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Their Child's Long Term Illness

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EDITORIAL

THE SIGNIFICANCE OF ACADEMIC PREPARATION*

Rozella M. Schlotfeldt

Our democratic way of life which eschews leadership that is legitimized as a consequence of wealth and privileged heritage subscribes to the notion that leadership appropriately comes from those in whom society has invested heavily as they have partaken of the higher learning. Moreover society expects its well educated professionals, specialists, and scholars to ask the truly important questions and to go in search of answers to them. Society expects its educated leaders to identify social and professional goals that are worthy of attainment and to identify and mobilize the means through which they can be achieved. Those recognized, well prepared social leaders are expected to enunciate the vexing problems with which the world is plagued and to organize the resources through which they can best be resolved.

Among those whose minds have been opened and expanded by virtue of their having partaken of the higher learning are those who have been privileged to comprehend the truly tremendous capacities, strengths and abilities of their fellow human beings. They are those who have studied in preparation for becoming health professionals. Some of them are nurses. They are those who, by virtue of their own unique opportunities for learning, have been compelled to perceive and to marvel at the magnificent potential of each human being whom they have been privileged to serve. They have been led to know and to appreciate the fact that each and every human being having reasonable genetic endowment represents a miracle relative to the delicate balance of his or her physical, physiologic, and emotional make-up; a remarkable harmony in function; an almost unbelievable ability to withstand illness, injury and adversity and to be restored; a native capacity for self-control; and an abundance of energy, along with innate motivation and eagerness for survival, for growing, for learning, for communicating, for loving, and for self fulfillment.

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Those who have such knowledge of human beings are true professionals who have learned that there is a language that transcends all barriers of foreign tongues. It is a universal language that compels those who master it to serve their fellow human beings with their minds, their hands and their hearts. Knowledge they have of people and of the environments in which they live compels them to ask socially significant questions about barriers to human growth, development, and productivity, and to identify and remove those barriers.

For nurses prepared to ask and find answers to important questions and to identify and find resolutions to social problems, what expectations are appropriately held in 1982 and thereafter?

As I see the challenges that lie ahead there are very important changes that must continue to be effected by leaders in nursing. I say continue to be effected because lasting and fundamental change in social institutions is very difficult to make; and it requires consensus on the part of those who are the agents of change and on the part of a critical mass of those who will be affected by it. The first is to effect those changes in nursing that will hasten its being and being recognized as a truly autonomous, primary health profession; the second is to bring about quite remarkable changes in the health care system; the third is to insure a substantial and ever increasing investment in scholarship and a concomitant increase in scholarly productivity on the part of nursing's philosophers, historians, educators, administrators, practitioners, and basic and clinical scientists.

It is to be regretted that society's expectations for all so-called health professionals have had a tendency to over emphasize the disabilities and dependency of persons needing services, rather than their inherent strengths, abilities and capacities for independence in seeking to be optimally healthy. Those expectations have tended to glorify the wisdom and authority of purveyors of heroic treatments of noxious conditions and to consider services rendered by all health professionals to be those which focus on accurately diagnosing and treating human ills. Nurses have willingly or unwillingly contributed to such misperceptions of their important work by failing to communicate clearly and to consistently demonstrate that the focus and scope of their work is that of accurately appraising and effectively enhancing the health status, health assets and health potentials of those they serve. Surely nurses compensate for the dependency persons experience during temporary or sometimes long lasting dysfunction or disabilities when they are suffering from acute and protracted illnesses and sequelae of disease and injury, but nurses' goal in all cases is to work with those they serve in restoring their independence, abilities, functions, and comfort

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and to safeguard and to motivate their own will to be restored to the highest possible level of health of which they are capable. Indeed, nurses greatest success is attained when those they serve achieve optimal levels of health, function, comfort and are on their way to full independence in seeking maximal self fulfillment. Quite obviously nurses who carry such arduous responsibility must be well educated, knowledgeable, competent, and justifiably self confident. Quite obviously their work complements but never supplants the work of the physician; they work in association with all other health professionals.

The nursing occupation does not yet have a critical mass of those well educated professionals who truly understand their own contributions to the health care system. It is incumbent upon those who have the insights which derive from professional education to exemplify and also to communicate the contributions that nurses have to make as primary health professionals. Exciting new demonstrations are taking place in community health agencies, in retirement centers, in health workshops, in birthing centers, in schools, in industries, in apartment house complexes and in correctional institutions wherein nurses are demonstrating the worth of their contributions relative to promoting peoples' health and helping them to be restored to maximum function. Nurses are demonstrating the economic value of their services too as the true nature of their work is exemplified in providing acute and long term care. And since ours is a capitalistic society, nurses are growing ever more astute in demonstrating that their services as primary health professionals represent a wise investment that is worthy of prospective as well as retrospective reimbursement.

Changing the health care system, the second challenge for today's knowledgeable, well prepared nurses is closely related to the responsibility of changing the public's image of nursing and the role that nurses appropriately play. The costs of so called health care, which really is more accurately described as sickness care, now consume almost 10% of the gross national product, with over 90% of those expenditures underwriting the costs of care during episodes of acute illness and chronic disease states. Some of those noxious circumstances are preventable. Knowledge already available portends the economic pay off of investing in health promotion services for all people, while not decreasing disease prevention and sickness care services. However, the quick pay off climate which pervades the corporate and political worlds has, to date, deterred the investment of large amounts of either public or private funds in promoting the health of citizens of this nation. For the immediate future, at least, nursing's intellectual leaders will need to rely upon demonstrations of the value of health

promotion services for small groups of persons such as learners, workers, and retirees, with careful documentation of the long range pay off that can derive from services geared to helping subjects become involved in independently seeking to be maximally healthy.

Perhaps the greatest responsibility of nursing's educated leaders is that of continually enhancing the scholarly productivity of professionals and scientists in the field. In the past two decades quite remarkable progress has been made by nurses who are educated at the highest level of scholarship. The burden placed on nursing's scholars to engage in research, to practice, to teach, to publish, to administer, and to represent nursing in important political arenas is heavy, and it will continue to be so. There is little question however, that nurses' typical over-developed sense of responsibility will need to be substantially exploited for some time to come in order to increase the numbers of investigators and to argument their systematic inquiry. Meanwhile, nurses will need to seek understanding and support for their very essential work designed to advance knowledge about the scientific and humanistic bases of nursing practice and the health seeking mechanisms and behaviors of human beings.

LA RECHERCHE INFIRMIÈRE AU SERVICE DE LA PRATIQUE	NURSING RESEARCH: A BASIS FOR PRACTICE

COLLOQUE NATIONAL CONFERENCE
les 12, 13 et 14 octobre 1983 — Montréal, Québec

Thème: La contribution de la recherche à l'avancement des sciences infirmières	Theme: Toward the development of a science of nursing
Vous êtes invités à soumettre des projets de recherche liés au domaine de la santé et susceptibles de contribuer à l'avancement des sciences infirmières.	Papers invited are those which address questions relevant to health and are significant in the development of nursing knowledge.
Afin de faciliter la planification du Colloque, les personnes intéressées à présenter un projet sont priées d'en informer le Comité scientifique le plus tôt possible.	To facilitate program planning, persons interested in submitting a paper are asked to indicate their intention to the scientific committee as soon as possible.
De plus amples renseignements seront disponibles sous peu.	Complete information available soon.

Nursing Research Conference
3506 University Street
Montreal, PQ H3A 2A7

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ÉDITORIAL

L'IMPORTANCE DE LA FORMATION UNIVERSITAIRE*

Rozella M. Schlotfeldt

Notre mode démocratique de vie qui refuse de croire que le leadership tient à la fortune et à un héritage privilégié, souscrit plutôt à l'idée que le leadership revient de droit à ceux en qui la société a fortement investi au cours des études supérieures qu'ils ont poursuivies. D'ailleurs, la société s'attend à ce que ces professionnels bien formés, ces spécialistes et ces universitaires posent les questions vraiment importantes et tentent d'y répondre. La société s'attend à ce que ses leaders instruits définissent les objectifs sociaux et professionnels qui méritent d'être atteints, et identifient et mettent en oeuvre les moyens de les atteindre. Ces leaders sociaux reconnus et bien préparés, sont appelés à formuler les problèmes épineux auxquels le monde doit faire face et à organiser les ressources permettant de les bien résoudre.

Parmi ces personnes dont l'esprit s'est largement ouvert à la suite de leur formation universitaire, il y a celles qui ont eu le privilège de saisir les capacités, les forces et les talents vraiment remarquables des êtres humains, ce sont ces personnes que les études ont préparé à des professions dans le domaine de la santé, dont les infirmiers et infirmières. Ces mêmes personnes, par le fait même de leur chance exceptionnelle de poursuivre des études, ont été amenées à percevoir le magnifique potentiel de chaque être humain qu'il leur a été donné de servir et à s'en émerveiller. Elles ont été amenées à découvrir et à apprécier le fait que chaque être humain doté d'un capital génétique raisonnable, est en soi un miracle, si l'on tient compte de l'équilibre délicat de sa constitution physique, physiologique et affective. Quelle remarquable harmonie dans le fonctionnement de l'être humain! Quelle incroyable aptitude à réagir à la maladie, aux blessures, à l'adversité et à s'en rétablir! Quelle énergie, quelle motivation innée de survivre, de croître, d'apprendre, de communiquer, d'aimer et de se réaliser!

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* Extrait du discours prononcé par le docteur Schlotfeldt le 25 mai 1982 à l'occasion de la collation des grades du premier groupe de docteurs en sciences infirmières (N.D.).

Les gens qui ont acquis une telle connaissance de l'être humain, sont de vrais "professionnels" qui ont appris qu'il est un langage qui transcende toutes les barrières de langues. Ce langage universel force ceux qui en sont pénétrés à mettre tout leur être: leur esprit, leurs mains et leur coeur au service de leurs frères, Leur connaissance des gens et du milieu dans lequel ils vivent les oblige à poser des questions pertinentes quant aux obstacles à la croissance, au développement et à l'épanouissement de l'être humain et les oblige aussi à éliminer ces obstacles.

Quelles seront, en 1982 et dans les années à venir les attentes des infirmiers qui sont prêts à cerner les problèmes sociaux et à leur trouver des solutions?

Un coup d'oeil sur les défis qui les attendent me permet de voir que des changements importants doivent être poursuivis par les chefs de file en soins infirmiers. Je dis "poursuivis" parce que des changements fondamentaux et durables dans les institutions sociales sont difficiles à réaliser; de plus, cette évolution requiert un consensus de la part des agents du changement et de la part de la "masse critique" de ceux qui en subiront les conséquences. Le premier défi est donc d'apporter des changements qui permettront de faire reconnaître plus rapidement le caractère vraiment autonome des sciences infirmières, profession de la santé de premier plan; le second défi est de susciter des changements tout à fait considérables dans le système de soins; le troisième défi sera de s'assurer d'investissements substantiels et toujours croissants dans les études de cycles supérieurs en sciences infirmières et d'une productivité plus abondante de travaux de recherche de la part des philosophes, historiens, pédagogues, administrateurs, praticiens et des chercheurs dans le domaine des soins infirmiers.

Il est regrettable que les attentes de la société à l'égard des soi-disant professionnels de la santé, tendent à mettre en évidence les incapacités et la dépendance des personnes qui requièrent des services, plutôt que la force, la capacité et l'aptitude naturelles à l'être humain dans la recherche d'un état de santé optimal. Ces attentes tendent aussi à glorifier la sagesse et l'autorité des dispensateurs de traitements spectaculaires et à considérer que les services rendus par tous les professionnels de la santé sont ceux qui sont axés sur le diagnostic exact et le traitement des maladies. Les infirmiers ont, volontairement ou non, contribué à ces perceptions erronées de leurs fonctions importantes en négligeant de démontrer clairement que l'orientation ou la perspective de leur travail est d'évaluer avec précision et de mettre en valeur l'état de santé, les capacités, et le potentiel des personnes qu'ils servent. Les infirmiers suppléent certainement à la dépendance dont les personnes

font l'expérience durant des périodes plus ou moins prolongées de maladie ou d'incapacité, mais l'objectif du personnel infirmier, dans tous les cas, est de collaborer avec les personnes qu'il sert pour les amener à recouvrer leur indépendance, leurs capacités, leur fonctionnement et leur bien-être et les amener aussi à motiver leur propre volonté dans le but d'atteindre la meilleure santé possible. Le plus grand succès des infirmiers est certainement de voir les malades qu'ils ont servis parvenir à un état optimal de santé, de fonctionnement et de bien-être et de constater que ces malades se dirigent vers l'autonomie complète qui leur permettra de parvenir à la plus grande réalisation d'eux-mêmes. Il va de soi que les infirmiers qui assument des responsabilités aussi lourdes, doivent être bien formés, renseignés et compétents et qu'ils doivent faire preuve d'une solide confiance en eux. Il est également évident cependant que leur travail est le complément de celui du médecin, et qu'ils ne peuvent jamais remplacer ce dernier. Les infirmiers travaillent en collaboration avec tous les autres professionnels de la santé.

