NURSING PAPERS
PERSPECTIVES EN NURSING

Modèles conceptuels

An Explanatory Study of Social Withdrawal Experiences of Adults

Factors Associated with Career Choice of University Women in Medicine and Nursing

A Conceptualization of Concept

Summer/Été 1983 **Vol. 15, No. 2**

NURSING PAPERS/PERSPECTIVES EN NURSING is published quarterly under the joint sponsorship of the School of Nursing, McGill University, 3506 University Street, Montreal, Quebec, H3A 2A7, and the Faculty of Nursing, The University of Alberta, 3-118 Clinical Sciences Building, Edmonton, Alberta T6G 2G3. Letters regarding subscriptions, changes of address and other business matters should be sent to the Managing Editor, *Nursing Papers*, McGill University.

SUBSCRIPTION RATES: Institutions (including hospitals, schools, libraries and agencies): $22/one year; $40/two years. Individual subscriptions: $16/one year; $30/two years. Please add $5 per year for overseas airmail service.

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NURSING PAPERS/PERSPECTIVES EN NURSING est une publication trimestrielle réalisée conjointement par l'École des sciences infirmières de l'université McGill, 3506, rue University, Montréal (Québec) H3A 2A7, et la Faculté des sciences infirmières de l'université de l'Alberta, 3-118, Clinical Sciences Building, Edmonton (Alberta) T6G 2G3. Toute correspondance relative aux abonnements, à un changement d'adresse ou à d'autres questions doit être adressée à l'adjointe administrative à la rédaction, *Perspectives en nursing*, Université McGill.

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ANNONCES: 300$ la page; 175$ la demi-page.

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Dépôt légal: Bibliothèque du Québec.

NURSING PAPERS
PERSPECTIVES EN NURSING

Volume 15, No. 2
Summer/Été, 1983

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Mise à jour **Update**

— NATIONAL NURSING RESEARCH CONFERENCE —

les 12, 13 et 14 octobre 1983 — Montréal, Québec

À la date de clôture de notre appel de projets de recherche, nous en avions reçu 76 de par le pays. Le Comité scientifique en a retenu 36 qui ont tout particulièrement trait au thème du colloque, "la contribution de la recherche à l'avancement des sciences infirmières," dont certains seront présentés en séance plénière et d'autres, en ateliers parallèles.

Les autres soumissionnaires pourront se faire entendre sur la "place du marché de la recherche": aspect novateur de ce colloque visant à permettre la consultation, la mise en réseau et la mise en commun des ressources. Si vous n'êtes pas déjà inscrit au plus important colloque de recherches infirmières jamais organisé, on vous incite à le faire le plus vite possible.

At the closing date of the call for research papers, 76 had been submitted from accross the country. The Scientific Committee selected 36 with particular relevance to the conference theme, "Toward the Development of a Science of Nursing," some to be presented in plenary and some in concurrent sessions.

The remaining submitters will be able to have a hearing in the Research Market place: a novel and innovative feature of the Conference providing for consultation, networking and resource pooling. If you have not already registered for the largest nursing research conference yet, please do so immediately.

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

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Please refer to the masthead for the new rates effective with the Fall 1983 issue (Vol. 15, No. 3).

AUGMENTATION DES TARIFS

Les nouveaux tarifs qui entreront en vigueur avec le numéro de l'automne 1983 (Vol. 15, no 3) sont inscrits dans les renseignements généraux.

EDITORIAL

Faculty. Don your thinking caps, hone your visual acuity and shed your apathy. While we are busy elsewhere others may be relieving us of one of our proudest possessions — our university status. With the loss will go our professionalism to say nothing of the heart and soul of our developing health care services.

The skeptics among you don't believe it. But lend me thine eyes for a moment while I tell you a true tale of intrigue and professional legerdemain.

For many years now several schools have worked toward the creation of institutional arrangements, the recruitment of credentialed faculty, and the high quality of nursing programs necessary to enhance our ability to achieve the level of scholarship and professional autonomy compatible with the professional university milieu. While our efforts have been so directed perhaps a real menace has been lurking in the wings — hiding behind a rhetoric of collaboration and commendation yet deceptive, vital and potentially devastating in its intent. Threats to nursing programs in the university or the intentional demeaning of same, are not as anomalous as one might think, yet they are receiving very little, if any, attention. Faculty tend to be accommodating, to accentuate the nice, wholesome, positive aspects of our relationships to significant others and eliminate the negative ones, a decidedly easy if not very productive, or clever stance.

In fight parlance, we excuse the quick jabs to the "midsection" as "the price we must pay to get their support when we need it," a totally unsupported dictum in the real world. We are in fact perceived as the "patsies" of the system, as our hard-earned place in academia is insidiously eroded.

The effect of recent threats to nursing programs posed by academic medicine, and university administrative officers and committees who bow to the pressures and power of that professional lobby and status, are now becoming apparent. Closure and near closure of baccalaureate programs in the U.S. are purported to be unrelated to any increased effort to counter the growing power and public visibility of nursing as it extends its role in primary care and family health. Others see this as the beginning of what may be a reversal of the reluctant support gleaned during years of economic growth. An attack upon the research credentials and quality of the research of a profession's members is the most direct way to attack a group's qualifications for membership in the elite academic community. Medicine's paternalism, coupled with a lack of political sophistication in nursing maintain a symbiotic relationship in which medicine dominates.

What is even more alarming, however, is the opportunity afforded by so-called "reviews," often dominated by physicians, to decree that the directions of programming, research and nursing services follow traditional medically oriented paths. The experience described below is not, I can assure you, one of a kind. others may not be so blatant, for they may not be permitted to be so, yet clearly the direct influence of medicine on nursing's exploitation in academia and elsewhere is common. Beneath the conflicting interests of medicine and nursing is the fear of physicians that nurses not tied to the medicine/nursing "team" will realize their own power potential and thereby diminish the power of organized medicine.

In a recent review of one School of Nursing,[1 2] the Committee found that there had been considerable innovation in program development and that employers assessed the quality of the School's graduates as outstanding. They were also of the opinion that the research focus of the School was "not worthy of the tradition of research" in that University. Why? Because in their view good nursing research projects "are within the purview of good medical practice." These deal with topics such as the measurement of pain, infectious disease control, the impact of heart surgery, and pediatric home care programs. This is the *only* kind of research which should be tolerated and encouraged. Such topics should be the central research focus to the exclusion of all nursing practice health care issues, they said.

In another section of the report, the Committee notes that legitimate research credentials are non-nursing Ph.D.s. Faculty members should speak to traditional *medical* concerns, using typical *medical* research designs. Descriptive, and/or exploratory research is unscientific, inferior and not credible. Publications in monographs and nursing journals are not acceptable for these are not science. They are discounted in their entirety. Those journals which are acceptable as professionally legitimate are in more developed disciplines, that is, *external to the discipline of nursing.*

In this instance, there was no representation on the review committee from nursing, from social science, or from the philosophy of science to provide input on the nature of the development of new professions, and on scientific method as related to the growth of knowledge in new fields. It was clear that the object was not an "objective" review but rather the purposive generation of calculated misinformation. The School had an acknowledged leadership role in the development of nursing research which must be challenged by medicine. I'm sure at least some of the members of the Committee were not even aware that they were being used in a nefarious scheme.

Assuming the still tenuous position of nursing research among the health sciences, I do not believe we can easily sustain such attacks upon individual Schools nor should we be placed in the position of constantly defending the credibility of the type of nursing research now rapidly developing in many universities and health care agencies. As in all established disciplines, each research report should stand on its own merit as assessed by the researcher's peers, the acknowledged experts in the field.

Nursing must replace its tendency toward accommodation with a concerted attack upon the basic structural defects of the university system which allow a travesty such as the one described above to occur. At the same time we must declare war on the costly illness-oriented health care system which both spawns and nurtures the kind of relationships seen in academia. Coming to terms with the downward economic trends and the growing wave of antiprofessionalism requires collective action and a political vehicle for a unified nursing. As Wolf has suggested there is a "growing demand for health-promoting self-care and alternative healing methods which is an invitation to the nursing profession."[3] It is equally true that the development of a new cadre of practicioners and nurse researchers must not be based on the assumption that "the current system is working and would work even better if nurses were more in control of the system."[4]

Joan M. Gilchrist
Shaw Professor of Nursing
McGill University

June 1983

EDITORIAL

Professeurs en sciences infirmières, faites travailler vos méninges, réveillez-vous et secouez votre apathie! Pendant que nous nous affairons ailleurs, il se peut qu'on soit en train de nous déposséder de notre bien le plus précieux — *notre statut universitaire.* En le perdant c'est non seulement notre professionnalisme qui disparaît mais également le souffle et le coeur de nos services de santé qui progressent constamment.

Les sceptiques parmi vous ne me croiront pas. Je leur demande simplement un moment d'attention pour leur raconter une histoire vraie, cousue d'intrigues et de tours de passe-passe professionnels.

Depuis de nombreuses années, plusieurs écoles de sciences infirmières oeuvrent à la création d'agencements dans les établissements, au recrutement de professeurs ayant des titres et qualités pertinents, ainsi qu'à l'accroissement qualitatif des programmes de sciences infirmières, tous indispensables si nous voulons atteindre dans notre profession le niveau d'excellence et d'autonomie compatible avec le milieu universitaire professionnel. Tandis que nous conjuguons nos efforts en ce sens, un réel danger plane sur nous; il se masque sous une réthorique de collaboration et de louanges trompeuses, mais c'est une réthorique vitale et potentiellement destructrice à cause de l'esprit qui l'anime. Les menaces qui pèsent sur les programmes de sciences infirmières à l'université ou leur dénigrement voulu ne sont pas aussi rares qu'on pourrait le penser, et pourtant on y fait très peu sinon pas du tout attention. Les professeurs sont généralement conciliants et tendent à mettre l'accent sur les aspects positifs et agréables de nos rapports avec les gens perçus comme importants et à ne rien dire des aspects négatifs, ce qui est une position relativement facile, mais peu efficace et pas très éclairée. En langage de combat nous pardonnons des coups directs et rapides "au bas de la ceinture" en disant que c'est "le prix à payer pour gagner l'appui de ces gens quand on en a besoin." Ce dire est totalement indéfendable dans le monde réel. L'on nous perçoit en fait comme les dindons de la farce tandis que s'érode insidieusement la place que nous nous sommes si vaillamment taillée au sein du monde universitaire.

