs of the community. (A community "need" results when a desired resource is not available from the environment, or when the community is unable to accept and assimilate the resource — Hanchett, 1979).

A multi-service center was possible, however, only if the participating subsystems or elements of these subsystems could agree on timing, location and goals of the center. Collaboration occurred; the proposal for a multi-service center was accepted and the center opened in 1981.

ADVANTAGES AND DISADVANTAGES

We found that this systematic approach had five distinct advantages:

1. It facilitated comprehensive assessment of the community's health related needs.

   Community service priorities are invariably health-related, although they are not always recognized as such. A holistic approach to "human" services delivery can overcome this problem. A systematic assessment of client health needs promotes logical problem-solving and informed decision-making.

2. It helped coordinate and integrate prior research efforts.

   Community studies and reports tend to be carried out in isolation, examining only one subsystem of the community. This inevitably causes fragmentation and duplication of reports.

3. It incorporated an epidemiological approach.

   Community concerns are not always documented by statistical data. Figures from government and agency surveys can be extracted and summarized for the community's use.

4. It included input from citizens.

   The major source of input in a community-focused study should be the community's residents. Their suggestions are crucial in assessing priority needs, planning relevant health-related services and developing new programs to meet these needs.

5. It promoted teamwork.

   Integration of professional expertise is an important adjunct to citizen participation. Ongoing communication and collaboration among nurses, other health team members, and residents of the community throughout the assessment and planning phases can produce viable alternatives in community services. General systems theory is considered to be an interdisciplinary language of professionals and theoreticians alike.

The major disavantage of this approach was the time it took to conduct the baseline study. The length of time varies with the size of the community involved and how familiar the nurse is with the community. It is apparent, however, that the benefits of systematic community assessment clearly outweigh the costs.

CONCLUSION

Many community studies that are carried out in isolation by external experts later gather dust on some professional's shelf. Surely a systematic approach to identifying priority community needs, one that involves the community itself, would help prevent such waste. Subsequent planning of comprehensive coordinated health-related services could then proceed in an organized fashion. The general systems theory approach to assessment which was used in this study proved extremely useful.

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RÉSUMÉ

Evaluation de la santé communautaire: approche systématique

On s'est servi de la théorie des systèmes généraux pour évaluer une collectivité en matière de santé et planifier les services appropriés. On a choisi pour ce faire une localité de banlieue dont la population s'était multipliée par six en moins de dix ans; or, l'évolution des services liés à la santé n'avait pas suivi le même rythme. Cette localité a été arbitrairement définie selon des lignes géopolitiques. Les sous-systèmes déterminés en vue de l'analyse comprenaient non seulement la santé mais également les communications, l'économie, l'instruction, le droit, la politique, les loisirs, la religion et les activités sociales. On a recueilli des données historiques et actuelles à partir de sources primaires et secondaires et on les a classifiées selon leurs influences positives ou négatives sur la santé. Cela a abouti à la proposition d'un centre à plusieurs services, conçu pour coordonner les services sanitaires offerts par les sous-systèmes. Le centre a ouvert ses portes en 1981. Cette approche systématique a facilité une évaluation complète et a permis de coordonner les efforts de recherche en incorporant les données épidémiologiques, en faisant participer les clients et en encourageant le travail en équipes interdisciplinaires.

GROWTH AND DEVELOPMENT — FOR ELDERS REMINISCENCE, AN UNDERUSED NURSING RESOURCE

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GROWTH AND DEVELOPMENT — FOR ELDERS

Gerontology and geriatrics are young fields of study, and yet the process of aging and the achievement of great age have always been of interest. The saying that "All men would live long, but none would be old" reflects the anxiety that all feel about the observed incapacities of some elders. Dr. Cyril Gryfe (1980) has provocatively stated that "age is no problem until you get sick", making the point that for the older individual, health is the chief concern and prevention the chief process, in maintaining the highest level of wellness possible for the longest period possible.

Developmental Tasks:

Nurses have always been involved with elderly patients in acute care hospitals or in various extended care settings, but like most of the population, they have been slow to recognize that elders are not just middle-aged adults who have been around longer than usual. They have needs and resources distinct from those of middle-aged adults, and they are capable of growth and development. The effective gerontological nurse is committed to the belief, among others, that the elder with an intact psyche is capable of growth and development until the end of his life.