On ne trouve pas encore dans la profession infirmière de "masse critique" de professionnels bien formés qui comprennent vraiment leur propre contribution au système de soins. Il incombe à ceux qu'éclaire une solide formation professionnelle, de servir d'exemples et également de préciser les contributions que les infirmiers sont appelés à apporter en tant que professionnels de la santé. A ce sujet, on observe des exemples stimulants dans les organismes de santé communautaire, les centres d'accueil pour retraités, les ateliers de santé, les centres d'accouchement, les écoles, les entreprises, dans les complexes domiciliaires de même que dans le milieu carcéral: on y voit les infirmiers démontrer la valeur de leur contribution à l'amélioration de la vie des gens et l'on constate l'aide qu'ils apportent pour mettre ces gens sur la voie de la guérison. Les infirmiers font également la preuve de la valeur économique de leurs services, puisque la vraie nature de leur travail est d'assurer des soins aux malades frappés de maladies aiguës tout comme aux maladies chroniques. Et puisque nous vivons dans une société capitaliste, les infirmiers font preuve de plus en plus d'astuce en prouvant que leurs services de professionnels de la santé primaire représentent un investissement sage et digne d'un remboursement prospectif tout aussi bien que rétrospectif.

Le second défi, apporter des changements au système de soins, défi qui se pose à la génération d'infirmiers bien formés et bien informés d'aujourd'hui, est étroitement lié à la responsabilité de changer l'idée que le public se fait de la profession infirmière et du rôle que les infirmiers doivent jouer. Les coûts de soins de santé, qu'on devrait plus exactement appeler soins aux malades, correspondent à environ 10%

du produit national brut, 90% de ces dépenses étant consacrées aux coûts des soins assurés pendant des maladies aiguës et des maladies chroniques. Certains de ces coûts pourraient être évités. Nous savons déjà qu'il est avantageux d'investir dans la promotion des services de santé pour tous tout en maintenant les services de prévention des maladies et de soins aux malades. Toutefois, le climat qui prévaut dans le secteur privé et dans les milieux politiques favorise un système rapidement rentable. C'est pourquoi l'investissement de sommes importantes provenant de fonds privés ou publics en vue de la promotion de la santé des citoyens du pays a été jusqu'ici découragé. Dans l'avenir immédiat, du moins, les chefs de file intellectuels des milieux infirmiers devront démontrer à de petits groupes tels que les étudiants, les travailleurs et les retraités, la valeur des services de promotion de la santé en comptant sur une documentation soignée des avantages à long terme de services visant à aider ces personnes dans leur propre recherche du plus haut niveau de santé possible.

La plus grande responsabilité des chefs de file infirmiers est peut-être de faire valoir sans relâche les travaux des chercheurs dans ce domaine. Au cours des deux dernières décennies, des progrès remarquables ont été réalisés par des infirmiers ayant atteint le plus haut niveau de formation. Les chercheurs infirmiers font face à la lourde tâche de concilier leurs travaux de recherche avec la pratique de leur profession, l'enseignement, la publication, et leurs activités de gestion; ils sont aussi appelés à représenter le milieu infirmier dans les arènes politiques importantes.

La situation n'est pas près de changer. Il n'y a pas de doute, toutefois, que l'on devra continuer à exploiter le sens des responsabilités, hypertrophié chez les infirmiers, encore quelque temps si nous voulons accroître le nombre de chercheurs, et justifier leurs recherches systématiques. Pendant ce temps, les infirmiers devront rechercher la compréhension et l'appui dont ils auront besoin pour mener à bien leur tâche essentielle qui est de faire avancer la connaissance des bases scientifiques et humanistes de la profession ainsi que les mécanismes et les comportements qui amènent l'être humain à rechercher la santé.

LETTERS

Essence of Nursing — What other readers think.

This note is in reference to a letter written by Edna M. Wallhead of Lakehead University regarding the possibility of having an edition of *Nursing Papers* devoted to discussion, comments, research, etc. on the essence of nursing. I would like to strongly reinforce this suggestion. I think such an edition would be of a quality to satisfy the standards of *Nursing Papers*. There are considerable studies and research being done on "caring" as thé "core", the "essence" of nursing. Theory development in relation to "caring" is also being considered.

This is my area of interest and I have just completed a descriptive study in relation to "caring". I have had an article published in *Nursing Papers* and would be delighted to have the opportunity to publish the findings from my study in *Nursing Papers*.

Williamina Watson, Associate Professor, College of Nursing, University of Saskatchewan.

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My colleague Helen Shore and I were pleased to read Professor Wallhead's letter (Fall 1982) suggesting that an issue be devoted to articles on the essence of nursing. We have a deep interest in the topic and are willing to submit a paper. We hope that sufficient interest is shown to enable you to devote an issue to this topic.

Janet M. Gormick, Assistant Professor, School of Nursing, University of British Columbia.

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**THIRD WEST COAST CONFERENCE ON
CANCER NURSING RESEARCH**

August 4-5, 1983 — Portland Hilton, Portland, Oregon

Information: Ruby H. Rutherford or Mary Lou Hawkins
American Cancer Society
5660 South Syracuse Circle, #101
Englewood CO 80111

THE DEVELOPMENT OF A FAMILY COMPETENCE INSTRUMENT RELATED TO HEALTH *

Virginia Boardman • Stephen J. Zyzanski

ANALYSIS, REVISION AND RESCALING

Investigators have shown that illnesses cluster in families (Downes, 1945) and that patterns of illness are repeated in successive years (Rogers & Reese, 1965). Cassel (1976) has suggested that "a remarkably similar set of social circumstances characterizes people who develop tuberculosis (Holmes, 1956) and schizophrenia (Dunham, 1961; Mishler & Scotch, 1963), are victims of multiple accidents (Tillman & Hobbs, 1949) and commit suicide (Durkheim, 1951). They are individuals who for a variety of reasons . . . have been deprived of meaningful social contact." One related social psychological variable, interpersonal competence, based on Mead's (1934) social behaviorism theory and defined by Foote and Cottrell (1955, p. 49) as "capabilities to meet and deal with the changing world, to formulate ends and implement them" has been suggested as related to the ability of persons to achieve optimal health.

Accoring to Mead (1934) rational behavior, mind, self, language and communication are developed only through repeated interactions with other human beings. The individual learns the meaning of his own behavior only through reflecting upon the response of other persons to his behavior. As verbal and non-verbal gestures are exchanged over an extended period of time, the same gesture calls out the same response in interacting individuals. They come to share the same meaning for specific verbal and non-verbal gestures. The gestures become significant symbols whose meaning is shared, resulting in

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language which makes communication possible between the participants. When the behavior of one individual impinges upon that of another, each learns the role of the other. Since the individual has learned the roles of others, he can predict how they will respond to his behavior. As he experiences interaction with more diverse groups of persons he develops a generalized other, a predictable set of responses from his environment. Cottrell, a student of Mead's, has devoted much of his professional career to the application of Mead's social behaviorism theory to the development of interpersonal competence of individuals, families and communities (Cottrell, 1953; Foote & Cottrell, 1955; Cottrell, 1964, 1977).

While Cottrell had not used the term family competence in his previous work, he drew from his work on interpersonal and community competence (Foote & Cottrell, 1955; and Cottrell, 1977) to conceptualize family competence as composed of seven components (1970):

1. *Commitment* of family members to family group objectives such as education, home, protection, and looking out for each other, preference for family companionship.

2. *Communication* — confiding in one another, talking things out, feeling understood and feeling that one understands the other, the ability of the family to arrive at a working consensus on issues and problems, and the ability of the family to communicate with individuals outside the family.

3. *Pride in* and respect of the family.

4. *Self confidence* — confidence in the family's ability to manage its own affairs and to effect necessary changes in the social environment outside the family.

5. *Judgment* — ability to identify and weigh alternatives and courses of action; to consider consequences in making decisions.

6. *Creativity-resourcefulness* — productivity of new ideas and approaches in resolving problems and achieving goals, willingness to try new ways; knowledge of and willingness to use the resources of the community in the interest of the family.

7. *Participation* — in the commitment of family members to a collective process in the community, their contribution to a definition of goals, as well as to ways and means of their implementation and enjoyment.

Based on this conceptualization, Cottrell collaborated with the present investigators to construct a 64 item questionnaire (Appendix) designed to measure these components.

To test the power of these theoretically conceived components, and family competence as a whole to discriminate between families with high and low levels of health, elementary school absences were assumed to be an indirect measure of family health (Basco, Eyres, Glasser, & Roberts, 1972); and illnesses were assumed to cluster in families (Downes, 1945).

In order to study the relationship between family competence and elementary school absences, one pool of elementary school children with ten or more episodes of absence two years in succession and another pool with three or fewer episodes of absence two years in succession were identified. From these two pools 100 randomly selected families of high absence children were matched by race, sex, grade, and school attended by the index child, with 100 randomly selected families of low absence children to yield a study sample of 200 families. Absence data were collected from the school record. Information required for measurement of family competence and the control variables (social position, number of chronic illnesses and number of illnesses causing loss of time from work or school (excluding the index child), absence of father from the home, family size, number of preschool children and number of siblings younger than the index child, mother's age, and belief in education) was obtained via home interviews with the mothering person in each family (Boardman, 1972; Boardman, Zyzanski, & Cottrell, 1975).

The goal of the investigation was to determine whether family competence as conceived was associated with rates of school absence of the index child.

The number or response options for individual items making up the seven components varied from eleven to two. Therefore, to give all items comparable weights, the responses to the items were converted into standards scores. The responses to items within each component were then averaged to yield component scores. The total competence score was the sum of the seven standardized component scores.

After a series of preliminary analyses of the data, two final analyses were performed. To determine both the independent and the joint contribution which the control and matching variables and family competence made in the delineation of families with a high or low absence child and to evaluate the contribution of the total competence score after having partialled out the combined influence of all the

other variables, a stepwise partial correlation analysis was performed. In this analysis all the variables except family competence were considered in the partialling procedure and each entered in the order of its strength of association with the absence level of the index child. Family competence was held out until all the variation that could be attributed to control or matching variables was determined and partialled out. Family competence, considered only after all other variables were partialled, was found to be significantly associated with absence level (p .05). The seven variables which demonstrated significant partial correlations with absence level were: belief in education, number of time losing and chronic illnesses (excluding the index child), number of preschool children, father in the home, race, and social position.

To verify the significant relationship between family competence together with its seven components, and absence level, a two-way multivariate analysis of covariance was performed, cross-classifying the sample by social position and absence level. This analysis treated separately as covariates each of the six variables indicated by the partial correlation analysis as being significant and independent contributors of absence behavior. With the effects of the six covariates and social position eliminated, statistical tests for absence status in relation to the total competence score and three components: participation, self-confidence, and judgement were significant (p .05).

Since chronic and time losing illnesses (excluding the index child) were measured as control variables, the opportunity existed to study the relationship between family competence and its components, and absence, as well as illness levels in other family members. The two illness variables, chronic illness and time-losing illness, were each dichotomized as "no illness reported in family members" or "one or more illnesses reported in family members." These results were then combined to form a variable with four possibilities: 1) both time-losing and chronic illness reported in the family members, 2) only chronic illness reported in family members, 3) only time-losing illness reported in family members, and 4) no illness reported in family members. One way analysis of variance was used to test the relationship between illness of family members (excluding the index child) and family competence and its components. The level of significance was set at .05. Families reporting illness scored lower on family competence (F=3.4, p .05) and the components of self confidence (F=3.5, p .05) and judgement (F=3.2, p .05) than did families reporting no illness.

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A cross tabulation of families by absence level of the index child and illness level as categorized above yielded a chi square value of 10.02 (p .05). Absence level in the child was significantly related to illness level in other family members.

The instrument showed promise of being highly useful in predicting specific areas of family functioning related to health and illness. However it was cumbersome to use in its original form, both in the large number of items and the complex scoring system. Therefore with the collaboration of a psychometrician (S.J.Z.) the investigator proceeded to revise the instrument and its scoring.

METHOD

Factor analysis. The original 64 items measuring the seven components of family competence were derived from social behaviorism theory. The first step in exploring the empirical structure underlying the family competence construct was to submit the responses of the random sample of 200 mothers to principal axes factor analysis. The major use of factor analysis is to extract a smaller number of valid factors contained in a larger set of independent items. In this application there is an exploration and detection of patterning of variables with a view to discovering new concepts and a possible reduction of data. The solution which seemed to provide the simplest explanation of the construct contained four factors. Of the 64 original items, 18 loaded more than .25 on "family interaction", 6 items loaded similarly on "community participation", 22 items on "family problems," and 20 items loaded on the factor "non-family resources." The names of the factors were assigned tentatively after examining the content of the items having the largest loadings on each factor.

Stepwise regressions. Since some of the items which loaded more than .25 on individual factors may be redundant, the subjects' scores for items loading more than .25 on each factor were regressed in a stepwise fashion against the subjects' respective factor scores.*

Items explaining at least 1% of the variation in the factor score were noted. A second set of regressions was computed with chronic and time losing illness as dependent variables and the 64 original family competence items as the independent variables. The purpose of these

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* The factor scores for an individual are computed from the data (test scores) and factor analytic information. A person who scores high on several variables that have heavy loadings for a factor will obtain a high factor score on it. Guertin, W. H. & Bailey, J. P., Jr. Introduction to Modern Factor Analysis. Ann Arbor, Michigan: Edwards Bros., Inc. 1970, 192-197.

regressions was to identify items explaining the variation in the families' illness experience. Eight items which explained a significant amount of the families' illness experience were noted. The eight items that loaded at least .25 on one of the four factors and were significantly related to illness experience were then forced into the stepwise regressions on the respective factor scores before the items previously noted to have explanatory power. When the eight illness related items were considered first, some of the originally significant items were redundant and were dropped from their respective factors.

Reliability. The four scales formed above were then tested for internal consistency reliability using Cronbach's coefficient (Guilford, 1954). Those items that were strongly correlated with all other items in their respective scales and the total scores were retained in the scales. Through the three procedures 28 of the original 64 items were dropped from the instrument, leaving 36 items in the revised instrument. The final Cronbach's Alpha reliability coefficients were .82 for the total competence instrument, .83 for family interaction, .70 for family problems, .67 for non-family resources, and .91 for community participation.