L'effet de récentes menaces qui pèsent sur les programmes de sciences infirmières commence à se faire sentir. Ces menaces proviennent de la médecine universitaire ainsi que des administrateurs et des membres de comités qui, dans les universités, courbent l'échine sous les pressions, le pouvoir et le statut de ce lobby professionnel. La suppression ou la quasi-suppression des programmes de baccalauréat aux Etats-Unis est censée n'avoir aucun rapport avec la tendance marquée à contrecarrer la puissance croissante et la notoriété publique des sciences infirmières à mesure qu'elles jouent un rôle accru dans les soins primaires et la santé familiale. D'autres y voient le début d'un revirement possible de l'appui réticent glané au cours des années de croissance économique. La façon la plus directe d'attaquer les compétences d'un groupe qui vise à faire partie de l'élite universitaire consiste à dénigrer ses titres et qualités ainsi que la valeur intrinsèque des recherches que mènent ses membres. Le paternalisme des médecins, combiné à l'insuffisance d'articulation politique des sciences infirmières, maintient un rapport symbiotique entre les deux professions, en vertu duquel c'est la médecine qui domine.

Ce qui est beaucoup plus inquiétant toutefois, c'est l'occasion fournie aux comités, soi-disant "d'évaluation," souvent dominés par des médecins, de décréter que l'orientation des programmes, des recherches et des services infirmiers doit suivre les voies traditionnelles de la médecine. L'expérience que je décris ci-dessous n'est pas, je peux vous l'assurer, unique en son genre; d'autres ne sont peut-être pas aussi flagrantes, mais il est indéniable que l'influence directe de la médecine sur l'exploitation des sciences infirmières dans le milieu universitaire et ailleurs est pratique courante. Derrière les intérêts conflictuels de la médecine et des sciences infirmières, il y a la hantise des médecins que les infirmières qui n'ont pas de lien avec "l'équipe" médecine/sciences infirmières, prennent conscience de leur pouvoir en puissance et diminuent par là le pouvoir de la médecine organisée.

Lors de l'évaluation récente d'une école de sciences infirmières,[1,2] le comité a constaté que ses programmes étaient extrêmement novateurs et, à en juger par les commentaires des diplômées et de leurs employeurs, que la qualité des diplômées de l'école était exceptionnelle. Ce comité était également d'avis que l'orientation de la recherche dans cette école n'était pas digne de la tradition de la recherche dans cette université. Pourquoi? Parce que, selon eux, de bons projets de recherches "doivent se situer dans l'optique générale d'une bonne pratique médicale."

Ces projets doivent donc avoir trait à la mesure de la douleur, à la lutte contre les maladies infectieuses, à l'impact de la chirurgie cardiaque et aux programmes de soins pédiatriques à domicile. C'est là le *seul* type de recherche que l'on doive tolérer et encourager. Ces thèmes doivent être au coeur de tous les projets de recherche à l'exclusion de toutes les questions de pratique infirmière, au dire des membres de ce comité.

Dans une autre section du rapport, le comité remarque que les seuls titres authentiques en recherche sont des Ph.D. dans des disciplines autres que les sciences infirmières. Les professeurs de sciences infirmières ne devraient traiter que de problèmes se situant dans les voies déjà tracées par la *médecine* et n'utiliser que des devis typiques à la recherche *médicale*. Les recherches descriptives et (ou) exploratoires vont à l'encontre de la science, sont inférieures et ne sont pas crédibles. Tout article publié dans une monographie ou dans une revue de sciences infirmières n'est pas acceptable car il ne s'agit pas de revues proprement scientifiques. On les écarte donc d'emblée dans leur totalité. Les seules reconnues comme véritablement professionnelles sont les revues de disciplines plus développées, c'est-à-dire *autres que les sciences infirmières*.

Dans le cas qui nous occupe, aucun membre en sciences infirmières, en sciences sociales ou en philosophie des sciences ne faisait partie du comité d'évaluation pour apporter l'information pertinente sur la nature de l'évolution des nouvelles professions et sur la méthode scientifique appropriée au développement des connaissances dans les nouveaux champs d'études. Il est clair que le but de ce comité n'était pas une évaluation "objective" mais plutôt la publication préméditée d'informations trompeuses et calculées. L'école en question avait en effet joué un rôle de leader dans l'évolution des recherches infirmières, ce qui semblait tout à fait intolérable à la faculté de médecine. Je suis sûre que certains des membres du comité ne se rendaient même pas compte qu'on se servait d'eux dans un dessein aussi vil.

Compte tenu de la position encore fragile de la recherche infirmière au sein des sciences de la santé, je ne crois pas que nous puissions souffrir que de pareilles attaques soient dirigées vers certaines écoles de sciences infirmières. Je ne crois pas non plus que nous devions avoir à défendre constamment la crédibilité du type de recherche qui se développe aujourd'hui rapidement dans de nombreuses universités et organismes de soins en matière de santé. Comme dans toute discipline établie, chaque rapport de recherche vaut par ses propres mérites tels qu'ils sont évalués par les pairs qui sont des spécialistes chevronnés de la discipline.

Les infirmières doivent abandonner leur attitude conciliante pour lancer une attaque concertée contre les vices fondamentaux de structure dans le système universitaire, qui permettent le genre de travestissement préalablement décrit. Par la même occasion, nous devons déclarer la guerre au système fort coûteux de soins axé plutôt sur la maladie que sur la santé. Ce système engendre et entretient le type de rapports que l'on voit souvent dans le monde universitaire. Pour faire face à la tendance économique à la baisse et à la vague croissante d'antiprofessionnalisme, il faut des actions collectives et un véhicule politique d'unification des sciences infirmières. Comme Wolf l'a fait remarquer, "la demande de promouvoir l'auto-soins ou la prise en charge en matière de santé ainsi que les méthodes alternatives holistes ne cesse d'augmenter, ce qui constitue une invitation directe à la profession d'infirmière."[3] Il est également vrai que la mise sur pied d'un nouveau groupe-cadre de praticiens et de chercheurs en sciences infirmières ne saurait se fonder sur la prémisse que "le système actuel fonctionne et fonctionnerait encore mieux si les infirmières et infirmiers le contrôlaient davantage."[4]

Professeur Joan M. Gilchrist
Titulaire de la chaire Shaw
(Sciences infirmières)
Université McGill

juin, 1983

REFERENCES

[1] Report of the Review Committee for the School of Nursing, McGill University, August 1982.

[2] Draft Response of the Faculty of the School of Nursing to the Report of the Review Committee, McGill University, October 1982.

[3] Wolf, K. A. ANS Open Forum, Politics of care, *Advances in Nursing Sciences.* 1980, 2(3), 100.

[4] Ibid., 99.

INTERNATIONAL PRIMARY HEALTH CARE CONFERENCE

November 22-25, 1983 — Kensington Exhibition Centre, London
Title: Towards Tomorrow's World — Community Care
Conference Chairman, Royal College of Nursing, c/o Rcn South Eastern area office, 85 East Street, Epsom, Surrey KT17 1Dt

ERRATUM — Spring, 1983 issue, Vol. 15, No. 1

"The Delphi Technique as a Method for Selecting Criteria to Evaluate Nursing Care"

In the note about the authors on page 51, the description should read:

> "Kathleen Scherer is the Principal Investigator and Patricia Farrell is the Co-Principal Investigator of A Project to Measure the Quality of Nursing Care in Manitoba."

The footnote on page 58 should read:

> "Scherer, K., & Farrell, P. A Project to Measure the Quality of Nursing Care in Manitoba is in progress and is funded by Health and Welfare Canada (N.H.R.D.P.), Project No. 6607-1238-46."

MODÈLES CONCEPTUELS

Evelyn Adam

Le thème "Pluralisme théorique et pédagogie" suscite tout naturellement une discussion sur les modèles conceptuels. D'une part, les modèles pour la profession d'infirmière sont souvent confondus avec des théories et, d'autre part, les modèles conceptuels sont quelquefois sujets à controverse lorsqu'il est question de pédagogie en sciences infirmières. Une question se pose alors: est-il compatible avec la pédagogie d'avoir à la base d'un seul programme d'études plus d'un seul modèle conceptuel? Plus précisément, est-il pédagogique de baser un programme de formation sur plusieurs conceptions de la profession d'infirmière?

Il est certes avantageux d'avoir une pluralité de théories dans un programme. Il est moins certain qu'il soit souhaitable d'avoir, dans un seul programme, une pluralité de modèles conceptuels. A cette période de notre histoire professionnelle, il est certainement heureux qu'il existe plusieurs modèles conceptuels; je ne questionne nullement l'avantage d'avoir à choisir parmi plusieurs conceptions de notre discipline. Ce que je questionne, c'est l'adoption de plusieurs conceptuels dans un seul milieu. Ce que je remets en question, c'est le fait qu'un programme de formation professionnelle s'inspirerait de plusieurs conceptions de la profession. Si un pédagogue peut se servir de plusieurs théories, peut-il se baser sur plusieurs modèles conceptuels à la fois?

Les dictionnaires nous rappellent que, dans l'antiquité, un pédagogue était un esclave — un esclave qui menait à l'école les jeunes garçons. Dans les temps modernes, un pédagogue est celui qui enseigne aux enfants, celui qui a soin de leur éducation. De nos jours, un pédagogue en sciences infirmières est donc la personne qui a soin de la formation des futures infirmières et infirmiers. Ce pédagogue, en planifiant pour ses étudiantes diverses expériences d'apprentissage, se sert d'une multiplicité de théories. Le programme entier est cependant élaboré à partir d'une conception de la profession et cette conception, avouée ou non, guide le choix des multiples théories utilisées.

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Cet article est tiré de sa conférence prononcée lors de la réunion annuelle de l'ACEUN au Congrès des Sociétés savantes, 1982, Université d'Ottawa et dont le thème était "Pluralisme théorique, pédagogie et la décennie."

Afin d'examiner la question — Est-il pédagogique d'avoir plus d'un modèle conceptuel à la base d'un seul programme de formation? — je traiterai d'abord de ce qu'est un modèle conceptuel, ensuite de l'influence qu'exerce le modèle sur notre vie professionnelle et, enfin, des critères d'évaluation pour un modèle conceptuel.

QU'EST-CE QU'UN MODÈLE CONCEPTUEL?

Un modèle conceptuel est une conception, une abstraction, une façon de conceptualiser une réalité. Un modèle conceptuel *pour* la profession d'infirmière est une conception *de* la profession d'infirmière. Sans le qualificatif "conceptuel," le mot modèle est souvent perçu comme synonyme de modalité, de méthode ou d'exemple à suivre (Adam, 1983). Un modèle *conceptuel* est forcément plus abstrait qu'une méthode. Un modèle conceptuel *pour* une profession est une façon de conceptualiser ce que la même profession pourrait ou devrait être. Il y a lieu d'insister sur les mots "pourrait ou devrait être." Un modèle conceptuel pour la profession d'infirmière n'est pas une définition de la profession; il n'est pas ce que sont les soins infirmiers mais plutôt une conception de ce qu'ils pourraient ou devraient être. Le jour viendra peut-être où nous dirons que la profession *est* ce qu'aujourd'hui nous voudrions qu'elle soit. Les soins infirmiers ne sont pas, actuellement, ce qu'ils pourraient devenir. Ce qu'ils pourraient devenir est précisé dans un modèle conceptuel.