As childhood is a time of expanding resources, of trying out physical behaviors and abilities; and adolescence is a time of trying out various social relationships and styles of interacting; young and middle adulthood is a time of consolidating one's choice of a mate, and of transmitting values through the generation of a new family. The results of these processes thus form part of the unique pattern of Canadian society. In the last phase of life, after experiencing the expansion of youth and the consolidation of middle years, the elder comes to the last phase of conservation of resources: physical, psychological and social.

In this as in previous phases, there are several developmental tasks to be mastered: the restructuring of uncommitted time, complex grief work consequent to multiple and superimposed losses, management of one's physique, and coming to terms with the only life available. Late maturity is not a passive time; to maintain integrity despite the many negative biological and social changes which occur, requires stamina and psychic energy.

Use of Time:

Retirement from the world of work is only the most obvious change, and the precursor of many others. Its effect on fiscal status is well known. What is less recognized is the difficulty many people have with the task of dealing with the uncommitted time made available by retirement. Is it to be regarded as leisure, or as idleness? Is it to be "used", "filled up" or "killed"? Many people look forward to an unending holiday when they can do what they please, when they please; but the paradox is that time and funds do not sufficiently co-exist. In addition, the special quality of a vacation comes in major part from the fact that it is limited and the usual regime, suspended for a time, awaits the vacationer.

Dealing with time is also a psychological task involving values. It is important that activities of value to the individual, whether new or old, be maintained in some satisfying degree. Physical activity should not be reduced; indeed mild increment is advantageous. Exploration of new social activities or expansion of established commitments is possible in an expanded time frame, and helps to establish new roles and contacts to replace those lost through retirement.

What is important in relation to uncommitted time is that a schedule be developed so that the framework of the working day is replaced by a framework which gives pattern and organization to life. This makes the world and one's own life meaningful; it is the abrupt disruption of a life pattern which makes retirement at the 65th birthday so difficult. When this task is inadequately mastered, boredom, apathy and depression are frequent consequences.

Complex Grief Work:

Retirement, whether resisted or anticipated and planned, imposes many losses, as has been indicated. Those whose working lives have been spent implementing plans made by others may have little experience in identifying abstractions such as their values, although they may be superb "trouble-shooters" in their work. Similarly, although middle and upper-management personnel may be excellent at problem solving, it may be difficult for them to recognize that retirement poses

psychological problems unlike those with which they are familiar in their working life. (Bradford, 1979). What is not readily recognized is that many of the losses sustained at retirement are superimposed and the grief work required to resolve the various losses becomes much more complex than that done in earlier life, when losses are usually sustained singly. Fortunately, persons of retirement age increasingly demonstrate resilience and ability to establish substitutions for losses sustained.

When the loss of income, work roles, established activity patterns and some social roles become overwhelming, this close sequence of losses may lead to a pattern of reverberating grief, so that the person is unable to escape the denial — anger — depression cycle identified by Kubler-Ross (1975) and move on to the development of substitutes for losses sustained. As examples, both the senior executive who retains an office on the executive floor although officially retired, and the workman who drops in at lunch time to have a chat with "the boys", demonstrate difficulty in handling the loss of the work role and its satisfactions. If grief work is not carried out effectively (with or without assistance), the apathy and depression so commonly observed among elders ensues to the major detriment of quality of life.

Development of Ego Integrity:

A third major task of elders, especially the senior elders or the "old-old", is what Erikson (1975) calls the achievement of ego integrity: the recognition that one has spent most of one's allowance of life, the reconciliation of accounts, and the coming to terms with oneself. This is a task usually accomplished over a fairly long period of time in a rather sporadic manner. The process of life review (Butler, 1968) occurs episodically throughout life, but when there is an accumulation of regrets for past actions or omissions, there may be grief, guilt or anger that frequently requires help to assuage. The experience of life review and "coming to terms" is most certainly one of growth, frequently leading to a new serenity (Lewis and Butler, 1974).

Physical Management

To deal positively with the onset of physical limitations consequent to long life also requires growth of a different kind. New patterns of activity must be developed, and it takes ingenuity in many cases to circumvent limits imposed by a fractious interior environment, as well as an increasingly complex environment which seems to require expanding proportions of energy to cope with it. Health maintenance must of course be attended to, and this requires knowledge — frequently lacking — about the altered nutritional and other needs of well or ill elders. Though health maintenance surely will take more

time and energy in age than in youth, it should be no more than a part of life's routine, as is toothbrushing during the middle years. The difficulty of doing this in the presence of chronic dysfunction is acknowledged. Middleaged and young people love elders who are interested in the world around them, even if the elders cannot actively participate; this interest in others can reduce the focus on chronic conditions. It is important that elders do not drift into the luxury of concentrating on their physical condition as the focus of life.