The empirically derived components. The four empirically derived components evolved essentially from five of the theoretically conceived components. Communications became family interaction, participation became community participation, creativity-resourcefulness became non-family resources, and judgment and self confidence became family problems. The responses to the items measuring the original components of commitment and pride in family contributed little to the final family competence instrument.

The factor loadings for the final nine items making up the component family interaction ranged from .31 to .73. Seven of the nine items making up the component were in the original theoretically conceived communication component. The original judgment and self-confidence components contributed one item each.

The second empirically derived component, community participation, is composed of four of the original participation items and one item from the commitment component. The factor loadings of these items ranged from .73 to .84.

The third empirically derived component, non-family resources, is composed of six items from the original creativity-resourcefulness component, and two items each from self confidence and participation. These ten items had factor loadings which ranged from .26 to .66.

The last empirically defined component, named family problems by a group of faculty consultants, was composed of 12 items representing all seven of the original components, with factor loadings ranging from .27 through .51. Self confidence contributed five items, judgment two items; while the other five components each provided one item.

The factor analysis, regression procedure, and reliability testing confirmed the contribution of five of the original components of the theoretically conceived construct of family competence as measured in this study.

Optimal scaling. In the original instrument scores were assigned to item response possibilities according to the investigators' best judgment. However, from the data generated from the 200 subject random sample, the response possibilities of each item could be weighted optimally, with the weighting determined by the subjects' responses to each item in relation to other items in the same scale. Using the original 200 subjects (mothers of high and low absence children), responses to each of the 36 items retained from the original competence instrument were optimally scaled by a method developed by Fisher (1948). The computational techniques used were programmed by Bock (1960) and developed further by Nishisato and Leong (1975). A very similar method of scaling of alernative responses to a given stimulus was independently developed by Guttman (1941). The scaling depended on the cross-tabulation of subjects by their choice of an item response possibility and the level of their component score divided into high, medium, and low categories. An example of the difference between the original scoring and optimal scaling is illustrated below.

A. Original intuitive scoring scheme:

Every family has its own way of doing things. There is no right or wrong way. We are interested in what is happening to families now. Place an "x" on the line according to where you think your family lies.

1. I can't take care of my own problems.

       1 2 3 4 5 6 7 8 9 10 11
Really true . . . . Not true at all

2. We vote in most of the local elections.

       1 2 3 4 5 6 7 8 9 10 11
Never   . . . .   Always

B. Optimal item scaling:

Every family has its own way of doing things. There is no right or wrong way. We are interested in what is happening to families now. Place an "x" on the line according to where you think your family lies.

I can't take care of my own problems.

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                1  1  1  1  1  1  5  5  5  5  7
Really true  ...................................  Not true at all
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We vote in most of the local elections.

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                1  1  1  1  1  2  2  2  2  2  6
Never        ...................................  Always
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Test of the optimally scaled items. The reliability coefficients for the four scales were recalculated using optimal item weights. There were no changes in the reliability coefficients. Originally the component scores were constructed by averaging the standard scores of the items making up the component. When statistical analyses were carried out comparing both the averaged component score and a simple addition of the optimally scaled scores of the items, little difference in the reliability or discriminating strength was observed. The component scores are now constructed simply by adding the optimally weighted items within each scale. The weights are "integer" numbers as indicated in the sample above.

Several of the statistical analyses carried out with the original 64 item instrument were repeated using the revised and rescaled 36 item instrument. With absence level as the dependent variable, stepwise discriminant analyses were performed holding family competence out until all the control variables from the original study explained as much of the variation between families of high and low absence children as possible. Family competence was then considered and was found to be negatively related to absence level (p .05).

After testing family competence in relation to absence level, time losing and chronic illness variables were placed in four categories, as described earlier. One-way analysis of variance between level of illness as categorized and family competence and its components yielded the following results: family competence, F=3.7, p .05, family interaction, F=3.6, p .05; non-family resources F=1.2, n.s.; family problems F=4.2, p .05; and for community participation, F=.59, n.s.

The means of the scores for family competence, family interaction, and family problems were significantly higher for families reporting no illness as compared to the means of scores of families reporting illness.

Summary and discussion

The original 64 item, theoretically conceived, family competence instrument was designed for use with families with children in elementary school. In a study of 200 randomly selected families, the total family competence score and three of the components, self confidence, judgment, and participation were negatively related to school absence level, an indirect measure of health. In addition the total competence score and the components, self confidence, and judgment, were negatively related to the reported amount of family illness.

The original theoretically conceived family competence instrument was revised and rescaled by means of factor analysis, multiple regression techniques, testing of internal consistency reliability, and optimal scaling procedures. Four empirically derived components emerged from the original seven components: family interaction from communication; community participation from participation; non-family resources from creativity-resourcefulness; and family problems from self-confidence and judgment. Responses to items measuring commitment and pride in family contributed little to the new instrument. The five contributing components have direct theoretical links to the interaction, communication, and the environmental predictability concepts of Mead.

The final empirically derived 36 item instrument was tested by extracting the responses to the 36 items and the absence and illness data from the original study. The revised family competence score retained its negative relationship with the absence level of the index child. In addition the revised family competence score and two factors, family interaction and family problems, were negatively related to reported illness levels of the families.

The revised family competence instrument appears to be useful for both clinical and research investigation of factors related to school absences and family illness level. Of particular interest is the identification of factors contributing to family competence. Identical total scores can be achieved by different combinations of factor scores. Thus, utilizing both total and factor scores, profile differences in families can be examined. Interactive relationships among the factors and global competence in relation to health outcomes can be identified.

Further development. The instrument at this time is based on one 200 subject random sample. Validation of the revised instrument with larger more representative samples from other populations is necessary. In addition the opportunity existed to make further revisions of the instrument so that it could be used to study families in later stages of the life cycle. Five items which are pertinent only for families with school children have been deleted. Other items which loaded on the respective factors and are relevant for families at all stages have been studied in relation to their power to explain the factor score and their contribution to the internal consistency reliability of the scale. Therefore two versions of the revised instrument now exist, one for the study of family competence in families having school children and one in families at all stages. The instruments and further information concerning instrument development are available from the first author.

APPENDIX (Sample items)

Family Competence Questionnaire
(For families with school children)

Proceed slowly and thoughtfully through the questions. Think about every question carefully. Put an "x" on the line according to your judgment as to where the answer lies from "most" to "least."

Component 1 — Family interaction

Generally, how much does each family member listen to what others say about the problem.
Not at all . . . . Listen carefully

Generally, how much does each family member feel he or she is understood concerning the problem?
Not at all . . . . Very much

Component 2 — Family problems

If I had more education, I could help my family more.
Not true at all . . . . Really true

I would expect our in-laws to take care of their own problems.
Not true at all . . . . Really true

Component 3 — Non-Family Resources

Can you think of a time when then the family had a real emergency in the *past few years* such as when one of the adults in the family has been very ill, or was in the hospital for more than a week, or had to be away from home for more than a week? During that time how much help did you get from:

Your neighbours?
No help. . . . . .Great deal of help

Your church?
No help. . . . . .Great deal of help

Component 4 — Community participation

Community activities of parents. Circle YES or NO for *each* parent.

	Mother	Father
Member of school parent association	Yes No	Yes No
Helps teacher or other parent with school activities one or two days a year.	Yes No	Yes No

REFERENCES

Basco, D., Eyres, S., Glasser, J. H., & Roberts, D. E. Epidemiologic analysis in school populations as a basis for change in school nursing practice — report of the second phase of a longitudinal study.*American Journal of Public Health*, 1972, *62*, 491-497.

Boardman, V. School absence, illness, and family competence. (Doctoral Dissertation, Department of Epidemiology, University of North Carolina, Chapel Hill, 1972). Dissertation Abstracts International, 1973, *33*, 3748B. (University Microfilms No. 73-4802).

Boardman, V., Zyzanski, S. J., & Cottrell, L. S., Jr. School absences, illness, and family competence. In B. H. Kaplan and J. C. Cassel (Eds.), *Family and health: An epidemiological approach.* Chapel Hill, North Carolina: Institute for Research in Social Science, University of North Carolina, 1975

Bock, R. D. Methods and applications of optimal scaling. University of North Carolina at Chapel Hill. Psychometric Laboratory Research Report No. 25, 1960.

Cassel, J. The contribution of the social environment to host resistance. *American Journal of Epidemiology*, 1976, *104*, 107-123.

Cottrell, L. S., Jr. New directions for research on the American family. *Social Casework,* 1953, *34,* 54-60.

Cottrell, L. S., Jr. Social planning, the competent community and mental health. *In Urban American and the planning of mental health services,* Symposium No. 10, pp. 391-402. New York: Group for the Advancement of Psychiatry, 1964.

Cottrell, L. S., Jr. Personal communication. Chapel Hill, North Carolina, 1970.

Cottrell, L. S., Jr. The competent community. In R. L. Warren (Ed., 2nd ed.) *New perspectives on the American community.* Chicago, Rand McNally College Publishing Company, 1977, pp. 546-560.

Downes, J. Sickness as an index of the need for health supervision of the school child. *American Journal of Public Health,* 1945, *35,* 593-601.

Dunham, H. W. Social structure and mental disorders: competing hypotheses of explanation. *Milbank Memorial Fund Quarterly,* 1961, *39,* 259-311.

Durkheim, E. *Suicide: A study in sociology.* Glencoe, Illinois: The Free Press, 1951, pp. 210-216.

Fisher, R. A. *Statistical methods for research workers.* New York: Hafner, 1948, Section 49.2.

Foote, N., & Cottrell, L. S., Jr. *Identity and interpersonal competence.* Chicago: The University of Chicago Press. 1955.

Guilford, J. P. *Psychometric methods.* New York: McGraw-Hill, 1954, p. 385.

Guttman, L. The quantification of a class of attributes: a theory and method of scale construction. In P. Horst, P. Wallin, L. Guttman (Eds.), *The prediction of personal adjustment.* New York: Social Science Research Council, 1941, 318-348.

Holmes, T. Multidiscipline studies of tuberculosis. In P. J. Sparer (Ed.) *Personality stress and tuberculosis.* New York: International Universities Press, 1956, Chapter 6.

Mead, G. H. *Mind, self and society.* Chicago: University of Chicago Press, 1934.

Mishler, E. G., & Scotch, N. A. Sociocultural factors in the epidemiology of schizophrenia: a review. *Psychiatry,* 1963, *26,* 315-351.

Nishisato, Z., & Leong, K-S. Opscal: A fortran program for analysis of qualitative data by optimal scaling. Measurement and evaluation of categorical data. Technical Report #3. University of Toronto, Toronto: 1975.

Rogers, K. D., & Reese, G. Health studies — presumably normal high school students. II Absence from school. *American Journal of Diseases of Children,* 1965, *109,* 9-27.

Tillman, W. A., & Hobbs, G. E. The accident-prone automobile driver: a study of the psychiatric and social background. *American Journal of Psychiatry,* 1949, *106,* 321.

RÉSUMÉ

Les aptitudes de la famille et la santé

Un instrument de mesure a été conçu à partir de la conceptualization de Cottrell des aptitudes de la famille, qui avait sa source dans la théorie du comportement de Mead. Les 64 points de l'instrument ont été conçus afin de mesurer sept composantes proposées par Cottrell: l'engagement, la communication, la fierté familiale, la confiance en soi, le jugement, la créativité-ingéniosité, et la participation. L'instrument a été testé sur un échantillon de deux cents familles choisies au hasard et ayant toutes des enfants à l'école primaire.

Les aptitudes de la famille et trois éléments: la participation, la confiance en soi et le jugement avaient une corrélation négative avec le taux d'absentéisme des enfants sujets et le taux de maladies chroniques et de maladies qui entravent les activités dans les familles (à l'exception des enfants sujets). L'examen de l'instrument dérivé de la théorie à l'aide de l'analyse factorielle des principaux axes, de la régression multiple et de l'évaluation de consistance interne de la fiabilité a permis de réduire l'instrument de mesure des aptitudes à 36 points et quatre composantes: 1) participation communautaire, 2) ressources extérieures à la famille, 3) interaction familiale, et 4) problèmes familiaux. Deux des composantes de la théorie originale: l'engagement et la fierté familiale n'ont que très peu contribué à l'application de l'instrument de mesure empirique. Les quatre nouvelles composantes obtenues empiriquement sont étroitement reliées aux concepts d'interaction sociale et de l'élaboration de prévisions relatives au milieu de Mead. Les techniques d'échelle optimale ont simplifié l'évaluation des items, d'une combinaison de trois décimales à des chiffres simples. L'instrument révisé d'évaluation empirique est maintenant prêt à être testé par les chercheurs sur d'autres populations; il permettra d'obtenir une meilleure compréhension de sa valeur en identifiant les familles chez lesquelles la probabilité de maladie est très élevée.

A REPORT ON FACULTY PRACTICE: PROMOTING HEALTH IN A CHILDREN'S DAY CENTRE

Hélène Ezer • Judith MacDonald

Within the university academic community, schools of nursing have been attempting to carry out the university's goals of teaching, research, and service to the community. It is imperative that nursing demonstrate its competence in these areas if the profession is to reach a full collegial role within the academic community which has little tolerance for any discipline that seeks exemption from these responsibilities.

Additional pressures exerted by leaders in the practice settings, demand that university faculty become more actively involved in demonstrating their skills and influencing the direction of change.