Un modèle conceptuel *pour* une discipline est donc une conception globale de la même discipline — une perspective distincte pour cette discipline. Une discipline (Roy & Roberts, 1981) est un domaine d'investigation marqué d'une perspective unique. Le fait même de parler de la discipline d'infirmière laisse supposer que notre domaine a, en effet, une perspective qui nous distingue des autres professions de la santé, une perspective qui indique une façon de regarder les phénomènes du monde réel. Donaldson et Crowley (1978) font une distinction entre les disciplines académiques et les disciplines professionnelles; les sciences infirmières, ayant un but pratique de service, se situent parmi les disciplines professionnelles. Les mêmes auteurs précisent que chaque discipline a évolué à partir d'une perspective distincte qui a déterminé les phénomènes d'intérêt particulier à cette discipline. Si notre domaine d'investigation est vraiment une discipline, il est alors caractérisé par une perspective distincte. Un modèle conceptuel précise cette perspective.

Un modèle conceptuel pour notre profession est donc une perspective distincte et globale qui caractérise notre profession. Une longue discussion sur la définition d'une profession, d'une demi-profession,

d'une profession naissante, déborderait les cadres de ce texte. Rappelons qu'on parle, de façon courante, de la profession d'infirmière comme on parle de la profession d'avocat ou de la profession de médecin; les infirmières se comptent parmi les professions de la santé, parmi les professions d'aide et les professions de service. C'est, en effet, depuis 1541 que le mot profession a la signification de "vocation savante"; trente-cinq ans plus tard, en 1576, le sens du mot s'est élargi pour comprendre toute vocation ou emploi au moyen duquel une personne gagne sa vie (Cogan, 1953, p. 34). Dans le présent article, le mot profession a donc le sens d'un domaine de préoccupation humaine qui exige des études avancées.

Plusieurs auteurs (Chance, 1982; Fawcett, 1980; Lancaster & Lancaster, 1981; Newman, 1979) s'accordent pour dire qu'un modèle conceptuel n'est pas une théorie, mais plutôt le précurseur d'une théorie. En effet, un modèle conceptuel n'est pas fait de propositions interreliées; il n'est pas constitué d'hypothèses vérifiées. Un modèle n'explique pas une partie du monde empirique; il ne décrit pas des phénomènes du monde réel et il ne prédit pas des aspects de la réalité. Un modèle conceptuel pour une discipline indique plutôt les phénomènes qui sont d'un intérêt particulier pour cette discipline; il spécifie le centre d'intérêt de la discipline et ainsi peut conduire à l'élaboration d'une théorie qui, elle, servira à expliquer, décrire, prédire, diriger, et faire comprendre une partie du monde empirique (Roy & Roberts, 1981). Une théorie est donc utile à plus d'une profession. Un modèle conceptuel pour une discipline n'est, par contre, utile qu'à cette même discipline.

Si un modèle conceptuel est une conception de notre profession, l'inverse n'est pas nécessairement vrai. Toute conception de notre discipline n'est pas un modèle conceptuel. Chaque lecteur, infirmière, infirmier ou non, a certainement une conception personnelle de la profession d'infirmière. Il semble difficile, voire impossible, de ne pas en avoir une. Certaines de ces conceptions personnelles sont claires et précises; d'autres sont un peu floues et donc difficilement communicables. C'est lorsqu'une conception est claire et précise, lorsqu'elle est complète et explicite, qu'elle s'appelle modèle conceptuel. Afin de mériter le nom de "modèle conceptuel," une conception doit, selon Johnson (Riehl & Roy, 1980, p. 7), comprendre postulats, valeurs et six éléments (Figure 1). Ces trois composantes forment un tout cohérent. Prendre des parties de plusieurs modèles pour en faire un modèle éclectique ne serait donc pas un procédé souhaitable; ce faisant, on risquerait de perdre la cohérence interne et la logique intrinsèque au modèle et ainsi aller à l'encontre d'une perspective globale.

POSTULATS
VALEURS
ELEMENTS: *But,* idéal et délimité, du professionnel
Client — la cible de l'activité professionnelle
Rôle social du professionnel
Source de la difficulté, éprouvée par le client
Intervention du professionnel (centre et modes)
Conséquences de l'activité professionnelle

Figure 1. Les composantes d'un modèle conceptuel pour une discipline.

Les postulats proviennent soit d'une théorie, soit de la pratique, soit des deux à la fois. Certaines infirmières privilégient un modèle qui est fondé surtout sur une théorie; d'autres, voyant notre discipline profondément enracinée dans la clinique, lui préfèrent un modèle qui découle surtout de la pratique. Dans les deux cas, les postulats sont vérifiables s'ils ne sont pas déjà vérifiés. Un postulat commun à plusieurs modèles est l'énoncé suivant: la personne est un être bio-psycho-social.

Les valeurs, quant à elles, ne sont pas sujettes aux critères de vérité. Ce sont les valeurs qui touchent à la profession et elles doivent s'accorder avec les valeurs de la société que sert la même profession. Une valeur retrouvée dans plusieurs modèles est la croyance que la profession d'infirmière apporte une contribution importante dans le domaine de la santé.

Quant aux six éléments, ils sont soutenus par les postulats et les valeurs et ils précisent les paramètres conceptuels de la discipline.

L'INFLUENCE DU MODÈLE CONCEPTUEL

La conception qu'une infirmière a de sa propre discipline exerce forcément une certaine influence sur ses activités professionnelles. Lorsque cette conception est claire et précise, complète et explicite, c'est-à-dire un modèle conceptuel, elle lui fournit des directives, sous forme d'abstractions, pour la pratique, la recherche et la formation infirmières. Quel que soit son champ d'activité, l'infirmière est guidée par l'image mentale qu'elle a du service qu'elle rend à la société. Praticienne, chercheur ou enseignante, ou administratrice d'un de ces secteurs, l'infirmière a un point de départ conceptuel; elle a une perspective globale.

Le point de départ conceptuel influe sur la pratique infirmière. Que son milieu d'exercice soit un hôpital, un centre de santé, une école, une résidence privée ou une entreprise, l'infirmière vise un but idéal et délimité, elle conçoit son client de façon précise et elle assume un rôle social particulier; de plus, elle reconnaît des problèmes de santé qui relèvent de sa compétence spécifique, elle envisage son intervention selon les modes à sa disposition et elle s'attend à certaines conséquences voulues. Sa perspective globale est la même, que son client soit malade ou en santé, qu'il soit jeune ou âgé, et qu'il ait un diagnostic cardiaque, orthopédique, psychiatrique ou autre. La praticienne peut-elle s'inspirer simultanément de plus d'*une* perspective globale? Peut-elle viser plus d'un but à la fois? Peut-elle conceptualiser son client de plus d'une façon, etc.?

Quant à la recherche, l'infirmière tient à faire de la recherche *infirmière*, à faire avancer la science *infirmière* et à contribuer aux connaissances propres à sa discipline. L'infirmière-chercheur identifie un problème de recherche *infirmière* en fonction de la perspective qui la caractérise.

La recherche infirmière, effectuée à partir d'une perspective distincte, peut conduire à l'élaboration d'une théorie. Il ne s'agira pas d'une théorie *des* sciences infirmières, ni d'une théorie *des* soins infirmiers, ni, non plus, d'une théorie *de* la profession mais plutôt d'une théorie *en* sciences infirmières. La nuance est beaucoup plus qu'une question de mots. Une théorie étant un système de propositions qui sert à décrire, à expliquer, à prédire, à diriger, et à faire comprendre une partie du monde empirique (Roy & Roberts, 1981), il n'est pas nécessaire — il est peut-être même impossible — d'avoir une théorie *de* la profession d'infirmière. Notre discipline n'est pas, en elle-même, un sujet d'investigation scientifique (Johnson, 1978). Une théorie *de* la discipline servirait à décrire, à expliquer et à prédire le service professionnel qu'offre l'infirmière, ce qui n'est guère souhaitable. Ce qui est, par contre, extrêmement souhaitable, c'est d'élaborer des théories concernant les phénomènes qui intéressent l'infirmière. Et quels phénomènes intéressent l'infirmière-chercheur? La réponse est dans la conception qu'elle a de sa discipline. La réponse est dans son modèle conceptuel. Cette réponse peut s'exprimer en termes d'équilibre, d'indépendance ou d'adaptation, pour ne nommer que trois possibilités. Il reste que le point de départ conceptuel, en précisant les phénomènes d'intérêt particulier à la discipline, oriente les questions de recherche; la perspective, distincte à la discipline, spécifie les problèmes de santé qui sont du ressort de l'infirmière et oriente ainsi la recherche d'intervention pour prévenir et résoudre ces problèmes.

Si la perspective de la discipline n'est pas claire, l'infirmière-chercheur est tentée d'emprunter son point de départ conceptuel à une autre discipline — souvent celle dans laquelle elle a fait ses études supérieures. Si les phénomènes qui sont d'intérêt particulier à sa propre profession ne sont pas identifiés, l'infirmière-chercheur s'applique à étudier les phénomènes qui sont d'intérêt particulier à une autre profession. Elle s'engage peut-être dans la recherche expérimentale avant que les variables spécifiques à cette recherche soient déterminées (Johnson, 1978, p. 9), avant que les termes descriptifs soient identifiés. Ainsi, ce chercheur fait de la recherche, mais s'agit-il de recherche *infirmière?* Ce chercheur fera avancer la science, ce qui est certes important, mais fera-t-il avancer la science *infirmière?* La recherche effectuée *par* une infirmière n'est peut-être pas nécessairement la recherche *infirmière.* Il est préférable, sans aucun doute, de faire avancer les sciences en général que de ne rien faire. Toutefois, il est stimulant de penser qu'un jour le temps et les énergies des infirmières-chercheurs seront investis dans l'étude des phénomènes tels les sept sous-systèmes de comportements, les quatre modes d'adaptation ou les quatorze besoins à satisfaire, pour reprendre les mêmes exemples déjà cités. Différents groupes de recherche choisiront différentes perspectives et chaque perspective conduira à des théories différentes et donc à différentes connaissances. Mais un groupe de chercheurs, peut-il partir de plus d'une seule perspective?

Qui sait? Un jour les théories en sciences infirmières seront peut-être aussi utiles aux autres professionnels de la santé, que les théories provenant d'autres disciplines sont aujourd'hui utiles aux infirmières. Ce jour-là, il faudra reprendre la discussion du pluralisme théorique!