None of these four tasks — dealing with uncommitted time, grief work for multiple and superimposed losses, coming to terms with one's life and managing one's physique — is easy. They can be made less difficult by the intervention of knowledgeable nurses on both preventive and secondary levels, since they so strongly affect mental and/or physical health. Because of their long experience in living, elders have many unsuspected or ignored resources which can be used in mastering these special tasks of the last phase of living. In so doing, elders can enjoy that sense of growth, development and consequent vitality which makes for the wholeness which some call self-actualization (Maslow, 1971) and some call ego integrity (Erikson, 1975).

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The garrulous old woman and the repetitious old man are well known, and may be avoided in gatherings of elders, whether they are in the community or in institutions. Yet such persons present us with a resource for nursing care which can be therapeutic in the highest degree. The reminiscences of elders serve many purposes and can be used to enhance the self esteem of the reminiscer; to share in the sense of belonging to a specific time or place in the long chain of human development; and to enlarge the professional's understanding of the past and its influence upon the current cohort of elders. As the future of the elderly person clearly becomes foreshortened, each person engages, covertly or overtly, effectively or ineffectively, in a process of life review. Reminiscence forms a major part of this review. It is a process which cannot be completed in a hurry, and which may require considerable assistance, particularly if there are feelings of guilt or strong regrets for actions not taken. Effective reminiscence, silent or otherwise, contributes much to a measure of that serenity which can be said to reflect ego integrity.

The achievement of ego integrity is according to Erikson (1963) the final task of (mature adult) development. It is described as the coming to terms with one's only life, and acknowledging the rightness of the life that has been lived (p. 268-9). One of the major purposes of reminiscence as a part of the life review process is to discern "consistency and purpose" throughout the lifespan of the reminiscer. To perceive the pattern in the life lived gives it meaning and as Frankl (1970) so eloquently indicates, man can tolerate almost any fact or circumstance if he can discern meaning in it. Other purposes of reminiscence may be to instruct the young, to ensure that something of the valued past will be carried into the future; to make retribution for regretted actions; to affirm the value of one's contribution to society and to have this confirmed by another; and to maintain self-esteem.

The purpose for which guided reminiscence is undertaken affects the nature of the activity. Individuals can be encouraged to review their own lives by developing a written or tape-recorded autobiography, assembling and ordering family photographs, renewing contacts which had lapsed with school friends or family members, or returning to locations of past significance. Discussion and exploration of the feelings aroused enhances the process. Some of these mechanisms are possible within the services available in a permanent residence. Reminiscence usually requires encouragement at first, but

frequently develops a momentum of its own. Sharing of information and exploring feelings aroused, enhances the effectiveness of the life review by strengthening the sense of identity, of continuity and of sharing the past with younger people. Marshall (1977) has identified that when life review is intensive and ranges over the whole life span, it is seen as a positive experience. Ebersole (Burnside, chap. 18) suggests that sharing group experiences common to all such as war, flood, depression, first job and pay cheque, begins the process of re-establishing identity and increasing self-esteem, especially when it is undertaken in groups. Important memories are not shared readily at first, for they are part of oneself and the sharing makes one vulnerable to the opinion of listeners. Until trust is established among members, group reminiscing remains general and relatively superficial. This, however, serves the purpose of facilitating socialization, noticeably absent between residents in most long-term care agencies, and prepares them for the more intimate task of life-review.

The style and content of reminiscence is revealing, as McMahon and Rhudick (1964) indicate. Their population of healthy, community-living Spanish-American War (1898) veterans whose average age was eighty-four, displayed a clear pre-occupation with the past, with practically no references to the future; the extent which they engaged in reminiscence was not related to level of intellectual competence. There were those who negatively compared "today" with "yesterday", reflecting some sense of invulnerability and strength derived from vigorous origins; while some recounted hair-raising escapades, perhaps another reflection of the sense of being a rather unique "survivor" and thus unusual; others "raised" repressed material for review and "worked it through"; still others were storytellers, as distinct from those who recounted escapades in their evident desire to contribute their knowledge of the past to social history, without negative reflection on the present. This sense of contributing significantly to the present through the past seemed related to self-esteem and successful adaptation to age, for these storytelling men were neither depressed nor did they deny the defects of old age. The ability to reminisce in itself seems to contribute to physical as well as mental health in age; the men who had the most difficulty in reminiscing were found to be the most depressed among these veterans, and they died at a significantly higher rate than the reminiscers, in the year following the interviews.