> Even though a small minority of nurse faculty members practice regularly, the vast majority are not influencing the quality of nursing care by their clinical input. At a time when the nursing profession is probably in its greatest state of flux, when it is crucial to assert the value of nursing in the changing health care system, and when public support needs wooing, nurse faculty members remain on the sidelines . . . The misuse of this large reservoir of talent is a great impediment to the progress of the profession . . . Students, by default of the faculty, must use staff nurses as models of clinical practice. These nurses are usually far less prepared than the nurse faculty members, and role induction suffers proportionately. (Christman, 1979, p.9)

These are not conflicting pressures. In applied disciplines, it is the field, or practice setting that raises issues for study and research and provides the relevance behind curricula. In university nursing departments the value placed on faculty practice may vary for historic, economic or organizational reasons, but increasing attention is being paid by administrators to the meaningful links that can be made with the clinical field, as faculty members are encouraged to devote time to clinical practice.

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However, not all faculty members feel equally at ease in meeting these demands. A feeling of impotence in affecting the development of a practice setting, a sense of personal inadequacy, insufficient time, and lack of support from the nursing department are some of the reasons given for their lack of involvement.

These reasons may be valid, but there may also be a certain developmental readiness for individual faculty members to take on all the dimensions of their role. Barley and Redman (1979) discuss at length the development of nursing faculty and their socialization into the faculty role. They view this development as moving along a continuum of stages according to the complexity and generality of the assumptions that underlie the individual's professional life. Full adaptation to the role may be seen as the ability to achieve balanced productivity in the university's defined goals and is determined by the faculty member's stage of development and the length of time spent in the academic role. The authors suggest that varying faculty compositions within the school will affect the individual member's performance in achieving productivity and that many university faculties are predominantly in the lower stages of development. They propose that the two areas of research and clinical practice may need to be integrated into an overall plan for faculty development if individual and collective performance is to improve.

What follows is the description of the clinical practice undertaken by two faculty members over a two and a half year period with a university-operated day care centre for children. It is seen as part of a commitment to the university objectives of teaching, research and service to the community and also to the need to continue to study and develop nursing practice.

BELIEFS UNDERLYING FACULTY PRACTICE

Integral to all conceptual frameworks for nursing practice is the premise that nursing is concerned with health. Health, as we view it, is not merely an absence of illness, nor simply the capacity to cope with life's problems as they arise. Rather, it is seen as a value, as a part of an active state where one learns from all events of life and uses this knowledge to anticipate the future and deal with it in a thoughtful and productive manner. We also believe that the physical, intellectual and emotional activity of dealing with developmental and situational events helps to build a resource pool for the individual. This pool can be used in much the same way as financial capital — invested at critical moments for potentially greater returns.

The health behaviours which add to the resource pool of the individual are first learned early in childhood. Unfortunately, this is the time when parents and children consult professionals only after problems have arisen. This pattern of service utilization is reinforced by health professionals who intervene when asked and leave as soon as a workable solution to the immediate problem is found. Most intervention is problem-oriented with little collaboration between professional and client to explore any issues beyond the immediate. Often, little attempt is made by professionals — except in a casual way — to highlight the skills or successes that a parent has gained while helping a child, or that the child has demonstrated after mastering a new developmental task or a stressful event. In a belief system where health promotion is at the heart of practice, the nurse endeavors to capitalize on every opportunity to identify out loud with the individual (adult or child) what he or she sees the task to be, what skills are already possessed that will help to deal with the problem and to examine how the insights gained in dealing with the present might be used to anticipate the future and more effectively cope with it.

This deliberate strategy of identifying existing coping skills and the active process of learning new ones is not an automatic way of problem-solving. Learning this strategy requires time and repetition. Consequently, a professional practice which attempts to develop it, demands repeated interventions and the passage of time, if one hopes to see and measure change in health behaviour.

THE IMPLEMENTATION

Nursing practice in a pre-school is described by a number of authors (McCarthy & Brett, 1979; Katsura & Millor, 1978; Hanson, 1977; Pridham & Hurie, 1980). As described, the role of nursing varies from acting as a consultant for problem children, assisting parents to provide optimum learning experiences for their young children, monitoring pre-schoolers' physical health and development, and providing an educational experience for nursing students in primary care. The diversity of these approaches reflects the various ways in which a setting such as this one might be used for nursing practice.

Our involvement with the McGill Community Family Centre began as an attempt to explore the possibility of using the day care centre as a practice setting for university faculty and as a learning environment for B.A./B.Sc. graduates enrolled in a generic master's program (Attridge, Ezer, & MacDonald, 1981). The proximity of the day care centre to the School of Nursing and the source of young, healthy and generally well-functioning families that it provided were attractive

features in initiating our involvement. These characteristics seemed to fit closely with our belief concerning health promotion within the family unit. This readily accessible setting seemed ideal for testing out the framework of nursing that is developing at the School of Nursing. In addition, it afforded us the opportunity to offer a service to the university and to the community of which it is a part.

When the MCFC was first established for the families of all McGill employees and students, it was envisaged as a centre where parents would be included to a great extent in the management and in the day-to-day affairs at the centre. At the time of our involvement, the director and a number of the day care staff had one or more children attending the centre. Parent luncheon meetings took place every six to eight weeks to discuss subjects of general interest, and parents were actively involved in painting and generally refurbishing the premises when needed. The centre operated with a fairly limited budget, all of its staff had received preparation in early childhood education (some at the university level), and the turnover rate was low.

In explaining our interest and presence in the day care centre, we were explicit about our beliefs concerning health and the importance of the family in understanding, determining, and being affected by a child's behaviour. We also expressed a willingness to discuss whatever issues the staff or parents might like to have addressed. We allotted one half-day/week to visit the centre, spending time talking with parents, talking with the children and observing them, and talking individually with the day care workers. We frequently reiterated that we did not have a preset agenda of critical issues, but that we were eager to discuss with the staff and the parents whatever ideas, or concerns about the children or about their own life within the work setting that they wished to share. In addition, we communicated with the parents on a regular basis through letters that were sent home with their children or through the Monthly Newsletter. In our own discussions following our visits to the centre, we shared observations, analyses and ideas of how we might be helpful.

At the outset, the Director and the staff were eager for nursing involvement, because it appeared to offer some sort of emergency medical service that they felt was needed. We complied with the initial request for first aid information and continued to give positive reinforcement for their responses to critical situations (a child's febrile seizure, falls, etc.) in an attempt to respond to their expressed need for this type of intervention. There were no true child emergencies at the centre over two and a half years.

In examining the issues that arose over the duration of our involvement, one that recurred most frequently for children in all the age groups was that related to food intake. For the most part, parents and staff were very much aware of what constituted a balanced food intake. The teachers frequently talked with the children about "good" food, and parents were asked not to send sweets or gum in the child's lunches. For several weeks in the fall of the year, a group of parents discussed the issue of supplying hot lunches on a rotating basis for their child's group, but they finally dropped the idea. A concern was expressed at different times by either a parent or teacher relating to a child who was too thin and would not eat adequately. The parents' and staff's food-related concerns were usually discussed with the nurse. The parents of one child sent large lunches and asked the staff to see that the child ate everything. With this child, our suggestion of dividing up the lunch throughout the day to make the quantity more manageable did increase the child's intake for a couple of weeks. At that point, her intake dropped again, but the teacher and to some extent the parents, had become less concerned and accepted the child's intake as adequate. Making observations that the rest of the child's behaviour compared normally with her peers and that, in fact, she was consuming a little of all the basic food groups was, in the end, reassuring. A father of Spanish origin became very angry with his daughter and with the teacher because the child would not eat. He compared her with her younger brother who almost equalled her in weight and certainly surpassed her in intake. The teachers at this time felt satisfied with the child's limited consumption as they were familiar with the waxing and waning of the children's appetites. Talking with them about less combative ways of discussing the issue with the father brought good results. Reference to curves of average heights for boys and girls was helpful in consolidating the judgment the teachers were making with regard to the children's food intake and their size. Discussion of these curves and their general interpretation was also useful to one teacher-parent who was somewhat distressed at her pediatrician's insistence that she cut back her own son's intake.

These concerns about food — what kind, how much and how little — recurred with remarkable regularity. The frequency with which they arose is perhaps related to the socio-economic class and education of the families and the staff of the day care centre, but it must also reflect the value that our society at large places on the art and the importance of feeding its children.

A second major theme was that of coping with separation. This first arose at a luncheon meeting when one set of parents commented that

their child had a hard time leaving his friends from the centre during the summer holidays. Another parent commented that she was most concerned about her son's adjustment to kindergarten in the following year because he had spent his first four years in the same setting. A few weeks after this, one of the teachers described hoarding behaviour in one child whose father had left the family. Another child had been increasingly disruptive in class and the teacher felt that it was related to his father's departure for the better part of each week as the family prepared for a move to another city.

For us, these observations suggested that separations were significant critical events for the children and that the teachers might try to deal with them. We received a mixed response to this suggestion from the teachers — some feeling that it was better not to upset the children in advance, and others feeling that children would not find any relevance in talking about events that they did not actually experience. After some discussion, we came to the decision that talking about going to kindergarten in a new school would be the most relevant approach to take. In response to the latter idea and out of our own knowledge and commitment to the idea of anticipatory preparation of children, we created John and Julia — two puppet friends who where going away to a new school following their summer vacation. John was excited and happy about his upcoming adventures, while Julia was afraid of the new school and sad to leave her friends and teachers. She did not want to go anywhere. The puppet show was performed just prior to the end of the school year when most of the children were leaving. By the second year of its presentation, we had become more spontaneous in our delivery and the teachers were much more sensitive and comfortable in handling the children's discussion afterward. As a result, the children were completely engrossed in the puppets. They talked with them directly, saying they felt the same way. One delightful five year old told Julia to take a friend with her to the new school and then she would not be frightened. Failing that, she told Julia that she could come with her. The teachers, who knew the children's feelings very well, talked with them about how it felt to be new and afraid. They recalled ways in which together they had been able to help the two new children who had recently joined their group. In fact, throughout the second year, teachers were particularly involved with the theme of saying good-bye. They planned parties and made special attempts to talk about the children's feelings around this theme.

The idea of anticipatory preparation for an event was behind a second project that we developed. Occasionally, throughout the

school year, one child might go to hospital for elective surgery or for a minor mishap. The teachers wanted a hospital tour arranged so that the children might see what hospitals were like. We felt it would be more relevant to simulate a visit to a doctor's office — an event that was common to all of the children, frequent for some, and frightening for at least a few. Our students in the master's program took this on as a part of their clinical experience with children. These students had completed a course in child development and were in the process of completing a module on helping children to cope with hospitalization. This involved working with children at home and in the hospital, and observing and assisting as parents and children dealt with the experience. It was the students' responsibility to plan this project and to carry it out in its entirety, but we gave them whatever suggestions and ideas we had from our experience. The simulated visit took place in the learning laboratory at the School of Nursing. The students divided the room into interest areas where groups of 3-4 children could each handle tongue depressors, stethoscopes, ophtalmoscopes and give injections to their stuffed animal — the friend that had accompanied them from home. They also prepared coloring books and handouts for the children and discussed with them ideas and topics they had prepared in advance. These activities involved relatively little time for the individual student, but had a remarkable payoff. Students felt it had given them the opportunity to put into practice ideas that were often difficult to implement in the hospital setting. They found that the feedback of seeing the change in a child's behaviour as he mastered his fears was invaluable in consolidating their own learning. Finally, the exercise gave them an opportunity to study the behaviour of pre-school children in groups.

Prior to these events letters were sent to the children's parents to explain what the child was about to experience and why we were undertaking the project. We also included some suggested readings from local public libraries for both parent and child. We invited parents to give us or the staff of the centre whatever feedback or comments they might have about how they or their child felt about this experience.

In addition to our work with groups of children, we maintained regular informal contact with all the teachers on the staff. This provided us with an opportunity to discuss individual children and to follow up whatever concerns they expressed. A number of interventions developed from these contacts. One of these was developing a scrapbook about babies that was used by teachers (and borrowed by parents) to talk about the arrival of a new baby. At another time, we met informally to share ideas about how to discuss discipline and limit

setting with a particularly indulgent father. This was particularly helpful to the younger teachers who where hesitant about approaching parents regarding their child's behaviour. We also shared ideas about helping another child who was having a difficult time adjusting to separation from her mother and to the day care centre environment. On one occasion, the director of the centre asked that we see one mother who was extremely depressed after her husband took their newborn infant and left permanently for Nigeria. One of us maintained regular contact with this mother over a period of eight months while she rallied her resources, took an apartment, returned to work, and began making new social contacts with other single mothers who lived nearby.

Contact with the parents as a group was easiest to maintain with parents of children in the infant group (one month — 18 months), where either the mother or the father generally came for the child's noon-day meal. With only a little encouragement, these parents shared information on child rearing and development with each other, and because they saw us regularly, discussed with us on an individual basis ideas and questions they had about a wide variety of family life and child care issues. The other sub-group of parents that we also came to know well were those who regularly attended the parents' luncheon meetings. This was a verbal group, keenly interested in any matter related to their children's welfare.

Current projects at the centre include a bulletin board entitled "A Young Family's Health." Time is a costly commodity for many of these parents particularly at the beginning and end of each day, so that this board offers information and ideas on a variety of topics, e.g. infants' diets, dental care, sleeping problems. The content changes every three weeks, and information can be read at the centre or is available in a handout format for those parents who choose to examine it at their leisure at home. This bulletin board format can also serve as a relevant project for nursing students who may continue to develop it in new directions.