Le modèle conceptuel exerce également une influence sur la formation infirmière. Un programme d'études est forcément basé sur une conception quelconque et lorsque la conception est un modèle conceptuel, l'étudiante est formée à poursuivre un but spécifique, à conceptualiser le client de façon explicite, à jouer un rôle social précis et ainsi de suite. Un programme de formation, basé sur une conception explicite, ne favorisera-t-il pas, chez l'étudiante, le développement d'une identité professionnelle distincte? Cette identité, n'encouragera-t-elle pas, chez la même étudiante, la créativité, l'individualité et l'utilisation judicieuse de son intuition en même temps qu'elle facilite l'intégration des connaissances scientifiques provenant de plusieurs théories?

Il est important de préciser que le modèle conceptuel ne figure pas au programme comme une matière à enseigner parmi d'autres. Au contraire, le modèle est à la base du programme; il est le point de départ conceptuel de tout le programme. Le modèle sert de charpente,

à laquelle on peut rattacher une grande variété de cours. Quel que soit le niveau de formation, là où les pédagogues prétendent former les infirmières, il y a une image mentale de la profession qui est transmise aux étudiantes. Stevens (1979, p. 130) l'appelle le modèle pour la discipline qui est communiqué aux étudiantes au moyen du modèle pour le curriculum. L'image mentale que les professeurs communiquent, consciemment ou non, exerce naturellement une influence sur les étudiantes. Il faut donc se poser deux questions: Est-il pédagogique, à l'intérieur d'un seul programme, de leur transmettre plus d'une conception de leur profession? Est-il pédagogique de transmettre une conception qui n'est ni claire ni explicite? Dans les deux cas, les étudiantes risquent de terminer leur programme sans avoir développé une identité professionnelle distincte et sans avoir acquis une idée claire de leur mandat social. Pourtant, nous envoyons nos jeunes bachelières dans le monde compétitif d'aujourd'hui en les exhortant à être des agents de changement et des travailleurs de la santé au même titre que les autres professionnels dans l'équipe interdisciplinaire. Nous incitons nos diplômés à s'affirmer en tant que femme ou en tant qu'homme et à apporter une contribution significative dans l'arène de la santé. Exiger autant de nos diplômés, sans leur fournir une base conceptuelle précise, risque d'attirer sur nous, de la part de ces même diplômés, des accusations d'injustice sociale.

Il est tout à fait légitime d'enseigner aux étudiantes qu'il existe plusieurs modèles conceptuels et que différents programmes s'inspirent de différentes bases conceptuelles. Le danger d'injustice envers les étudiantes existe lorsque leur programme de formation n'a pas de base conceptuelle précise et explicite.

Avant de terminer la discussion de l'influence qu'exerce sur nos activités un modèle conceptuel, il convient de rappeler qu'un modèle n'en est cependant que le point de départ. L'infirmière — praticienne, chercheur ou éducatrice — a besoin de beaucoup de connaissances dans les sciences humaines et biologiques. Elle doit avoir un bon jugement, de la maturité, et utiliser des méthodes systématiques de travail. L'infirmière doit également avoir des habiletés à établir et à maintenir une relation interpersonnelle qui sera perçue par le client comme une relation d'aide. Un modèle conceptuel ne remplace nullement les autres attributs nécessaires à l'infirmière; un modèle lui sert plutôt de charpente sur laquelle bâtir ses habiletés et ses connaissances, une charpente qui donne un sens à toutes ses activités, en apparence peut-être, disparates.

LES CRITÈRES D'ÉVALUATION D'UN MODÈLE CONCEPTUEL

Nous avons vu qu'un modèle n'est pas une théorie; il s'ensuit qu'un modèle n'est pas jugé selon les mêmes critères qu'une théorie. Un modèle conceptuel n'est pas à valider dans le sens de vérifier une

hypothèse ou de valider une proposition. La question "Le modèle X est-il vrai?" ne se pose pas (Johnson, 1974, p. 376). Le critère de vérité n'est pas approprié à une conception globale de toute une discipline. Toutefois, le modèle n'est pas à accepter aveuglément. Il y a des questions à poser, des normes à considérer, mais elles ne sont pas celles utilisées pour juger une théorie.

Les critères d'évaluation d'un modèle conceptuel, publiés depuis plusieurs années déjà (Johnson, 1974), ne sont pas toujours connus et bon nombre d'infirmières continuent à considérer les modèles comme des théories manquées ou des théories non-validées.

Les trois critères sont extrinsèques à la substance du modèle. Afin de décider si un modèle est "bon" ou "pas bon" pour une profession, on fait appel, non pas à la substance du modèle, mais plutôt aux décisions sociales en ce qui concerne la profession. Il s'agit de la congruence sociale, de la signification sociale et de l'utilité sociale du service professionnel lequel découle du modèle conceptuel. Il est entendu que ces décisions sociales ne peuvent être prises avant que notre service à la société s'inspire d'un modèle précis. Le jour où la pratique, la recherche et la formation infirmières s'inspireront du modèle X, on pourra évaluer le modèle X. De même, si dans d'autres milieux les trois champs d'activité étaient basés sur le modèle Y, alors on pourrait évaluer le modèle Y. Pour ce faire, il faudrait obtenir de la société, c'est-à-dire de la part des bénéficiaires, des clients, des patients, des malades, des consommateurs, les réponses à plusieurs questions.

Tout d'abord, en ce qui concerne la congruence sociale, les questions pourraient être les suivantes: les décisions et les interventions infirmières, qui découlent du modèle X, correspondent-elles aux attentes de la société? Le service professionnel, qui est basé sur le modèle X, concorde-t-il avec les attentes des bénéficiaires du même service? Nous savons, aujourd'hui, que la pratique infirmière n'est pas tout à fait ce qu'elle pourrait devenir; les clients qui auront l'occasion de connaître une nouvelle pratique échangeront peut-être leurs attentes actuelles pour d'autres. La société aimerait peut-être avoir des attentes autres que celles qui lui sont possibles aujourd'hui. Quoi qu'il en soit, le premier critère pour évaluer un modèle conceptuel est celui de la congruence sociale du service qui en découle.

Le deuxième critère est la signification sociale. Il s'agit d'obtenir des réponses aux questions suivantes: Le service professionnel, qui s'inspire du modèle X, a-t-il un impact significatif sur la santé des bénéficiaires? Les décisions et les interventions infirmières, qui découlent du modèle X, exercent-elles une influence positive sur la santé des gens? Si la profession d'infirmière disparaissait, la perte

serait-elle significative? Ce critère de signification sociale nous rappelle que l'existence même de notre service professionnel dépend d'un besoin de la société.

Quant au troisième critère, celui de l'utilité sociale, il s'agit de l'utilité du modèle pour les membres de la profession. Le modèle X est-il suffisamment clair et précis pour fournir des directives pour la pratique, la recherche et la formation infirmière? Plus spécifiquement, le modèle X est-il assez clair et complet pour être la base de la pratique dans toutes les situations? Le modèle X indique-t-il le but des soins infirmiers, quel que soit le milieu d'exercice et quel que soit le diagnostic médical? Indique-t-il clairement comment conceptualiser le client, qu'il soit jeune ou âgé, qu'il soit malade ou en santé? Le modèle, précise-t-il le rôle social de l'infirmière et ainsi de suite?

Aux infirmières-chercheurs, le modèle X est-il utile? Est-il assez explicite pour indiquer les phénomènes d'intérêt particulier à la discipline? Le modèle, suggère-t-il des questions de recherche à poser et précise-t-il le genre de connaissances qu'il faut développer?

Pour l'éducatrice, le modèle X offre-t-il une image mentale assez claire pour que les étudiantes développent une identité professionnelle distincte? Le modèle, est-il suffisamment précis pour être à la base d'un programme d'études? Indique-t-il en quoi consiste les matières propres à la profession, les matières connexes qui sont nécessaires et les théories qui sont essentielles pour former une infirmière?

Il est facile de voir qu'on ne peut évaluer le modèle X, ni le modèle Y, selon les trois critères de congruence, signification et utilité sociales, avant que le modèle X et le modèle Y deviennent la base conceptuelle de la pratique, la recherche et la formation et ce, dans plusieurs milieux. Pourtant, certaines infirmières hésitent à adopter un modèle parce qu'il n'a pas encore fait ses preuves. Après tout, le modèle choisi ne sera peut-être pas le bon, le meilleur, le "vrai." Briser ce cercle vicieux demande un certain courage car il y a certes un élément de risque dans l'adoption d'une conception explicite. Il serait utile de considérer, pendant un moment, le risque couru lorsque nos activités professionnelles s'inspirent d'une conception floue et incomplète. Puisque notre pratique, notre recherche et notre enseignement sont toujours basés sur quelque chose, considérons une base conceptuelle qui n'est pas trop claire et précise. Cette base a-t-*elle* fait ses preuves? Cette base est-*elle* la bonne, la vraie, la meilleure? Nous n'avons pas cette assurance. Notre conception privée et personnelle représente peut-être un risque aussi grand — sinon plus grand — que celui d'adopter un modèle conceptuel.

D'AUTRES CONSIDÉRATIONS

S'inspirer d'une conception explicite est extrêmement exigeant. Si les infirmières s'engagent vers un but précis, elles seront appelées à rendre des comptes sur la réalisation de ce but. Si les éducateurs s'engagent à former les étudiantes pour un rôle social spécifique, ils seront appelés à rendre des comptes sur le rendement de leurs diplômés. Et si les chercheurs s'engagent à ajouter aux connaissances concernant des phénomènes particuliers, ils seront appelés à rendre des comptes sur le corps de connaissances qui se développe. Comme toute autre profession de service, nous avons des responsabilités sociales et nous avons toujours valorisé le sens des responsabilités. Un modèle conceptuel ne fait que préciser ce dont nous sommes responsables.

Les divers modèles conceptuels qui existent ont été publiés, pour la plupart, par les infirmières américaines. Ils ne sont pas cependant des modèles américains. Ces modèles sont des conceptions de notre profession laquelle dépasse, de loin, les frontières géographiques d'un seul pays. Je ne crois pas qu'un modèle ait nécessairement la nationalité de son auteur. Cependant, le modèle n'est pas nécessairement universel, puisque les valeurs sous-jacentes ne concordent peut-être pas avec les valeurs de toutes les sociétés.

Dans le même ordre d'idées, un modèle élaboré par une infirmière au Manitoba ne sera pas un modèle manitobain, pas plus qu'un modèle conçu par une Québécoise ne sera un modèle québécois. L'auteur peut être de la Colombie-Britannique ou de Terre-Neuve; son modèle sera une conception de la discipline et la discipline ne se limite pas à une région géographique. Les postulats qui ne sont acceptables qu'à un seul pays ne seront pas les postulats à la base de toute une profession. Parce que les termes du modèle sont abstraits, ils doivent offrir une perspective très large.