Nurses working with elders who are active or house-bound in the community or who are in institutions, can be of considerable service to these elders and their available families by helping them to review

their lives through reminiscence. This is not necessarily part of a preparing-to-die process; Havighurst (1972) claimed that reminiscence is "universal at all ages after middle childhood" which he places around ten years of age. Responding to or stimulating reminiscent conversation can be done informally during meals or treatments, or can be structured through the use of groups of not more than ten. Thoughtful listening to repetitious comments of the garrulous or confused person may reveal themes reflecting the intolerable contrast between the present situation of incapacity and times past when the person was competent and/or much beloved. Such themes can supply a starting point for raising self-esteem and possibly restoration of some degree of improved capability.

The ways in which reminiscence can be encouraged are limited only by the individual's readiness to participate. Some persons prefer to review their lives alone and this is to be respected and facilitated; more people prefer to share and in doing so receive and give affirmation of identity and worth. Reminiscence is a useful strategy for assisting elders in the process of life review, through which they may retain identity, maintain self-esteem, cope with unresolved distresses and contribute significantly to the present.

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RÉSUMÉ

La croissance et le développement des personnes âgées

Selon cet article, les personnes âgées sont capables de croissance et de développement tout au long de leur vie. La troisième étape de la vie se caractérise par la conservation des ressources alors que les jeunes cherchent l'expansion et les moins jeunes la "consolidation".

Même si leurs ressources doivent effectivement être conservées, les personnes âgées doivent faire face à quatre tâches majeures: la restructuration du temps qu'il leur reste; l'affliction qui est plus complexe qu'aux autres moments de la vie parce que l'on subit de nombreuses pertes de façon simultanée plutôt que successive; les soins du corps; et l'acceptation de sa vie (il faut arriver à l'autointégrité d'Erikson).

Les infirmiers et infirmières, aussi bien de premier que de second niveau, peuvent aider les personnes âgées à accomplir ces tâches étant donné qu'elles affectent gravement l'état psychique et physique des gens. Les personnes âgées ont de nombreuses ressources qui peuvent servir à maîtriser ces tâches et leur permettent d'éprouver la satisfaction d'avoir réalisé quelque chose.

RÉSUMÉ

La réminiscence, une ressource insuffisamment utilisée en nursing

Cet article suggère que la réminiscence chez les personnes âgées est une excellente stratégie pour renforcer le processus d'examen de la vie.

Ce genre d'examen vise plusieurs objectifs: (1) discernement d'une identité constante tout au long de la vie de chaque être humain, (2) inculcation aux jeunes des valeurs du passé, (3) partage de son expérience et affirmation de la valeur de sa vie, (4) récompense des actions du passé que l'on regrette et (5) maintien de l'estime que l'on a de soi-même.

Cet article aborde divers moyens d'encourager et de diriger la réminiscence, moyens qui conviennent aux interventions de nursing: séances de groupe commençant par des sujets d'intérêt public allant progressivement vers des renseignements d'ordre plus personnel, agencement des histoires de famille, examen de photographies et d'objets de famille; examen de ses anciens amis, en expliquant "comment c'était" aux jeunes bénévoles qui s'intéressent au passé. Il est bien précisé dans l'article qu'il ne s'agit pas d'un processus de préparation à la mort, mais plutôt de quelque chose qui permet de mener une vie plus sereine jusqu'à la mort. Si ces souvenirs provoquent un certain désarroi chez certaines personnes âgées, il convient d'aider celles-ci à surmonter cette crise en s'attaquant à la source de leur désarroi.

L'évocation des souvenirs n'est qu'une stratégie permettant d'aider les personnes âgées à faire le bilan de leur vie. Ceux qui n'y tiennent pas ne doivent pas y être forcés; au contraire, ceux qui tiennent à partager leurs souvenirs peuvent par ce moyen conserver leur identité et l'estime qu'ils ont d'eux-mêmes tout en contribuant et à leur vie présente et à l'avenir.

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The planning committee for the Third West Coast Conference on Cancer Nursing Research is soliciting papers. The conference will be held August 4-5, 1983 in Portland, Oregon. The focus of the conference will be to improve cancer nursing through integration of theory, research and practice.

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