Our involvement with the day care centre over the past two years has highlighted for us the sense of community that surrounds the centre. Most children spend three and often five years here. They, their parents and the staff become very attached to one another. Parents are clearly concerned about their child's departure from the centre to a new school. It was interesting for us to see the Board of Directors of the centre, keenly interested in the puppet show, follow up the idea with a parent information session on choosing a kindergarten and facilitating a child's entry to a new school. We also see changes in

attitudes of the teachers who are much more actively involved in preparing children for upcoming events, planning parties as children leave, and making time in the children's day to talk about how they felt about their trip to the hospital emergency, the little brother at home and moving to a new house. Most of all it has been the responses of the children that have made the work of the centre such a delightful experience.

NEW DIRECTIONS IN PRACTICE AND RESEARCH

This setting has stimulated us to consider a number of ideas related to health promotion that may profitably be explored through research study. We need now to measure to what extent anticipatory preparation of children about to experience change (e.g. entry to a new social system) will affect their responses to that event. Is their adaptation to the new environment more rapid? Is it qualitatively different from that of the unprepared child? Are the children's behaviours at home notably different from the behaviours of children who are not prepared in advance? Is a child's ability to verbalize feelings of apprehension related to his ability to cope with them? Also, what child care options are considered by working parents? What factors affect parents' satisfaction with the choice of a day care centre as a child care option? These questions related to health work with young children and their parents have important implications for nurses working with families at this developmental stage.

There are a number of ways in which practice in a clinical setting like this one can be developed, depending on the nature of the day care centre, the time available for practice and the particular approach to practice of the individuals involved. The faculty practice described evolved in direct response to the nature of this particular day care centre. As it doubles in size, different issues will arise which will alter the specific nursing activities that we might undertake. However, the setting has offered a unique opportunity for a creative, flexible and feasible nursing practice where the time involved can be adjusted and juggled to fit in with other commitments to the university. In addition, settings such as this one provide excellent possibilities for joint faculty practice (as described) and for joint faculty-student practice and research.

Moving in new directions will bring nursing into closer touch with the health-related issues of family care. To date, we have not recognized the opportunities and directions that these settings offer, but we must begin to do so if we are to develop any insight or expertise in the domain which we claim belongs to nursing — that is, the promotion of health.

REFERENCES

Attridge, C., Ezer, H., & MacDonald, J. Implementing program philosophy through curricular decisions. *Nursing Papers*, 1981, *13* (1), 59-69.

Barley, Z. A., & Redman, B. K. Faculty role development in university schools of nursing. *Journal of Nursing Administration*, 1979, *9* (5), 43-47.

Christman, L. The practitioner-teacher. *Nurse Educator*, 1979, *4* (2), 8-11.

Hanson, M. The nurse's role in early childhood education. *Pediatric Nursing*, 1977, *3* (6), 30-32.

Katsura, H., & Millor, G. K. The difficult child in day care — a nursing challenge. *The American Journal of Maternal-Child Nursing*, 1978, *3*, 166-170.

McCarthy, N. C., & Brett, D. Learning primary preventive intervention in the day care centre. *Nurse Educator*, 1979, *4* (3), 12-14.

Pridham, K. F., & Hurie, H. R. A day care health program: linking health services and primary care nursing education. *International Journal of Nursing Studies*, 1980, *17*, 55-62.

RÉSUMÉ

Rapport sur l'exercice des professeurs: promotion de la santé dans une garderie

Les professeurs des facultés des sciences infirmières doivent faire preuve de compétence dans le domaine clinique, et partager cette compétence avec les autres infirmières de façon à poursuivre le développement de leur profession. De plus, l'université exige aussi la compétence en matière d'enseignement, de recherches et de services à la collectivité. Ces exigences, souvent perçues comme conflictuelles, peuvent s'intégrer l'une à l'autre si chaque professeur possède une perspection claire des soins infirmiers et s'inspire, dans l'exercice de sa profession, des ressources et du vécu tirés des différents domaines cliniques. Le présent article expose un exemple d'exercices cliniques dans une garderie universitaire et propose les orientations d'une étude plus approfondie.

PROMOTION DE LA SANTÉ DES FAMILLES EN MILIEU HOSPITALIER PÉDIATRIQUE

Raymonde Paquet Grondin • Monique Rinfret Bisson

Il est généralement reconnu que la santé constitue une priorité dans la vie des personnes. La promotion de la santé des individus et des familles représente ainsi une préoccupation importante de l'infirmière. Promouvoir la santé est habituellement considéré comme un des principaux rôles de l'infirmière engagée en santé communautaire. Nous sommes cependant d'avis que cette préoccupation concerne le travail de l'infirmière, quel que soit le milieu clinique dans lequel elle oeuvre.

Ayant enseigné depuis quelques années à des étudiantes-infirmières dans un centre hospitalier pédiatrique, nous constatons que ce milieu représente une excellente opportunité de promouvoir la santé des familles. En effet, la plupart des hôpitaux pédiatriques permettent la présence des parents auprès de leur enfant hospitalisé, à toute heure du jour et de la nuit. L'infirmière a donc l'occasion de considérer la famille comme étant la cible de sa pratique. Nous sommes en accord avec Allen (1980) qui affirme que la santé constitue plutôt un phénomène de famille ou de groupe qu'un phénomène individuel. Cet auteur explique également que la santé peut être apprise et développée, d'où l'importance de commencer ces processus tôt dans la vie. Plus un enfant est jeune, moins il possède d'habitudes de vie potentiellement nuisibles à sa santé. De plus, les enfants représentent les futurs adultes de la société; s'ils développent un mode de vie sain, ils ont de meilleures chances de devenir des adultes en santé. Selon Allen (1980), la famille constitue le centre de la santé. C'est au sein de leur famille et sous l'influence de celle-ci que les enfants croissent, se développent et apprennent à vivre de façon saine.

Les familles ayant un enfant hospitalisé vivent une situation stressante. Nous avons souvent observé que ces familles sont particulièrement ouvertes aux influences extérieures. D'après Lazarus (1966), des situations stressantes amènent les personnes à devenir plus vigilantes envers les stimuli internes et externes. L'infirmière peut donc saisir ces occasions pour aider les familles à composer avec la situation et tenter de faire du séjour hospitalier une expérience positive,

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c'est-à-dire une expérience de croissance et d'apprentissage. Cette démarche fait partie intégrante de la promotion de la santé des familles. Audy (1971) et Allen (1980) ont exprimé l'idée que la santé comporte différents aspects dont la capacité de la personne à composer avec des situations plus ou moins difficiles; l'apprentissage qui découle de ces situations consitue un autre élément important de la santé.

L'exemple qui suit, provenant d'une situation clinique dans un département de pédiatrie, illustre une relation entre l'infirmière et la famille engagées dans un processus de résolution de problème. Jim, un enfant de deux ans atteint de neuroblastome, était hospitalisé pour une intervention chirurgicale. Quelques jours après l'opération, l'enfant manifestait toujours un refus de s'alimenter, nécessitant une alimentation parentérale. D'après un psychologue, ce problème était relié à un état dépressif. Les parents se sentaient dépourvus et après quelques tentatives infructueuses pour aider Jim, la mère se découragea. Le père tenta aussi certaines approches mais sans plus de succès. L'infirmière commença donc à travailler avec les parents afin d'identifier les habitudes alimentaires de l'enfant, ses aliments préférés et ses routines lors des repas. A partir de ces données, l'infirmière et les parents essayèrent différentes approches, comme celles de tenir compte des préférences de l'enfant dans l'élaboration de son menu, d'apporter des mets de la maison, de lui servir son repas à la salle de jeu en compagnie d'autres enfants. Ces tentatives se soldèrent par des échecs. En réfléchissant davantage au comportement antérieur de l'enfant, les parents se souvinrent qu'une cousine de Jim avait beaucoup d'influence sur lui. Ils suggérèrent alors la présence de cette petite fille de cinq ans pour que les deux enfants puissent prendre leurs repas ensemble. Cette suggestion fut mise en application et Jim, stimulé par la présence de sa cousine, recommença progressivement à s'alimenter. Les parents exprimèrent des sentiments de valorisation et de satisfaction suite à cette expérience auprès de leur enfant.

Dans l'exemple précédent, l'infirmière et la famille ont travaillé ensemble à trouver une solution au problème. L'infirmière avait une compétence en tant que professionnelle de la santé mais les parents possédaient leur propre compétence. Ils connaissaient bien leur enfant, ses habitudes, ses réactions et son mode de fonctionnement. La tâche de l'infirmière consistait donc à mobiliser les forces et les ressources à l'intérieur de la famille et à mettre en évidence les connaissances des parents face à leur enfant. Cette intervention s'inscrit dans l'optique de la promotion de la santé comme la conçoit Dunn (1977), à savoir que la santé est orientée vers le développement maximum du potentiel d'un individu. Dans ce cas-ci, les parents ont constaté

qu'ils pouvaient apporter une contribution importante au processus de résolution du problème. Il est possible, à notre avis, que les parents soient mieux outillés pour composer avec d'autres situations similaires dans le futur, suite à l'apprentissage qu'ils ont fait. En effet, Audy (1971) souligne que toute agression peut avoir une fonction "d'entraînement" de sorte qu'après la guérison, l'état de santé sera meilleur qu'auparavant. La personne a appris quelque chose.

Alors que les parents sont encouragés à composer avec l'hospitalisation de leur enfant, l'infirmière doit être à l'affût d'une anxiété trop élevée chez ceux-ci. En effet, l'hospitalisation d'un enfant suscite de l'anxiété chez la plupart des parents (Freiberg, 1972; Ingersoll, 1981; Skipper, Leonard & Rhymes, 1968; Whaley & Wong, 1979). Selon Janis (1971), une anxiété très élevée empêche l'individu de fonctionner dans un processus de résolution de crise tandis qu'une anxiété dite modérée permet de développer des mécanismes pour composer avec la situation stressante et d'autres événements similaires dans le futur.

Certaines interventions permettent de diminuer le stress des parents en les familiarisant avec le milieu hospitalier (Bright, 1965; Goffman, Buckman & Schade, 1957). Ainsi, l'infirmière peut expliquer aux parents quels sont les services qui leur sont offerts concernant, entre autres, leur restauration, leurs soins personnels, les endroits de repos. L'infirmière se doit de mentionner aux parents la possibilité qu'ils ont d'être constamment présents auprès de leur enfant. De même, certains renseignements peuvent être donnés sur les différents endroits où l'enfant doit se rendre pour des examens et sur la possibilité pour les parents de l'accompagner.

La participation des parents aux soins que requiert l'enfant doit être favorisée par l'infirmière. Ainsi, les parents entreprennent des actions concrètes auprès de leur enfant. Des auteurs ont trouvé que l'activité physique constitue un moyen, un mécanisme pour composer avec une situation stressante (Gal & Lazarus, 1975). De plus, la participation des parents assure une relation continue avec l'enfant, relation dite essentielle au développement psychologique de celui-ci dans la tendre enfance (Bowlby, 1952; Chinn, 1979; Fagin, 1966; Robertson, 1958). Dès l'admission, l'infirmière peut expliquer aux parents la possibilité de leur engagement auprès de leur enfant, que ce soit pour les soins de base, la discipline ou la prise de décision concernant la routine de l'enfant (Hill, 1978). La participation des parents s'établit à la suite d'une entente mutuelle entre les parents et l'infirmière. Cette décision se base sur la capacité d'engagement des parents, leur degré d'anxiété et l'impact de leur participation sur leur bien-être émotionnel. Il faut également considérer la qualité des soins prodigués par eux et les effets

bénéfiques pour l'enfant de sa relation avec ses parents. L'infirmière doit également expliquer aux parents que leur participation peut être modifiée au cours de l'hospitalisation compte tenu de leurs besoins et de l'état de santé de leur enfant. Les parents sont invités à prodiguer des soins à leur enfant mais l'infirmière doit prévoir des périodes de repos pour ceux-ci (Bright, 1965). Ainsi ils sont soulagés de la charge constante du soin de leur enfant, pouvant, le cas échéant, engendrer de l'anxiété et de la culpabilité chez les parents s'ils s'avèrent incapables de rencontrer toutes les situations difficiles de l'hospitalisation.

Un aspect très important du travail de l'infirmière réside dans sa relation d'aide avec la famille. L'infirmière doit considérer les parents comme des partenaires égaux en leur communiquant son respect et en reconnaissant leur potentiel, leurs habiletés. Elle doit les aider à utiliser leurs capacités de compréhension de la maladie et de la réaction de l'enfant face à l'hospitalisation. Elle se doit de respecter la préoccupation des parents de devoir parfois se séparer de leur enfant et de respecter aussi leur souci de la qualité du soin apporté à ce dernier. L'infirmière doit se sentir concernée par l'expérience que vivent les parents. Par exemple, ce souci peut être transmis par le biais d'informations qu'elle fournit aux parents sur les besoins physiques et psychologiques de l'enfant. L'infirmière peut également offrir des occasions de rencontre entre plusieurs parents intéressés afin de leur permettre de s'encourager mutuellement, de partager leurs inquiétudes et leur expérience face à l'hospitalisation.

Suite à ces interventions de l'infirmière, une relation significative s'établit entre elle et la famille. De plus, la famille progresse dans son processus d'ajustement. Nous croyons qu'à ce stade-ci les membres sont plus ouverts à regarder d'autres aspects de leur santé. La maladie d'un membre amène souvent la famille à remettre en question certaines de ses habitudes de vie.