Le choix d'un modèle conceptuel ainsi que la création d'un nouveau modèle se font en fonction de leur évaluation éventuelle, c'est-à-dire la congruence, la signification et l'utilité sociales. Ceci exige, forcément, qu'on y retrouve les postulats, les valeurs et les six éléments. La conceptualisation de ce que notre discipline pourrait ou devrait être est un long processus qui dépend, non seulement d'un apport rationnel et scientifique, mais aussi d'intuition, d'introspection et d'expérience professionnelle. Une infirmière qui commence ce long processus évitera de se restreindre à une période de temps déterminée; elle n'acceptera pas non plus d'élaborer un modèle conceptuel comme une production à effectuer sur commande. Stevens (1979) nous met également en garde contre un travail de groupe lorsque la tâche est celle de conceptualiser.

Tout ce qui s'appelle modèle n'est pas nécessairement un modèle conceptuel pour une discipline. Un "modèle d'intervention," par exemple, se limite souvent à une intervention précise dans une situation précise. Un "modèle de soins" traite souvent d'un ou des aspects de la pratique, sans offrir de direction pour la formation et la recherche. Un modèle pour un curriculum est une façon de voir un programme d'études, que ce dernier soit en mathématiques, en géographie ou en sciences infirmières. Par contre, un modèle conceptuel pour les sciences infirmières n'est utile qu'à la discipline infirmière.

CONCLUSION

La question du départ était: Est-il pédagogique d'avoir, à la base d'un seul programme de formation, plus d'*une* conception de la profession d'infirmière? Selon moi, la réponse est non. Au nom d'une identité professionnelle distincte pour nos diplômés, au nom d'une contribution importante à la santé des bénéficiaires et au nom de l'avancement de la science infirmière, je soutiens qu'à la base de chaque programme de formation, il ne faut qu'un seul modèle conceptuel.

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ABSTRACT

Conceptual Models

While theoretical pluralism is certainly an advantage for a nursing programme, it is questioned whether it is also desirable to have a curriculum based on more than one conceptual model for nursing. As the precursor of a theory, a conceptual model for nursing is a global perspective for the discipline; as such, it indicates nursing's particular focus and the phenomena that are of concern to nursing. As an explicit frame of reference, a model specifies that for which nurses must be accountable.

Nursing practice, education and research always have some conceptual point of departure. When that departure point is specific to nursing and when it is composed of assumptions, values and the six major units (Figure 1), it is a conceptual model. The criteria for evaluating a conceptual model are social utility, social congruence and social significance.

A curriculum based on one conceptual model for nursing should help students develop the distinct professional identity they need in order to assert themselves as members of the interdisciplinary health team. A programme that has several conceptual bases may, on the contrary, be anti-pedagogical.

AN EXPLANATORY STUDY OF SOCIAL WITHDRAWAL EXPERIENCES OF ADULTS

Nancy J. Cochrane

Social withdrawal may be a common problem among psychiatric patients and in persons who are experiencing stressful conditions in their social environment. As a psychiatric nurse the researcher identified this problem on in-patient wards and had little knowledge or skill to deal with it. It was also observed among staff members, especially the nurses themselves as they would frequently "withdraw" to the nursing station rather than attempt therapeutic communications with their patients. One could wonder if the specific nature of the nursing job had induced this withdrawal, or was it due to a reaction to the withdrawn patients? A similar state of affairs was again found when the researcher was a group counsellor in a provincial prison, and for more than five years she pondered about this perplexing situation.

While working as a research officer for one year, she finally was able to verify her perceptions of withdrawal by asking more than twenty psychiatric nurses if they felt withdrawn from their patients or if they noticed a pervasive amount of withdrawal behaviour in their patients. In order to obtain answers to these questions the phenomenon of withdrawal had to first be defined. Then many related questions fell into place, such as: What is the meaning and function of withdrawal for individuals? In other words, was withdrawal an active coping process or a self-defeating process for persons? What effect did withdrawal have in the lives of persons while they were engaged in it? Are withdrawn persons aware of their behaviour, and if so how do they name it or make meaning out of it?

Before these questions could be answered for the purpose of Ph.D. research, it became obvious to the researcher that it was first necessary to examine the nature of social withdrawal in order to better understand its function in the lives of adults. It was not only withdrawal behaviour but also the individual experiences of it that became the foci of interest in this study.

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As nurses begin to understand the varieties of social withdrawal experiences and their meanings and functions for patients, they may begin to identify withdrawn behaviour within a specific context and its effect on the persons involved. Nurses will then begin to understand their own reactions to withdrawn persons and also be able to identify their own withdrawal behaviour in the face of difficult patient problems (such as the grieving patient or the difficult "acting-out" patient). Social withdrawal may be a common human experience but so little is known about its basic components, including factors that affect it, both interpersonal and intrapersonal. So little is known about the process and functions of withdrawal in daily living. A clarification about the process of this phenomenon was seen to be helpful in directing nurses toward more appropriate interventions with patients during the various phases that occur during social withdrawal.

The purpose of this study was to understand the process of social withdrawal in the lives of a small number of adults. The researcher began with an assumption that social withdrawal can be a physical or psychological movement from other people and into self. The phenomenon called "social withdrawal" has been isolated as one variable whose dimensions have become clarified during this study including: the characteristics and types of withdrawal experiences, duration, context, outcomes, phases of changing perspective, and meanings and functions for the individuals concerned.

To date, social withdrawal has been examined in terms of behavioural variables with objective measurements during the past two decades in the fields of psychology, psychiatry, and sociology. There is a very confusing and complex set of terms that are applied to the conditions of social withdrawal and its manifestations in human behaviour often with conflicting meanings. In general, withdrawal behaviour has been identified as a part-process of many other related but very different phenomena such as depression, introversion, autism, schizophrenia, adolescent deviance, defense mechanisms, and reaction to stress and grief. The researcher concentrated primarily on the body of literature dealing with the existential experiences of persons in daily life, since this material pointed to withdrawal as an aspect of normal daily living (May, 1976; Moustakas, 1968, 1977; Sarton, 1973). This philosophical and social science literature presented an alternative meaning of withdrawal as being more than just a "maladaptive phenomenon." However, there was a paucity of literature about social withdrawal as an isolated phenomenon.

In the psychological and educational theory literature, social withdrawal was identified as a problem classroom behaviour of an increasing number of children and adolescents, with corresponding

symptoms of apathy, daydreaming, fatigue, and uncooperative behaviours (Appolloni & Cooke, 1977; Greenwood, Walker, & Haps, 1977). While some behaviour modification programs have been used in the attempt to prevent classroom withdrawal of children, there is little documentation about the experienced process of withdrawal in individual persons. In all of these studies, social withdrawal has been assumed to be a manifestation of anti-social and maladjusted persons that is caused by impoverished emotional nurturing and learning disabilities (Kanugo, 1979; Morris & Dolker, 1974; Susz & Marbeg, 1978).

Some studies have attempted to elicit individual perceptions of locus of control, powerlessness, and the degree of interpersonal distance needed for social comfort. For example, Duke and Mullens (1973) studied the "preferred interpersonal distance as a function of locus of control orientation in chronic schizophrenics, non-schizophrenic patients, and normals." They reported that the chronic schizophrenic patients perceived their locus of control external to themselves and they preferred to have more interpersonal distance than controls (non-schizophrenic patients). Preferred distance from interpersonal stimuli was greatest for schizophrenics and least for normals. Once again, the withdrawal perceptions and behaviours were attributed to abnormal reactions. Without the spontaneous descriptions of these persons' withdrawal experiences it is difficult to gain a full understanding of why, when, where and how withdrawal is experienced.

RESEARCH METHOD

A beginning exploration about the process of social withdrawal required an inquiry method that is suitable for one-variable, inductive, and descriptive studies that attempt to build theory rather than to test theory that already exists. This method was appropriate because of the paucity of theory that was available about social withdrawal experiences. Also, the data would be primarily qualitative rather than purely quantitative, since the researcher did not intend to objectively measure the behaviours of withdrawal. The analytical process developed inductively, or with a movement from particular events to tentatively proposed generalities about those events. This type of analysis differed from the more common method of research which is hypothetical-deductive. Deduction is marked by a movement from general observations to particulars in a reductive way. Swanson and Chenitz (1982) claim that "The more we attempt to explain phenomena by reducing the data to their least common denominator, the further we are from what we experience in the world around us." However, the researcher is restricting the importance of their statement to studies that are exploratory and that deal with understanding

the *meaning* of behaviours. Theory testing is appropriate when the meaning of behaviours is first understood within specified contexts. The research approach employed in this doctoral dissertation may also be called phenomenological, although the researcher has specified her approach as being dialogical or that which is yielded by verbal interviews with study participants (Buber, 1970; Gendlin, 1962; Giorgi, Fischer, & Von Echartsberg, 1971).

According to Diers (1979), exploratory or descriptive studies answer the question related to *"What is this?"*, and their main objectives are factor searching and factor isolating or naming. Also, this exploratory level of inquiry addresses the question *"What is happening here?"*; the study design is relation-searching and the kind of theory yielded is factor-relating (situation-depicting and situation-describing). On the other hand, hypothetical-deductive studies address the questions *"What will happen if . . . ?"* and *"How can I make . . . happen?"*. The latter employ study designs of association-testing, causal hypothesis-testing, and prescription-testing, and they yield predictive and prescriptive theories. Depending on the type of question that is being addressed in the research, the study design would be selected in the above ways.

In this study about the process of social withdrawal in adults, the questions that were addressed (in application of the above model of research) included: "What is adult social withdrawal?" and "What happens during the adult experience of social withdrawal?" The research methods most suitable to answering these types of questions are interview questions that identify important factors about withdrawal, as well as the relationship between the factors that will then provide a process of related factors. Both the factors and the entire process of the withdrawal experience are named so that they can be more easily understood and communicated. The named factors are formed into the concepts or short descriptive words or phrases that serve to describe the commonalities of the participants' withdrawal process. In this way the factors are first isolated and then related.

a) *The Study Participants*

Only volunteers who were non-institutionalized adults were eligible for the study, since the researcher wanted to first understand the "normal" and everyday experience of social withdrawal without the confounding issues of institutionalization and current psychiatric treatment. The study was announced in three courses in a graduate department within the University of Toronto, and this resulted in getting 21 volunteers who were faculty members, graduate students, and friends of the students. Then eligibility criteria were established for selecting only 8 participants, as follows:

(i) a voluntary interest in being interviewed about their episodes of social withdrawal that have occurred within the past three months,

(ii) an identification of themselves as being socially withdrawn some time during the past three months,

(iii) an ability to communicate fluently in the English language as well as a willingness to communicate personal experiences that would be held confidential and anonymous, and

(iv) without being institutionalized for psychiatric disturbance or having received psychotherapy during the past three months and during the study period.

It is obvious that this purposive "sample" of participants has directly shaped the findings from this thesis. However, the purpose was not to gain a representative sample of adults' social withdrawal experiences, but an indepth understanding of some individuals' ongoing documentation about their periods of withdrawal.