L'impact du style de vie des personnes sur leur santé est de plus en plus mis en évidence dans les écrits (Friedman, 1981; L'Institut Vanier de la famille, 1980; Lalonde, 1974). L'infirmière peut donc assister la famille dans le développement de comportements de santé. Selon Hoke (1968), la santé n'est pas statique mais se réfère plutôt à une activité de vie. De plus, il voit la santé comme une forme de comportement qui peut être promu et développé.

L'infirmière peut identifier avec les familles les domaines où elles ont le plus besoin d'assistance. Elle peut, par exemple, revoir avec les parents leurs connaissances sur la croissance et le développement de l'enfant et sur le soin que requiert l'enfant tout au long de la

croissance. Une autre famille peut mettre en question certaines habitudes qu'elle désire modifier, par exemple, changer son mode de vie sédentaire pour une augmentation d'activités impliquant un exercice physique. D'autres parents peuvent être intéressés à discuter avec l'infirmière de moyens permettant d'améliorer les relations interpersonnelles avec leurs enfants, par exemple, la façon d'établir une meilleure communication avec leur adolescent. Enfin d'autres parents désirent connaître les soins physiques que nécessitera l'enfant après la période d'hospitalisation, car ils devront prendre en charge la santé de l'enfant à son retour à domicile.

Depuis le début du texte nous avons tenté de faire ressortir certaines interventions de l'infirmière dont le but est de promouvoir la santé des familles en milieu hospitalier pédiatrique. Cependant, une telle approche suscite des interrogations. En effet, comment peut-on déceler que la famille est prête à regarder ses comportements de santé alors qu'elle est à composer avec l'hospitalisation de l'enfant? Nous réalisons que plusieurs interventions n'apporteront pas de résultats immédiats mais pourront contribuer au développement de comportements sains au cours du processus de vie de la famille. Alors, comment est-il possible d'évaluer l'impact de ces interventions? Comme plusieurs actions de l'infirmière ont une portée à long terme, comment maintenir et stimuler la motivation du personnel infirmier engagé dans une telle approche de soins? Cette approche peut susciter de nombreuses autres questions. Des tentatives de réponse sauront être utiles à l'amélioration continue des soins auprès des familles d'enfants hospitalisés.

RÉFÉRENCES

Allen, M. A new perspective on nursing. In *Proceedings of nursing explorations: learning to be healthy: where do nurses fit?* Montréal: McGill University, 1980.

Audy, J. R. Measurement and diagnosis of health. In P. Shepard and D. McKinley (Eds.), *Environmental essays on the planet as a home*, New York: Houghton Mifflin Co., 1971.

Bowlby, J. *Maternal care and mental health*. Geneva: World Health Organisation, 1952.

Bright, F. The pediatric nurse and parental anxiety. *Nursing forum, 1965, 4* (2), 30-47.

Chinn, P. L. *Child health maintenance concepts in family-centered care*. Toronto: C. V. Mosby, 1979.

Dunn, H. L. What high-level wellness means. *Health Values: Achieving High-Level Wellness, 1977, 1*, 8-16.

Fagin, C. M. Pediatric rooming-in: its meaning for the nurse. *Nursing Clinics of North America, 1966, 1* (1), 83-93.

Freiberg, K. H. How parents react when their child is hospitalized. *American Journal of Nursing*, 1972, 72, 1270-1272.

Friedman, M. M. *Family nursing: theory and assessment*. New York: Appleton-Century-Crofts, 1981.

Gal, R., & Lazarus, R. S. The role of activity in anticipating and confronting stressful situations. *Journal of Human Stress*, 1975, 1 (4), 4-20.

Goffman, H., Buckman, W., & Schade, G. H. Parents' emotional response to child's hospitalization. *Journal of Diseases of Children*, 1957, 93, 629-637.

Hill, C. J. S. The mother on the pediatric ward: insider or outlawed? *Pediatric Nursing*, 1978, 4 (5), 26-29.

Hoke, B. Promotive medicine and the phenomenon of health. *Arch. Environ. Health*, 1968, 26, 269-278.

Ingersoll, G. K. When a child is hospitalized. In J. M. Tackett and M. Hunsberger (Eds.), *Family centered care of children and adolescents*, Toronto: W. B. Saunders Co., 1981.

Janis, I. L. *Stress and frustration*. New York: Harcourt Brace Jovanovich, Inc., 1971.

Lalonde, M. *Nouvelle perspective de la santé des canadiens*. Ottawa: Gouvernement du Canada, 1974.

Lazarus, R. S. *Psychological stress and the coping process*. New York: McGraw-Hill, 1966.

L'Institut Vanier de la famille. *La santé par et pour les gens dans les années 80*. Ottawa: L'Institut Vanier de la famille, 1980.

Robertson, J. *Young children in hospital*. New York: Basic Books, 1958.

Skipper, J. K. Leonard, R. C., & Rhymes, J. Child hospitalization and social interaction: an experimental study of mothers' feelings of stress, adaptation and satisfaction. *Medical Care*, 1968, 6, 496-506.

Whaley, L. F., & Wong, D. L. *Nursing care of infants and children*. Toronto: C. V. Mosby, 1979.

SUMMARY

Promoting Family Health in the Hospital Setting

This article illustrates the fact that working in a pediatric hospital setting represents an excellent opportunity to promote family health. Interventions aiming at helping families to cope with a child's hospitalization are presented. Ways to reduce the parents' anxiety are discussed, for example familiarizing parents with the hospital environment and encouraging them to participate in their child's care. The recommended relationship between the nurse and the family is one that is based on respect for each other's competencies. Other interventions aim at the development of family health behaviors.

CULTURE AND ILLNESS: PARENTS' PRECEPTIONS OF THEIR CHILD'S LONG TERM ILLNESS

Joan Anderson • Jennifer Chung

The family is often the primary decision-maker in matters related to health and illness. Litman (1974) states that, "the family constitutes perhaps the most important social context within which illness occurs and is resolved" (p. 495).

Spiralling health care costs have resulted in shorter hospital stays and a shift to home care services (Davis, 1980). Families are increasingly being called upon to take on the role of health teacher and caretaker. In those instances when a child has a long term health problem and is cared for in the home, parents must assume a major decision-making role in the child's treatment. Cultural meanings applied to sickness are therefore of considerable importance to health professionals and consumers (Kleinman, Eisenberg, & Good, 1978).

PURPOSE

This paper is based on a study which was conducted to examine how Chinese and white families dealt with the long term illness of a child in the home. More specifically, the study sought to explain how families perceived their child's health problem, and how family members managed their interactions with the child on a day-to-day basis in the home.

LITERATURE REVIEW

Much has been written about the chronically ill child and his or her family (for example, Adams, M., 1978; Adams, D. W., 1979; Anthony & Koupernik, 1973; Holaday, 1978; Mailick, 1979; Mann, Kmetz, Patel, & Weber, 1980; Mattsson, 1972). While this literature deals with parenting, the dynamics of family interaction, and adaptive tasks in relation to illness, little is known about how different cultural

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groups within the context of North American society experience and manage their child's long term illness in the home. This is not to say that there is not a wealth of information on how culture shapes illness experience (see, for example, Eisenberg, 1977; Fabrega, 1972; Good & Good, 1981; Kleinman et al., 1978; Leininger, 1978; Lewis, 1981; Zola, 1966). This literature argues that illness experience is strongly influenced by culture.

Kleinman et al. (1978) make a conceptual distinction between disease and illness. They state that:

> Illness is shaped by cultural factors governing perception, labeling, explanation, and valuation of the discomforting experience . . ., processes embedded in a complex family, social and cultural nexus. Because illness experience is an intimate part of social systems of meaning and rules for behavior it is strongly influenced by culture: it is . . . culturally constructed . . . Both concepts (disease and illness) are explanatory models mirroring multilevel relations between separate aspects of a complex, fluid, total phenomenon: sickness. (p. 252).

Illness can be perceived as the human experience of disease. This experience does not stand in a direct relationship to the disease as defined by Western biomedical science. "Similar degrees of organ pathology may generate quite different reports of pain and distress" (Kleinman et al., 1978, p. 251).

While the literature informs us that cultural categories confer specific meanings on sickness, what is missing are actual descriptions of how, for example, Chinese families in North American society manage a child's health problem in the setting of their homes. This study was therefore designed to find out families' perception of a child's health problem, and how they managed a child in the home.

METHODOLOGICAL AND THEORETICAL PERSPECTIVE OF THE STUDY

A qualitative approach was used in this study to obtain families' perception of a child's health problem. In recent years the qualitative approach has gained increased recognition among nurse researchers as one of the appropriate methods for the study of phenomena which are nursing's prerogative (for example, Anderson, 1981, a,b; Anderson & Chung, 1982; Davis, 1978, 1980; Degner, Beaton, & Glass, 1982; Field, 1981; Lindermann, 1974; Munhall, 1982; Oiler, 1982).

Many researchers who use a qualitative approach see their work as having its theoretical underpinnings in phenomenology. The phenomenological approach has its genesis in the writings of some European social theorists, most prominently, Edmund Husserl (1952), and Alfred Schutz (1964, 1967, 1973). The aim of this perspective is to formulate a model for the study of human behavior at the level of everyday social organization, which focuses on the subjective experiences of persons in everyday life. The relevance of this approach to nursing research has been addressed by some nurse researchers (Davis, 1978; Oiler, 1982).

The phenomenological approach assumes that there is value to an analysis of both the inner experience and outer behavior of a subject as viewed by both the researcher and the participants (Rist, 1979). Oiler (1982) points out that "the aim of the phenomenological approach is to *describe* experience as it is lived" (p. 178).

The phenomenological approach emphasizes indepth qualitative analysis of data to gain an understanding of how people interpret and give meaning to their situation. This often necessitates the presentation of verbatim accounts to show the reader how the researcher arrived at interpretations of the data.

The phenomenological perspective is of particular value in clinical nursing research when there is a wish to understand how people perceive their situation. It was for this reason that this methodology was selected to address the research question presented in this paper.

METHOD

Data were obtained over a one year period from seven white families and six Chinese families having a child with a long term health problem. Families were contacted with the assistance of health care personnel who agreed to present a letter describing the study to the families. Those families who wished to participate so informed the health care workers and gave permission for the researchers to contact them.

The families

The white families were all English Canadian, born and raised in Canada. They were of English (from British Isles) descent, with the exception of one family of Italian descent many generations back. They could all be categorized as belonging to the middle class. In the Chinese families, the parents had all emigrated to Canada from China, Hong Kong, and Taiwan. The parents in one family moved to Canada as children; the other parents emigrated in adulthood, and have lived

in Canada for varying lengths of time. The men all spoke English but some of the women were limited in their use of this language. Communication was facilitated by their husbands' presence during the visits to the families. Also, the research assistant spoke some Cantonese. The Chinese families could be categorized as belonging to the working and middle classes.

The children

The children were all born in Canada. They ranged in age from six months to ten years, and had a variety of long term health problems. The health problems varied in outcomes for the child. Four of the fourteen children had life threatening health problems (one family had two children with health problems). The other health problems could be categorized as non-life threatening. This category included two children with hearing impairments and one child with visual impairment. The children were looked after at home by their families. Only two children, one Chinese and the other white, were briefly hospitalized over the course of the study. The Chinese child was hospitalized for elective surgery related to her health problem, and the white child for fractures. This child had osteogenesis imperfecta, and fractured easily. The hospitalization was therefore related to his health problem.

Data Collection Procedures

Indepth interviews were conducted with the families in their homes. Each family was visited on three or four occasions, and from two to five hours were spent with each family at each visit, depending upon the time of day, and other family commitments. All family members living in the home usually participated in the interviews, except in those instances when other commitments took priority over the researchers' visits. As well, the researchers observed parent-child-sibling-playmate interactions under a variety of circumstances in the home, and participated in activities with families. These activities included play with the children, mealtimes, and recreational activities such as watching television.

In only one family did a grandparent live in the home. This was in one of the Chinese families. He participated in the interviews, and his interactions with the child were observed and tape recorded.

The interviews and family interactions were tape recorded. In addition, fieldnotes were made of each visit to permit the documentation of those activities that could not be captured on tape.

Data Analysis

Audiotapes were transcribed after each interview, and coded so that participants' names would not appear on the transcripts. Repetitive

patterns were identified in the data and fieldnotes, and these were used to develop conceptual categories.

The joint collection and analysis of data over the course of the study reflect the strategies for carrying out qualitative research described by Glaser & Strauss (1965). The conceptual categories were worked out in a systematic way by the principal investigator and the research assistant in relation to the data gathered.

The analysis of the data from each interview generated questions that were followed up in the later interviews. This permitted clarification of the families' accounts of their experiences. This total process facilitated the tightening up of the conceptual categories, and the elucidation of their conceptual properties.

THE FINDINGS

This paper will focus on two of the five major conceptual categories developed from the data that reflect differing perceptions of illness in white and Chinese parents. These categories show how illness experiences can be located within cultural contexts.

Whereas the white families emphasized the "normalization" of their child, a repetitive theme in the interviews with the Chinese families was maintaining the "contentment" and "happiness" of their child. These conceptual categories were *independent of a child's actual health problem*. That is, regardless of the health problem of the child, the notion of treating the child as "normal" was a constant theme in the interviews with the white families, and the notions of "contentment" and "happiness" of the child constant themes in the interviews with Chinese families. These could be regarded as *invariant properties of illness experience located in the data from each cultural group*. It is for this reason therefore, that these categories are highlighted in this paper. The one grandparent who participated in the study subscribed to this notion of having a happy and contented child. These dimensions of illness experience will be discussed, and parents' accounts presented.