From the group of 21 volunteers, only 8 were selected by the researcher as subjects for the study. The reasons for restricting the study to only 8 persons primarily reflected the need to manage the data that would be yielded from frequent and indepth interviews over a period of one year. From the pilot study, the researcher realized that the data would be copious and multi-variate even with a very small number of study subjects. Also, the desire to isolate and then relate factors about social withdrawal did not require a large number of persons since it would only complicate the study even more. A case study or case series approach to the data collection included a selection of a group of people who were the most different in age, occupation, and ethnicity from each other. The following information gives an overview of the subjects' characteristics:

Age:	25, 27, 28, 34, 36, 41, 43, 67
Sex:	4 males, 4 females
Education:	1 highschool level, 7 university level
Occupation:	1 unemployed, 1 artist, 1 retired army officer, 1 nurse, 1 counsellor, 1 professor, 1 minister/monk, 1 teacher.
Ethnicity:	1 Thai, 1 East Indian, 1 German, 5 Canadian

Although the data have been analyzed in the dissertation with very broad comparisons made between subjects for the above variables, this will not be examined in any detail in this report of the findings.

b) *Data Collection Technique*

A 3-month pilot study with 9 volunteers (6 of whom continued in the study proper) was completed to refine a verbal interview method with the most relevant questions about social withdrawal. The following material refers only to the study proper and not the pilot test period.

In the first interview each participant was asked to relax, reflect back in time, and with eyes closed (the latter was optional) so that each person could obtain a focus upon the features of their most recent (occurring within the past 3 months) withdrawal experience. A technique called "focusing" was used which required a mental visualization of the withdrawal image and a re-experiencing of the feelings and thoughts within the situation (Christensen, 1974). Once the person was able to focus upon a scientific withdrawal episode, the researcher then probed with questions pertaining to the following information:

1. The context of the withdrawal incident, including when and how it occurred and in response to what specific event.
2. A description of the particulars or events occurring within the process of the withdrawal experience, including duration of events.
3. The movement out of withdrawal, its context and outcomes.
4. An identification of their repeated withdrawal experiences from childhood to the present.
5. An abstraction of the overall meanings and functions of their withdrawal experiences, considering past and recent episodes.

A mean number of 8 interviews were conducted with each study participant, with a range of 16 meetings varying from 1 to 4-1/2 hours in duration for each meeting. The participants were never interviewed as a group but always individually. The informal dialogical approach to data collection continued until the researcher was clear about each person's withdrawal experiences. Interviews were arranged by the researcher and the individual differences in need and desire to talk about their withdrawal episodes varied with the person and with the number of withdrawal episodes that each person experienced during the study period.

c) *Data Analysis*

The researcher found a paucity of techniques for analyzing qualitative data that would preserve the descriptions of the study participants rather than reducing them to categories alone. Another difficulty was in the forms of the data. Several participants expressed images of their withdrawal experiences through drawing pictures,

writing diaries, poetry, and through physically portraying the experience to me with physical gestures and motions. Many of the experiences were indeed difficult for the participants to articulate and even to bring to conscious thought.

The analytical method is likened to factor analysis or content analysis whereby specific events are first identified in each participant's array of experiences, and then these are compared between participants in the attempt to ascertain the differences and similarities in these events or factors of experiences. For example, the researcher very quickly noticed that each participant had undergone a perspective transformation during their reactive withdrawal experiences to a specific crisis of events. This perspective transformation affected their previous points of view, and it was seen by the participants to be essential to their coming out of the withdrawal period (Mezirow, 1978).

Individual insights from the participants became highlights that formulated groups of concepts within the process of each person's withdrawal period. With the identification of the similar concepts of data (clustered events) followed the naming of phases within a pattern or process of withdrawal that was common to all participants. So, there was an analytical movement from the isolation of factors of events, to concepts, to named phases forming a process of withdrawal. Each named phase derived from the experiences of the participants, and the researcher was engaged in an interpretative account of the data.

d) *Reliability and Validity of the Findings*

The concepts of "credibility" and "auditability" have been proffered by Guba and Lincoln (1981) as substitutes for the specific terms "validity" and "reliability" for use when conducting an inquiry in social sciences that encompasses a qualitative or naturalistic mode of investigation.

Methods of credibility (validity):

(i) *Host verification* involved checking the accuracy of the raw data by sending a copy of each transcribed interview to a participant for verification prior to each subsequent interview and prior to the analysis of data. Also, data interpretations were first validated with each person prior to their final documentation in the form of the dissertation.

(ii) *Corroboration* consisted of monitoring all data for consistencies and inconsistencies that were yielded by each participant.

Methods of auditability (reliability):

(i) *Independent observer analysis* was completed by three dissertation committee members and one student who tested the correlation between sections of raw data with the interpretations in the analysis. This activity is also called "outside auditing," with a review of the data collection and analysis procedures to test appropriateness and good judgment. This separate judgment serves as an analogue to the principles of inter-rater reliability and replicability tests that are favoured by scientific inquirers.

(ii) *Phenomenon recognition* was ascertained by presenting the interpreted findings about social withdrawal to two non-participant groups (classes of graduate students, 38 total persons) and then asking them whether the findings not only made sense to them but if they represented their own experiences of withdrawal. Feedback forms indicated a 70% agreement with the study findings.

FINDINGS

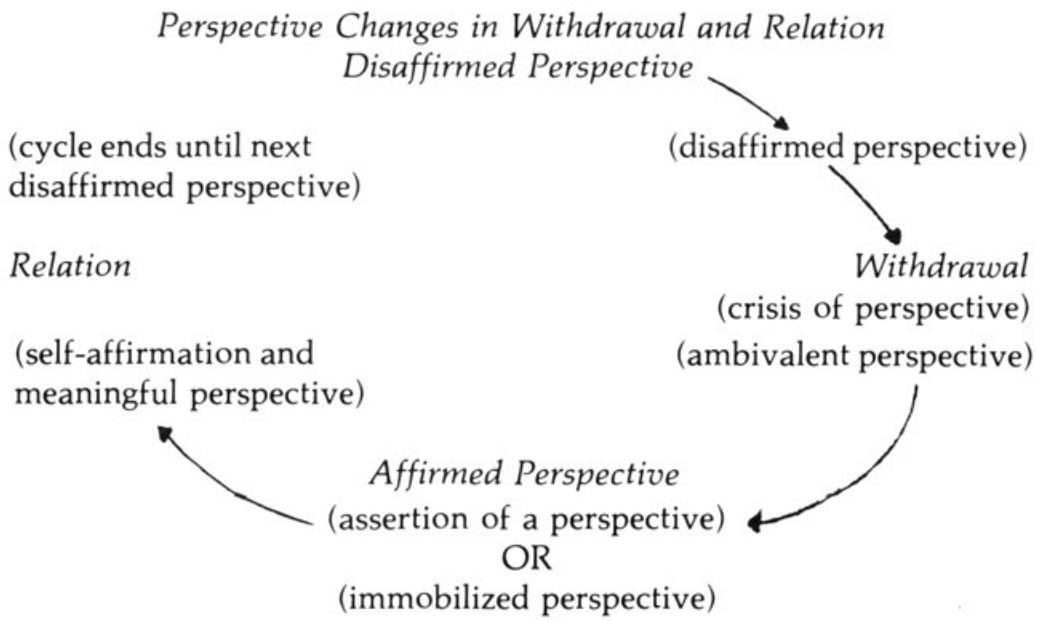
The total number of withdrawal episodes that were identified and discussed by all participants together had a range of 20 with a mean of 5 episodes occurring from childhood to present. This does not, however, represent the actual number of withdrawal episodes that occurred in these people's lifetimes, but only the episodes that could be recalled and which were perceived to be important to the participants.

The data consisted of verbatim transcriptions of more than 2,400 pages of typed dialogue. Three types of social withdrawal experiences were identified from the data: active, passive, and reactive withdrawal. *Active withdrawal* was the least disruptive and most natural experience that was needed for contemplation, reflection, and thinking. Although only two participants reported this type of withdrawal experience, it is assumed that the other 8 participants also had this type of withdrawal but only focused on other types of withdrawal about which they were more aware and to which they attributed the meaning of "withdrawal." The type of withdrawal experience that was most reported by participants was probably dependent on what they conceptualized as a "withdrawal activity," and this varied from person to person. Active withdrawal is a very healthy and adaptive coping response to an overload of stimuli in the environment. Selective response to these stimuli includes brief moments of reflective withdrawal and periods of clarifying one's thoughts in preparation for action. *Reactive withdrawal* is probably a coping mechanism that is used as a defense against a stressful stimulus. it is precipitated by a disaffirming event such as an interpersonal conflict,

and this was the most common source of a disaffirming event for the 8 participants. *Passive withdrawal* is a more extreme form of reactive withdrawal, and in common with reactive withdrawal it is indicative of a maladaptive coping response to a stressful event. However, this withdrawal is a more prolonged period of immobilized inactivity that may become symptomatic of psychiatric or emotional disturbance (Cochrane, 1981).

Individual tendencies revealed that 2 persons had active withdrawal lasting from brief moments to several hours, 5 persons had reactive withdrawal that varied from a few hours to several weeks, and one had passive withdrawal for up to 3 months. These withdrawal tendencies were also consistent with their early childhood and adolescent withdrawal tendencies, which may point to a developmental sequence in the course of this phenomenon. It appeared that the majority of adult withdrawal experiences in this group were reactive in response to stressful events, and the stressful stimulus was almost always an interpersonal confrontation or conflict that sometimes resulted in a loss or separation from the relationship (for examples, marital/partnership termination, death of important person, job loss, confrontation from authority figure).

The following diagram illustrates the major movements that were identified in one withdrawal process. The events which name each movement in the circle portray the relationship between social withdrawal and social relationship, and they are perceived to be in a sequential relation to each other. This diagram may help the reader to understand the following set of events which marked five phases within the process of reactive withdrawal. It is *not* a common cycle to all three types of social withdrawal: active, reactive, and passive.



The process of reactive withdrawal was analyzed in detail because it was the most common type of withdrawal. The following summary depicts the phases within the process of reactive withdrawal.

Phase I: A Disaffirming Event

This invoked the disaffirmation of a similar perspective; it is a disruption in one's previously held belief system and set of understandings about a particular person or event. One participant said: "Part of it was a loss of an important relation . . . All of a sudden his withdrawal was just snap! It was as if he just disappeared, left an empty space which I had to refill, and that was difficult to readjust to . . ." It is evident here that there is an interactive (social) effect of the withdrawal sequence such that the aversive stimulus may actually be withdrawal behaviour from a significant other person. More than three persons used the word "disruptive" and "overwhelming" to describe the disaffirming event. The researcher interpreted that there was an unexpected change in their external experience, and this change was marked by a disaffirming event to their personal identity and to their lifestyle perspective.

Phase II: A Crisis of Perspective

This phase included disorientation, confusion, perfuse anxiety, lack of control (internal), painful emotions, overload of thoughts and feelings, and depression, which is represented in the following data from six different participants:
"I don't know what's happening to me."
"I'm shaking and I feel like being sick."
"I am so tied up with negative emotions that I cannot move."
"I had depression . . . I wanted to rip feelings out of me."
"I was overtaken by emotions . . . My heart was aching."
"I scattered, went crazy. Confused. No meanings. Began to withdraw to myself." "I had no control over it."

Fear often resulted from this lack of awareness of what was occurring or could occur to the person during the crisis. Some participants doubted their level of integrity and sanity when they were in this phase. A sense of powerlessness was embraced in the references to statements such as: "It's a horrible realization that I can't take care of myself right now." Some participants felt "immobilized" by their emotions, and one person said she was "saran-wrapped and tied up with pain." The clinical significance of this phase of the withdrawal is that it is easy to observe temporary manifestations of mental disturbance that may soon pass. The danger would be to label the symptoms of this phase of withdrawal without understanding the full process of the withdrawal as a coping response to a distressing life situation. This

Contrary to the above experience, one person attempted suicide during his withdrawal and he was hospitalized on a psychiatric unit so that he could receive assistance to end his withdrawal experience. phase lasted from a few minutes to 2 to 3 weeks in six of the study participants. The persons who had a tendency toward active withdrawal did not experience any of the above, and they felt very much in control of their internal wellbeing and external environment. Lefcourt's (1976) theories of internal-external locus of control were helpful for the understanding of this phase.

Phase III: An Ambivalent Perspective

Competing perspectives and emotional vacillation were common in this phase of reactive withdrawal. It may represent a process of disintegrating old perspectives and integrating new perspectives at the same time, with a resulting "heightened perspective," as one participant called it. It is a "confrontation with self" and a time of "pulling apart the pieces and parts" of the dilemma. "I had a divergence of ideas and impulses" one person said, and this was part of what she called a "centring process" that eventually got her in touch with her innermost values, goals, and priorities. All participants said that it was also a time of reflective thinking when the competing issues had to be worked out and clarified. The ambivalence of competing and sometimes conflicting alternatives provides the time of "holding back" prior to taking a course of action. This is actually the stage of conflict resolution in the problem-solving process of coping, and all six participants who experienced reactive withdrawal identified a conflict that they needed to work out during this phase (Spivack, Platt, & Shure, 1976).

Phase IV: The Assertion of a Perspective OR *Immobilized Perspective*

This phase was appropriately named by one person as an "existential turning point," and by another person as a "moment of decision," since it represents the juncture of two possibilities: the assertion of a "heightened perspective" or becoming "stuck," "depressed," and "inert." This is the phase of acting upon a decision by asserting a new behaviour or attitude, or reclining still further into withdrawal, but this time to a passive withdrawal experience. The perspective shift can be seen in one participant's description: "I was getting older and realizing that I could make things happen to a certain degree, but I had to let go of the past, let go of an old image of myself." One person called it a phase of "breaking through barriers." Verbal expressions is an important part of this phase, which is evident in the following statement: "Finding words to describe and interpret my experience is part of regaining control and power. Remaining inarticulate drives me crazy."

Clinical depression became apparent at this point in the withdrawal, and the participant appeared to be self-preoccupied with his troubles. He said that he was in a continued state of "confusion and anxiety." He felt "helpless" and "unable to cope." Worse still, he felt "alienated from everything around," and "resigned" to his circumstances.

It is feasible that if the withdrawal episode is not terminated during this phase there may be deeper and more prolonged periods of indecision that represent an inability to cope or to solve the problem. Two persons claimed that they required the assistance of other people to help them to end their withdrawal episode and to regain an internal "sense of control over what was happening in the withdrawal."

Phase V: The Self-Affirmation and Meaningful Perspective

One person summed up the outcome of this phase for her: "The process of meaning-making is the process to regain personal power . . . I am driven towards the gestalt." This phase is marked by a feeling of comfort and ease in social relationships; in short, the conflict is resolved and there is a sense of gestalt or completion. The "insights came" for one person, and for another there was personal "acknowledgement" by an important person. It was after they had ended their withdrawal (wilfully) that all participants were able to recall the details and make sense from the specific events and phases of their withdrawal experiences. It seems that during the withdrawal itself there is difficulty in being aware of what is actually happening. Following the withdrawal process there can be the creation of meaning about the crisis and the response to the crisis. It is important to note that the two participants' experiences of active or rhythmic withdrawal were not at all painful but were perceived to be in harmony with their environment and with their personal development. It is proposed that a deeper process of withdrawal occurs following a personal disaffirmation, and a still deeper and potentially harmful process of withdrawal occurs in a passive and debilitating state where the duration of the withdrawal is much longer (up to several months).

It is likely that the majority of the participants had reactive withdrawal and the minority of them had a tendency to have active withdrawal because this was a highly selected group of people who had originally identified themselves as being "withdrawn" during the three month period prior to the study. This is perhaps not a "representative" sample of people in that respect, although one may hypothesize that reactive withdrawal is the more common type of experience in the face of crisis for many other individuals.

IMPLICATIONS FOR NURSING PRACTICE

It is vitally important for nurses to be able to understand withdrawal behaviour and withdrawal experience of all patients, since withdrawal may be a "natural" response to the stress of illness. These findings are not only relevant for psychiatric nurses who may witness the manifestations of withdrawal as a basic and underlying function in most clinically disturbed individuals, but also for persons in distress. Withdrawal behaviour may be understood within the context of a stimulus-response paradigm where it is a coping response to an aversive stimulus in the patient's immediate environment. Even a lack of privacy, which is so often experienced during hospitalization, may provide the aversive stimulus to provoke a process of withdrawal within a patient. More importantly, though, it is usually in response to a significant disruption in one's life and often with a resulting interpersonal loss that withdrawal is activitated. The withdrawal process may be similar to crisis resolution.

The identification of withdrawal behaviour should always be validated with the patient's experience, since there may sometimes be poor concurrent validity between behaviour and experience. When a withdrawal experience has been confirmed with the patient it is then important to carefully assess the context or stimulus for the withdrawal. The withdrawn individual may be able to verbalize what is happening and, indeed, the verbalization and contact with another person is therapeutic in itself. Once the problem is identified it is important to help the patient work through the phases of problem-solving, which include the generation of options and alternative behaviours (Spivack et al., 1976), and good decision-making that is appropriate to the problem stimulus. An understanding of the patients' perceived obstacles toward the goal must be realized in order to coach a patient through this phase of self-doubt and ambivalent thinking. Communication with the patient is probably the most effective way of intervening with a withdrawal episode, but it is imperative that nurses become sensitive to times when it is appropriate to let the patient endure some silence so that a natural thinking process can be issued. The helper stance precludes a forced set of opinions onto the patient, which in the end only complicates the patient's own problem-solving process (because there is yet another aversive stimulus to deal with concomitant to the existing problem).

Last of all, it is imperative that nurses be able to identify the differences between a self-inhibiting and potentially destructive withdrawal experience from a self-enhancing and potentially healthy coping process in each individual. This is sometimes difficult to assess, since the experience of withdrawal may be operationalized in a variety

of ways among patients. The existing body of knowledge about withdrawal experience and behavioural expression is inadequate, and it is difficult to find an objective "measure" of this phenomenon. The nurse can, however, closely monitor the patient's withdrawal behaviour but always with notes about the patient's own context and perceptions of the experience. The withdrawal experience can be classified according to the analysis that is proffered in this thesis, according to active, reactive, and passive withdrawal, with evidence of the patient's interpersonal and intrapersonal experiences to support the choice of classification. With passive withdrawal there is very little interpersonal contact initiated by the patient towards another person. Instead, there is more intrapersonal preoccupation and lack of physical activity, and clinical symptoms of depression may become apparent. It is important, however, not to confuse withdrawal with depressive behaviour because it is hypothesized that they are two different phenomena. This hypothesis remains to be tested in a currently conducted analytic survey of the coping responses of parasuicide patients who are undergoing extreme stress.

CONCLUSION

Theory building research is best followed up by theory testing research, since the findings from this explanatory inquiry are highly inferential and tentative. One of the difficulties of descriptive research of this kind is that precise measures of prediction, replicability, *external* validity, and reliability of the findings are as yet unknown. The findings must be tested in a more rigorous and systematic fashion through hypothetical-deduction and through randomized controlled trials. The researcher is currently testing the findings yielded from her dissertation by conducting an analytical survey of coping patterns in a random sample of persons, and then a randomized controlled trial will test the effects of a coping skills program with an experimental and control group of parasuicide patients.

A process of reactive withdrawal has been described, and some of the social contexts and outcomes of withdrawal experiences have become clarified. Very little has been proffered about the behavioural dimensions of withdrawal, and further research is needed to develop this area.

In his book called *How Adults Learn*, Roby Kidd (1973) unveiled an essential meaning of the learning process, which he called "being, becoming, and belonging." He purported that researchers and practitioners have tarried too long upon the surfaces of human encounters of daily living to the sad neglect of understanding the experiences of being human. We need to expand upon our understandings about

common human phenomena, particularly those phenomena that relate to the human effort to cope with adverse circumstances in daily living. The cultural variations of social withdrawal would contribute to our knowledge of the social contexts and acculturation processes that are other factors which may direct the course of withdrawal experience.

Last of all, the distinctions between social withdrawal and the grieving process must be carefully examined in future work, along with the distinctions between depression and schizophrenia with social withdrawal. More sensitive assessment tools may enable us to clearly identify and classify the differences in these clinical features. In addition, social withdrawal must not be restricted in meaning as a clinical symptom; it could be viewed in the light of human adaptive processes that may assist individuals to achieve a very potent coping response and learning event. On the other hand, withdrawal may become a very self-inhibiting coping response that is ineffective for some persons. These distinctions must be further clarified through continued research about social withdrawal.

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RÉSUMÉ

Étude exploratoire des expériences de recul social chez les adultes

Le recul social peut se manifester fréquemment chez les patients psychiatriques et également chez les personnes qui vivent des expériences de stress dans leur milieu. La présente étude vise à comprendre, au moyen de l'analyse de cas, le processus de recul social vécu par huit adultes. L'étude part de l'hypothèse que le recul social peut être un mouvement psychologique ou physique, un retrait face aux autres, et en soi-même. Les données recueillies ont permis d'identifier trois types de recul social: le recul actif, le recul passif et le recul réactif. L'analyse de contenu a révélé un processus commun de retrait chez six participants, processus qui comprenait les étapes suivantes: négation de la perspective, crise de perspective, perspective ambivalente, assertion d'une perspective et affirmation de soi. Ces cinq étapes n'étaient communes qu'au processus de recul réactif et l'analyse des résultats a porté principalement sur un examen détaillé de ce processus. Cela signifierait que le recul réactif pourrait être une réaction qui permettrait de faire face au stimulus aversif du milieu social, mais il peut être relié à un trouble émotif s'il se prolonge ou devient passif.