The White Families: Normalization as a dimension of illness experience

One of the underlying themes in the accounts of the white families was that they treated their child as a "normal" child. They viewed their child's health problem, as defined by Western biomedical science, as distinct from their perceptions of the child as a "normal child," and some parents changed their lifestyles so that the child would not stand out as being different (Anderson, 1981 (b); Anderson & Chung, 1982).

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The usage of the term "normal" needs to be clarified. By this is meant the commonsense notion of normality, that is, the "ordinary," "average" child who does not stand out as being different from his or her peers. This is what the parents meant when they said their child was normal, as borne out in their accounts to the researchers.

This feature of minimizing the difference of the sick child from other children was evident among all parents, regardless of the child's health problems. Family members in the families with diabetic children, for example, altered their eating habits so that the child would not have a different diet. This is borne out in this parent's account:

> Father: He eats the same food exactly as we eat . . . We are not having sugar except when we are having coffee, that's about it . . . I wouldn't want to bring up a kid on a strict diet.

Parents curtailed the use of "sweets" in the home. One parent described, for example, how she substituted dream whip for icing when she made a cake, which was about once a month. She stated that they all liked dream whip, and used it so that the child would not feel different. Similarly, according to the mother, treat consisted of potato chips or cheesies. In her words, "it is not really a sweet, it doesn't make him feel any different."

The siblings in these families also altered their eating habits so that the children with diabetes would not have a different diet from their own. One of the researchers spent some time watching television with the children in one family. They all ate "cheesies", and the "well" sibling told her that he never ate candies when his brother was around. Similarly at dinner time, the child with diabetes was not required to have different dessert from other family members.

This feature of minimizing the difference of the child from other family members, and emphasizing the child's normality was also evident among parents who had children with life-threatening diseases. Here is one mother's account:

> Really, he is to us now a normal child and it is a day-to-day basis but the pressure is off. Really we just treat him normally. This is the best way to look at it and do because if you are going to worry about it, I think you can cause harm to the child and that is not good for the child.

It is of interest that this particular family would not allow the researchers to interview their 10-year-old son, out of concern that such an interview might upset him. The discussion of certain topics was not allowed with the child.

Parents of a child born with a cleft palate and hydrocephalus also emphasized that they treated the child as normal. They were quick to point out that the child now looked normal since her operation, even though the child's physiological abnormality was still quite obvious to the observers.

In the situations where a child was required to do exercises, parents ensured that these were done, and in fact a child would sometimes demonstrate the exercises to the researchers. What was stressed by parents in the interviews was that such treatments had to be carried out to facilitate the child's rehabilitation. So, although in the interviews the parents focused on how they treated the child as normal, in actual practice the child still had to cope with the limitations of the health problem, follow treatment schedules, and keep medical appointments for diagnostic tests and treatments (Anderson, 1981 a, b).

The Chinese Families: "Contentment" and "happiness" as a dimension of the illness experience

It is of interest that the patterns of interaction in Chinese families observed by the researchers were different from those in the white families; they had a different way of dealing with the child's illness. One of the main themes observed in the Chinese families was that they placed emphasis on the child's "contentment" and "happiness." The achievement of normality in so far as this involved rigorous rehabilitative exercises and other treatments was not constructed as an important dimension of illness experience in the Chinese families. Rather, they tended to treat the child in terms of what they could do to help cope with the limitations placed on everyday life activities. This was particularly evident among the parents with a handicapped child. As one parent with two deaf children put it:

> I think K. and I are very practical people, and it took us, I don't think as long, as most people to accept . . . So therefore, I feel that, . . . because of that we just said "okay, fine, we don't have . . . a normal child." We channeled our energies towards what can we do to help with this handicap, instead of trying to not acknowledge that he has a handicap. Because we know he won't be normal and that's all there is to it. We'll have to be able to teach him to cope with situations.

What was evident in this particular family was a "clash" with the requirements of health professionals. In fact, on the first visit to this family the mother expressed her concern that health professionals tended to "push" the child and wanted him to measure up to some

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norm. According to her, health professionals (researchers included) did not recognize the child's difference, nor did they recognize milestones that the child accomplished, which may be great achievements for him although they may not measure up to the professionals' views of normalcy.

Families, when describing their children to the researchers, focused on the features that made the child "stand out" as being different. Here is one mother's account of her two-year-old son with Down's Syndrome as compared to her four-year-old son:

> When he was born, he was really quiet. He just lie down on the bed and did nothing . . . He is different, he is a quiet baby and the other is a noisy baby.

This feature of perceiving the child as being different from other family members was also evident among the responses of the families' significant others. Here are two parents' accounts:

> Parent 1: My parents, my mother rather, and my sisters, have trouble coping with them . . . Now they've more or less accepted that they are different and they will make allowances.

> Parent 2: I told my parents, my side, and didn't tell my husband's side. Because my mother-in-law doesn't like him at all.

According to these parents, their response to the attitudes of their significant others in relation to their child was to limit their contact with these significant others or to avoid bringing their child to the homes of their significant others when they visited.

Quite clearly, the parents' perception of the child as being different was also consistent with their actual management of the child's everyday life. Further indication of this was borne out in one mother's description of how she managed her two deaf children when they had colds. This mother said that she tended to administer a fair bit of decongestants to her two children. Her reason for doing so was to prevent her children from getting ear infections to which, unlike other children, they were susceptible.

Underlying the management of the child's health problem was their emphasis on maintaining and promoting the comfort of the child. Treatments prescribed by health professionals were organized within the context of this significant aspect of family life. This was particularly evident among the parents with either a physically handicapped or developmentally delayed child who were required to perform exercises with the child as part of the treatment regimen. For example, one

father with a developmentally delayed child as a result of prematurity indicated that he and his wife seldom did the exercises to assist the child in gross motor development because the child disliked the exercises and cried when they were being done. Another father with a child born with hydrocephalus remarked that he would stop doing exercises with his child when she cried, and to comfort the child he would give her food or drink.

Some of the families attempted to do the exercises during the researchers' visits — they demonstrated that they knew what should be done. It was significant, however, that these demonstrations were promptly discontinued at any show of discomfort by the child. Thus, among the Chinese families maintaining the comfort of the child took precedence over stricly following treatment that might disrupt the harmonious state of the child even if following treatment might ultimately result in some improvement in the child's condition. Rather, the families subscribed to the notion of "looking after" the child in the best possible way. That is, they wished to fulfill the needs of the child. The notion of normalization was not highly stressed.

DISCUSSION

The data from the Chinese and white families revealed some striking contrasts in terms of how they viewed a child with a health problem, how they viewed the phenomenon of normalization, and how they interacted with the child. It would appear from this study that "normalization" is a culturally located phenomenon. It was noted that the white families emphasized the normality of their child. In contrast to the white families the Chinese families tended to help the child cope with limitations, and emphasized the comfort and contentment of the child.

What is at issue here is that the Chinese families had a different world view from the white families, and most often from the health professionals who worked with them. This was borne out in informal discussions with health professionals during the course of the study. They said that the emphasis of their programs with these families was to help the child to live as normal life as possible.

The normalization process is often considered as a way of improving the quality of life of the person with a health problem. Wolfensberger (1972) is one of the leading proponents of normalization. His work is accepted by many health professionals as one model which provides direction for the provision of care to persons with physical or mental handicaps. What seems to be the case is that health

professionals and white lay persons subscribe to a similar viewpoint. That is, a person with a health problem ought to be treated as normal so that he or she will not stand out deviant.

This was definitely not the case in the Chinese families. In fact, when a child had a health problem the child was protected from the discomforts of treatment. Let us note that Chinese families put a high priority on having a normal child; as one mother put it, "everyone wants a normal child." However, if the child had a health problem, then the main thrust was to help the child cope and to have as contented a child as possible.

It became clear during the course of the study that raising a child with a health problem and assuming the role of health teacher were new experiences for Chinese families. When asked what would have happened if their child had been born in Hong Kong or China, they said that there were no services for such children, and quite likely the child might not have survived. If the child survived the family would have "looked after" the child. Families that could afford it usually employed someone to look after the child.

This raises an important point. When health professionals request that these families carry out the treatments of the child they are asking that the families do what may be unfamiliar to them. It stands to reason, therefore, that families may find it difficult to comply with health professionals' requests. There is a need to question if some of the models currently used which place an expectation on parents to manage a child's health problem are appropriate within the context of Chinese families. From this study it could be argued that the opportunities for the child's rehabilitation may have been minimized, as families were unfamiliar with the roles they were supposed to assume. An important question that arises is whether, in the long run, this will have negative consequences on the child's rehabilitation. Further study is needed to focus on the outcomes of treatment of these children.

IMPLICATIONS FOR PRACTICE

The findings from this study have implications for professional nursing practice, particularly with Chinese families. It was noted earlier that for Chinese families normalization was not the issue, nor did the treatments prescribed by health professionals take top priority. Protecting the child and keeping the child contented were important to them. It was also noted that assuming the role of health teacher was a new experience. In fact, some of the families said they would have liked more frequent visits from health professionals to help them look

after the child, and to teach the child. In a sense, their expectations conflicted directly with those of the professionals who expected families to teach their child, and to promote their child's health.

This study emphasizes how cultural factors influence the ways in which families manage treatments in the context of everyday life, and points to the need for practitioners to take into account a family's priorities and understanding of the situation if culturally acceptable care is to be provided. Kleinman et al. (1978, p. 254) have argued that patients and practioners operate from within different explanatory models which are often discrepant in cognitive content, therapeutic values, expectations and goals.

> Where there are major differences in social class and cultural beliefs, these comparisons should systematically search for tacit conflicts in expectations and goals . . . Here the clinician mediates between different cognitive and value orientations. He actively negotiates with the patient, as a *therapeutic ally*, about treatment and expected outcomes. (p. 257)

The process of negotiation, critical to providing effective care, can only take place if the nurse understands the patient's perspective. This will demand getting information from families about their priorities and expectations, and organizing care for the family based upon their particular situation. Kleinman et al. (1978) point out that "no simple outline (for negotiation) suffices at this stage, because negotiation between explanatory models depends on where discrepancies lie and whether they affect care" (p. 257). What is important is the ability to identify discrepancies between explanatory models and to seek out ways of working with the family that will result in efficacious care.

There were differences between the priorities of health professionals and the priorities of the Chinese families who participated in the study. For professionals, helping a child to develop motor skills was critical, but for families the comfort of the child took precedence over the development of motor skills. In this light, failure to follow the professionals' recommendations for the child may be an expression of the conflict in priorities that exists between the professional and client, and not an expression of negligence on the client's part. This being the case, professionals need to negotiate with their clients so that the care provided can be culturally acceptable.

REFERENCES

Adams, D. W. *Childhood malignancy. The psychosocial care of the child and his family.* Springfield, Illinois: Charles C. Thomas, 1979.

Adams, M. Helping the parents of children with malignancy. *The Journal of Pediatrics,* 1978, *93,* 734-738.

Anderson, J. M. An interpretive approach to clinical nursing research. *Nursing Papers,* 1981, *13* (4), 6-12 (a).

Anderson, J. M. The social construction of illness experience: Families with a chronically ill child. *Journal of Advanced Nursing,* 1981, *6,* 427-434 (b).

Anderson, J. & Chung, J. The differential construction of social reality in chronically ill children: An interpretive perspective. *Human Organization Journal of the Society for Applied Anthropology,* 1982, *41* (3), 259-262.

Anthony, E. I., & Koupernik, C. *The child in his family: The impact of disease and death* (Vol. 2). New York: John Wiley & Sons, 1973.

Davis, A. J. Disability, home care and the care-taking role in family life. *Journal of Advanced Nursing,* 1980, *5,* 475-484.

Davis, A. J. The phenomenological approach in nursing research. In Norma Chaska (Ed.), *The nursing profession: Views through the mist.* Scarborough, Ont.: McGraw-Hill Ryerson Ltd., 1978.

Degner, L. F., Beaton, J. I., & Glass, H. P. *Health care organization and life-death decision making.* Paper presented at the National Conference Nursing Research, Victoria, B. C., April 1982.

Eisenberg, L. Disease and illness. *Culture, Medicine and Psychiatry,* 1977, *1,* 9-23.

Fabrega, H. The study of disease in relation to culture. *Behavioral Science,* 1972, *17,* 183-203.

Field, P. *Ethnography as a research methodology in nursing: An evaluation of the method.* Paper presented at the meeting of the Society for Applied Anthropology, Edinburgh, Scotland, April, 1981.

Glaser, B., & Strauss, A. Discovery of substantive theory: A basic strategy underlying qualitative research. *American Behavioral Scientist,* 1965, *8,* 5-12.

Good, B. J., & Good, M. D. The meaning of symptoms: A cultural hermeneutic model for clinical practice. In L. Eisenberg & A. Kleinman (Eds.), *The relevance of social science for medicine.* Boston: D. Reidel, 1981.

Holaday, B. J. Parenting the chronically ill child. In P. A. Brandt, P. L. Chinn, V. O. Hunt, & M. E. Smith (Eds.), *Current practice in pediatric nursing.* St. Louis: C. V. Mosby and Co., 1978.

Husserl, E. *Ideals: General introduction to pure phenomenology.* New York: Macmillan, 1952.

Kleinman, A. Lessons from a clinical approach to medical anthropological research. *Medical Anthropology Newsletter,* 1977, *8,* 4, 11-15.

Kleinman, A., Eisenberg, L., & Good, B. Culture, illness, and care. Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine,* 1978, *88,* 251-258.

Leininger, M. *Transcultural nursing, concepts, theories and practices.* Toronto: John Wiley and Sons, 1978.

Lewis, G. Cultural influences on illness behavior: A medical anthropological approach. In L. Eisenberg & A. Kleinman (Eds.), *The relevance of social science for medicine.* Boston: D. Reidel, 1981.

Lindemann, C. *Birth control and unmarried young women.* New York: Springer, 1974.

Litman, T. The family as a basic unit in health and medical care: A Social-behavioral overview. *Social Science and Medicine,* 1974, *8,* 495-519.

Mailick, M. The impact of severe illness on the individual and family: An overview. *Social Work in Health Care,* 1979, *5* (2), 117-128.

Mann, G. M., Kmetz, D. R., Patel, C. C., & Weber, C. The effects on the family of life-threatening childhood disease. *Essence,* 1980, *4* (2), 87-94.

Mattsson, A. Long-term physical illness in childhood: A challenge to psychosocial adaptation. *Pediatrics,* 1972, *50* (5), 801-811.

Munhall, P. L. Nursing philosophy and nursing research: In apposition or opposition? *Nursing Research,* 1982, *31* (3), 176-177, 181.

Oiler, C. The phenomenological approach in nursing research. *Nursing Research,* 1982, *31* (3), 178-181.

Rist, R. C. On the means of knowing: Qualitative research in education. *New York University Education Quarterly,* Summer 1979, 17-21.

Schutz, A. *Collected papers I: The problem of social reality.* The Hague: Martinus Nijhoff, 1973.

Schutz, A. *Collected papers II: Studies in social theory.* The Hague: Martinus Nijhoff, 1964.

Schutz, A. *The phenomenology of the social world.* (N. P.): Northwestern University Press, 1967.

Wolfensberger, W. *Normalization: The principle of normalization in human services.* Toronto: National Institute on Mental Retardation, 1972.

Zola, I. K. Culture and symptoms — an analysis of patients' presenting complaints. *American Sociological Review,* 1966, *31,* 615-630.

RÉSUMÉ

Culture et maladie: les parents face à une maladie chronique chez leur enfant

Le présent article traite de la façon dont les familles chinoises et les familles blanches font face à la maladie chronique de leur enfant, dans le milieu familial. Les renseignements recueillis des familles révèlent qu'il existe des contrastes frappants entre les deux groupes de familles, tant dans leur façon de considérer l'enfant affligé d'un problème de santé que dans leur façon d'envisager le "phénomène de normalisation." On y examine les implications que les conclusions de l'étude représentent pour les professionnels des soins infirmiers.

HOW TO EAT A WHALE — THINGS NEVER TOLD ABOUT GRANT WRITING IN GRADUATE SCHOOL

Barbara Pieper

Melinda Mae

Have you heard of tiny Melinda Mae,
Who ate a monstrous whale?
She thought she could,
She said she would,
So she started right at the tail.

And everyone said, "You're much too small,"
But that didn't bother Melinda at all.
She took little bites and she chewed very slow,
Just like a good girl should . . .

. . . And in eighty-nine years she ate that whale
Because she said she would!

by Shel Silverstein

Melinda Mae eating her whale well depicts the novice faculty member incorporating grant writing and research into the faculty role. The faculty role is often described as an integration of teaching, research, publication, and community service. But if one is teaching in an undergraduate program, the research role integration may seem like eating two whales instead of one! An important aspect of the research process is the submission of the research proposal for funding. In hopes that it will not take 89 years to conquer the research whale, I will present some laws for the beginning researcher regarding the submission of a proposal for funding. I selected the word "laws" with much care. According to Dubin (1969), a law is a generalization from observable facts that are representative of outward conditions. A law is not based on chance coincidence. After talking with experienced research colleagues who expressed many of the same learnings, it seemed that the word "law" was appropriate for labeling these factors.

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LAW 1. SMALL GRANTS ARE AVAILABLE.

Small grants allow the research neophyte an opportunity to develop research skills. A small grant is considered to be one of less than $20,000. Money is available and small projects allow the research beginner an opportunity to build the "track record" so often needed for large grant funding approval. The Canadian Nurses Association has a reference list regarding granting sources, *Nursing Research in Canada: Guide to Information Sources.* Private agencies which fund research should also be explored — for example: disease oriented agencies such as Heart Association or Diabetes Association, nursing professional organizations and community or industrial organizations. The funding from the agency may or may not allow for faculty salary — meaning much of the research process will have to be completed on the researcher's own time in the latter case.

LAW 2. TIME ORGANIZATION IS CRITICAL.

Time organization is critical for anyone applying for research funding but doubly so for the novice. The grant should be written far enough in advance of the submission date to provide time for colleague critique. Faculty not involved with the project may clarify specific aims, note variables not described in the methodology, and find errors in the selected statistical procedures — just to name a few. It is difficult to believe that the masterpiece proposal one has toiled over for so many hours could have inconsistencies, but it is better that a colleague find these in the proposal rather than the granting agency.

Deadline submission dates should be noted carefully. Agencies are usually quite firm on the grant deadline, but changes can occur. A grant planned and written early may be decisive for the submission when an agency decides to move its grant submission date.

Work and family schedules may change, thus interfering with grant writing. Nursing faculty seem to have a knack for scheduling extra faculty meetings during the time one has designated for grant writing. Set priorities — miss a faculty meeting! If the grant is being written by a faculty group, research meetings should be planned around the individual with the least flexible schedule, one is then most assured all participants will attend. Research meetings should be organized and concise so group members do not feel valuable time is wasted. Besides work schedules, family functioning — i.e., ill children, visitors from out of town, etc. — may alter one's regimented time schedule. In totality, it is best to remember the old saying "blood loss is twice the amount estimated by the health professional" or writing time takes twice the time planned by the neophyte.

LAW 3. ADMINISTRATION WANTS TO KNOW.

The dean and department chairperson should be notified as soon as possible of the research plan, submission date of the proposal, and percentage of one's work time the project requires. Since they are most involved with determining work schedules, the dean and department chairperson appreciate knowledge of one's research commitment so as to facilitate planning of future teaching assignments. Notifying administrative individuals early alerts them in a courteous manner as to when to expect the proposal for signatures (see law 5).

LAW 4. SECRETARIES ARE GODS.

Secretaries in a research department have god-like qualities. Since they type numerous grant proposals, a good secretary can identify inconsistencies in the grant, offer suggestions for budget development, as well as type the grant in proper format. Informing the secretaries of when the proposal will need to be typed will allow them to arrange work schedules so as to plan sufficient time and personnel to devote to each proposal. Secretaries can also assist one with completion of various university forms which must accompany the grant. Needless to say, secretaries should be dealt with in a very considerate manner.

LAW 5. SIGNATURES TAKE TIME.

Grant proposals leaving the university require various signatures. These often include the signatures of the dean and department chairperson as well as a signature from the university's grant department. Obtaining signatures relates closely to time organization (Law 2) and notifying administration (Law 3). It is rather difficult to obtain the dean's signature for a grant proposal due tomorrow when she/he is out of town for the week and has no knowledge of the proposal.

Signatures from the university grant department are best facilitated by remembering Law 4, "secretaries are gods." A research secretary usually has much contact with university grant officials and can often introduce the neophyte researcher to the correct university persons for signatures and arrange that the person be available when a signature is needed.

LAW 6. MAILING TAKES MANY FORMS.

In mailing a grant proposal, the researcher must consider if the granting agency has a date whereby the proposal must be received at the agency or a date the proposal must be postmarked. If the proposal is completed far enough in advance (usually one week) regular mail

may be used. The post office can also inform one of other mailing procedures such as registered mail or special delivery. Use of regular mail is a financial saving over one day guaranteed mail delivery which begins at approximately $10.00 per letter. Although $10.00 may not seem like much money, a research proposal is not an ordinary letter and the weight of multiple copies often increases the price. Even one day guaranteed service is not problem free for a snowstorm may impede delivery time even a few hours and thus the agency may refuse to accept the proposal.

LAW 7. GRANT REVIEW BOARDS TAKE MANY FORMS.

Reviewers for national grants are usually individuals who have research expertise, a content speciality, and a publication record. Private foundation review boards may be of the same caliber as national review boards or have a mixture of individuals, i.e., some individuals with clinical expertise but little research experience, or vice versa. For a beginning researcher it is important to note that a private foundation review board may be less stringent in the review process and approve a proposal with a strong clinical significance if the researcher obtains assistance with methodology. Reviewers look more favorably on a proposal that follows the agency's writing guidelines. Granting agencies are most helpful in answering questions about their guidelines as well as offering suggestions for proposal development.

LAW 8. THERE IS NO SUCH THING AS A "SMALL" GRANT.

Writing a small grant is often as time consuming as applying for a large grant. Time is needed for writing, typing, and signatures. Grants of less than say $2,000 often appear spent before the grant money arrives. The novice researcher should be proud of accomplishments, no matter how small, even though it is a humbling experience when one compares oneself to a faculty colleague who has a $125,000 grant. Again, small grants provide the beginner with experience needed to apply later for larger funds.

LAW 9. RESERVE FILE SPACE FOR REJECTED PROPOSALS.

Unfortunately not all proposals one submits are accepted; initially one wonders if any proposals are accepted. Comments from reviewers are often available. It is probably best not to read these comments until one has had an opportunity to calm down emotionally. The comments are often helpful in writing future research proposals. No proposal should be discarded as it may contain ideas of importance for future use. An understanding person is a critical factor in helping to cope with the "rejection blues."

Yes, like Melinda Mae eating her whale, grant writing as part of the research process is feasible for the neophyte. Besides a "she could; she would" attitude, a sense of humor and a willingness to ask experienced researchers for assistance are highly recommended. Most important is a feeling of accomplishment. No matter how small the proposed project, one should be proud of the conceptualization process, planning, and writing effort that went into the proposal. Deciding to sit down at the research table is an important commitment. Little bites or big bites — how the research whale is eaten depends on the individual researcher. Any form of mastication will help one meet professional goals as well as assist in the development of nursing's research base.

REFERENCES

Dubin, R. *Theory building.* New York: The Free Press, 1969.

Silverstein, S. *Where the sidewalk ends.* New York: Harper & Row Publishers, 1974.

RÉSUMÉ

L'art de manger une baleine ou le secret des demandes de bourses d'études supérieures

La soumission de demandes de bourses est un aspect important de la recherche. Pour le chercheur débutant, la démarche en vue de l'obtention de sources de financement peut être l'occasion de rencontres intéressantes. Dans l'espoir de faciliter cette démarche, le présent article nous propose des "règles" dont le chercheur qui en est à ses premières armes, devra tenir compte lors de la préparation de ses projets de recherche.

INFORMATION FOR AUTHORS

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Procedure

Please submit three double-spaced copies of the manuscript on 216mm × 279mm paper, using generous margins. Include a covering letter giving the name, address, present affiliation of the author(s). It is understood that articles submitted for consideration have not been simultaneously submitted to any other publication. Please include with your article a statement of ownership and assignment of copyright in the form as follows: "I hereby declare that I am the sole proprietor of all rights to my original article entitled '   ' and that I assign all rights to copyright to the School of Nursing, McGill University, for publication in *Nursing Papers/Perspectives en Nursing.* Date __ Signature_____."

Style and Format

Acceptable length of a manuscript is between 10 ad 15 pages. The article may be written in English or French, and must be accompanied by a 100-200 word abstract (if possible, in the other language). Please submit original diagrams, drawn in India ink and camera-ready. Prospective authors are asked to place references to their own work on a separate sheet and to follow the style and content requirements detailed in the American Psychological Association Manual (2nd edition, Washington, D. C., A.P.A. 1974.)

Manuscript Review

Manuscripts submitted to *Nursing Papers/Perspectives en Nursing* are assessed anonymously by two members of a Review Board, using the following criteria:

Assessing content

Internal validity — relatedness: Is the problem the paper deals with identified? Is the design of the research or the structure of the essay appropriate to the question asked? Are the statiscal, research and logical methods appropriate? Can the findings be justified by the data presented? Are the implications based on the findings?

External validity — relevance, accountability: Is the question worth asking? Is the problem of concern? Are there problems of confidentiality or ethics? Are the findings of the research or the conclusions of the essay significant? Can the findings or the conclusions be applied in other situations? Does the article contribute to knowledge in nursing? In what way?

Assessing presentation

Are the ideas developed logically? Are they expressed clearly? Is the length appropriate to the subject? Does the number of references or tables exceed what is needed?

Publication Information

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

RENSEIGNEMENTS À L'INTENTION DES AUTEURS

La revue *Nursing Papers/Perspectives en Nursing* accueille avec plaisir des articles de recherche ayant trait aux sciences infirmières et aux soins de la santé. Veuillez adresser vos manuscrits au rédacteur en chef, *Nursing Papers/Perspectives en Nursing*, Ecole des sciences infirmières, Université McGill, 3506 rue University, Montréal, P.Q., H3A 2A7.

Modalités

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

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Examen des manuscrits

Les manuscrits présentés à la revue *Nursing Papers/Perspectives en Nursing* sont évalués de façon anonyme par deux examinateurs selon les critères suivants:

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A la réception du manuscrit original, l'auteur est avisé que le Comité de rédaction prendra une décision au sujet de la publication de son article dans les six semaines. Lorsqu'un manuscrit est renvoyé à son auteur pour qu'il le remanie, trois exemplaires dudit manuscrit remanié (daté et portant l'inscription "revu et corrigé") doivent être renvoyés au rédacteur en chef dans les quatre semaines. Les modalités complètes d'examen, de remaniement, d'édition, de composition, de relecture et d'imprimerie expliquent qu'il s'écoule souvent de six à huit mois avant qu'un article soumis soit publié.

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