FACTORS ASSOCIATED WITH CAREER CHOICE OF UNIVERSITY WOMEN IN MEDICINE AND NURSING

Jane Birdsell • Al Herman

In the past two decades as women began to enter the labor force in increasing numbers and for longer periods of time, interest began to develop in their career aspirations and vocational development. It became increasingly apparent that existing theories of career development and career choice were relevant for men but not for women (Bardwick, 1971; Farmer, 1978; Horner, 1968, Osipow, 1973). Researchers were encouraged by these authors, and others, to explore those factors which influence career and achievement motivation in women, in order that a theoretical model for career development in women might be formulated.

The career goals of college women have been categorized as traditional and nontraditional. Traditional careers for women are those that are dominated primarily by women. They tend to allow one to have an intermittent involvement in that career and represent an extension of women's domestic role. Such occupations include nursing, teaching (elementary education), home economics, and library science. Nontraditional careers for women are those that are dominated primarily by men and, by their nature, are more demanding of time and energy, thus requiring greater career commitment. Such careers include science, law, dentistry, medicine, engineering, architecture, and the clergy (Almquist, 1974).

Comparisons of traditional and nontraditional oriented career women have become popular research in recent years and certain factors in family background and personality characteristics have emerged that distinguish between them. Early studies suggested that factors such as high parental education, foreign ancestry, first-born status, and working mothers were significant predictors of nontraditional career choice in women. Recent studies indicate that these background factors are less important than they once were thought to be. Personality data show the nontraditional career oriented woman to be high on "competency" traits related to the masculine stereotype and

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ideal, and also high on "warmth and expressiveness" traits of the feminine stereotype and ideal. The traditional woman, on the other hand, is seen to be higher on the "warmth and expressiveness" traits than she is on the "competency" traits (Almquist, 1974; Lemkau, 1979; Tangri, 1972).

The study of masculine and feminine sex role orientation has enjoyed an enthusiastic rebirth of intersest in the last decade, beginning with the study of sex role stereotypes and self-concepts in college students by Rosenkrantz, Vogel, Bee, Broverman and Broverman (1968). Broverman, Vogel, Broverman, Clarkson and Rosenkrantz (1972) first described stereotypic male characteristics as "competency" oriented and stereotypic female characteristics as "warmth and expressiveness" oriented. Bem (1974) suggested that a person might incorporate both masculine and feminine characteristics into one's personality and thus be "androgynous". She has designed an instrument for the purpose of measuring sex role orientation in which four categories are defined. Depending on one's self-endorsement of masculine and feminine traits, an individual is described as masculine, feminine, androgynous or undifferentiated. An androgynous person is one who scores above the median on both the masculine and feminine items and an undifferentiated person is one who scores below the median on both of these items. Women who chose nontraditional careers were seen to be androgynous, while women who chose traditional careers were seen to be feminine in their sex role orientation (Lemkau, 1979).

Women's role perceptions and life goals have altered significantly in the last decade. Not only has it become acceptable for women to pursue nontraditional roles, but barriers to women's achievement are gradually being broken down. As women overcome the societal pressures to adhere to feminine roles and increasingly choose previously male dominated, highly committed careers, it would appear that the nature of this choice does become more subtle and more complex.

It was the purpose of this study to investigate personality and demographic factors in college women who had selected traditional and nontraditional careers, specifically nursing and medicine. A further focus of this study was to examine personality and demographic data of women with different sex role orientations. It was intended that the findings of this study would contribute to the increasing body of research, designed to establish information that will lead to a theoretical model of career choice in women.

METHODOLOGY

Sample

Female students from the Faculties of Medicine and Nursing at the University of Calgary were informed about the study and asked to participate for the purpose of examining career choice in women. They were given a questionnaire package and asked to return it upon completion. Forty-five (54%) nursing students and 38 (50%) medical students completed the questionnaire providing a total sample of 83.

Women were chosen from the Faculty of Medicine rather than premedicine because of the fact that many women appear to change direction of their career pattern in the early years at university (Alper, 1974; Harmon, 1972). Cartwright (1972) noted that only fifty percent of the women who had serious intentions of pursuing a medical career in college actualized their plans. As two years at university is the minimum requirement for entry into the medical school at the University of Calgary, women who had completed two years of the four-year baccalaureate nursing program were chosen. This factor represented a relatively high degree of commitment to career choice in both groups. It was also an attempt to control for possible differences in age between the two groups.

Instrumentation

The questionnaire package included a demographic data inventory developed by the researchers, Jackson's (1974) Personality Research Form (Form A), and the Bem Sex Role Inventory (Bem, 1974).

The demographic data inventory was used for the purpose of asking subjects to provide information about their present age, marital status, previous job experience and academic achievement at the time of their entry into the faculty in which they are presently enrolled.

The Personality Research Form (PRF) is designed to measure 14 personality traits relevant to normally functioning individuals, in a wide variety of situations. It is based on theoretical conceptions of personality described by Murray (1938). Form A consists of a total of three hundred true and false items, which are divided into fifteen 20-item scales. These 15 scales measure such specific need characteristics as Achievement, Affiliation, Aggression, Autonomy, Dominance, Endurance, Exhibition, Harmavoidance, Impulsivity, Nurturance, Order, Play, Social Recognition, Understanding and Infrequency. The Infrequency scale is designed to measure pseudo-random response patterns and is not relevant to this study.

The norms for the PRF are based on a student population of over one thousand males and one thousand females. There are separate norms for males and females. Three measures of reliability have been

completed. A median K-R coefficient for the 14 variables (infrequency excluded) assessed on Form A is .76; median odd-even reliability is .78; median test-retest reliability is .81. Construct validity was assessed by correlating PRF scores with self and peer rating. In one study, combined scores from Forms A and B yielded a median correlation of .52 with peer ratings and .56 with self ratings. When a single form was used, correlations were lower. Additional convergent and validity studies render values that are considered above those usually reported for personality inventories.

The Bem Sex Role Inventory (BSRI) is designed to measure one's sex role orientation, assuming that masculinity and feminity are two independent dimensions. It has three scales: masculine, feminine, and neutral, each containing 20 personality characteristics. Each subject is asked to indicate on a seven point scale how well each of these personality characteristics describes her. Upon completing the Inventory an individual can be classified as Masculine, Feminine, Androgynous, or Undifferentiated, depending on her endorsement of masculine or feminine characteristics for herself.

The norms for this instrument were originally established by Bem (1974) on a total of 917 students. Test-retest reliability, after a four week period, showed coefficients of .90, .93, and .89 for the masculinity, feminity and androgyny scores respectively. Validation studies have been reported by Gaudreau (1977).

Methods of scoring the BSRI have been the topic of discussion and assessment for the past six or seven years. The method chosen for this study is the one recommended by Orlofsky, Aslin and Ginsburg (1977) and Sedney (1981). It is one which combines the t-ratio procedure, originally recommended by Bem (1974) and the median-split procedure, recommended by Spence, Helmreich and Stapp (1975) and subsequently adopted by Bem (1977).

RESULTS

The mean age for medical students was 26.37 and for nursing students 21.84. A t ratio indicated a significant difference ($p < .001$). There were 18 married and 20 single students in medicine whereas in nursing 9 were married and 36 were single. Chi square analysis showed these to be significantly different ($p < .05$). Further results showed that 21 of 38 medical students had previous professional job experience while none of the 45 nursing students had professional job experience. These differences were highly significant ($p < .001$). Similar significant differences were evident in that 34 women in medicine had one or more degrees while only one woman in nursing had a degree.

Univariate F ratios were obtained to test the significance of difference between women in medicine and nursing on each of the 14 personality variables of the PRF. Table 1 presents a summary of the means, standard deviations and F ratios.

Table 1

Mean, Standard Deviation, and F Ratio of Personality Variables Measured by the PRF for Women in Medicine and Nursing

Trait	Medical Students		Nursing Students		F Ratio
	Mean	S.D.	Mean	S.D.	
Achievement	14.84	2.38	14.02	2.66	2.16
Affiliation	15.63	2.34	16.31	2.17	1.88
Aggression	4.79	2.12	5.47	3.39	1.14
Autonomy	8.18	3.25	6.96	3.15	3.04
Dominance	9.45	4.26	10.60	4.05	1.59
Endurance	13.71	2.67	11.56	3.33	10.32**
Exhibition	9.53	4.09	9.80	3.95	.96
Harmavoidance	9.87	5.00	10.73	4.36	.71
Impulsivity	9.32	3.43	9.82	4.07	.37
Nurturance	15.40	2.15	15.56	2.44	1.00
Order	11.32	3.43	10.96	3.28	.24
Play	9.61	2.69	12.27	2.31	23.55***
Social Recognition	8.16	3.59	10.33	3.75	7.20**
Understanding	15.76	2.03	13.73	2.73	14.33***

n=83
df=1,81
p = .05
critical F=3.96

** $p < .01$
*** $p < .001$

Nursing students were significantly higher than medical students on Play and Social Recognition. Medical students were significantly higher than nursing students on Endurance and Understanding.

A chi square analysis was used to differentiate between medical and nursing students on sex role orientation as measured by the BSRI. Table 2 summarizes these findings.

Table 2

Sex Role Orientation of the Women in Medicine and Nursing According to the Combined T-Ratio, Median-Split Scoring Procedure of the BSRI

	Number of women in medicine and nursing in each classification			
	Masculine	Andro-gynous	Undifferen-tiated	Feminine
Medical Student	12	10	6	10
Nursing Students	7	14	2	22

n=83
df= 3
p =.05
critical X^2=7.82

X^2=7.95
p<.05

More women in nursing were labelled feminine and more women in medicine were labelled masculine. There were similar numbers of androgynous women in the two professions.

Univariate F tests were obtained to test the significance of difference among masculine, androgynous, undifferentiated, and feminine women on each of the 14 PRF variables. Table 3 shows these findings.

A priori analyses were performed on the variables for which directional differences were predicted and which yielded a significant F ratio. These analyses showed masculine women were significantly higher than feminine women on Aggression, Autonomy, Dominance, Endurance Exhibition, and Understanding. Feminine women were significantly higher than masculine women on Harmavoidance and Social Recognition. Androgynous women were significantly higher than feminine women on Aggression, Autonomy, Dominance, and Exhibition.

An F test showed no significant differences among masculine, androgynous, undifferentiated, and feminine women on age. Chi square analyses for the four groups of women showed significant differences ($p < .05$) on marital status where more feminine women tended to be single, and on job experience where more feminine women

Table 3

Mean, Standard Deviation and F Ratio of Personality Variables Measured by the PRF for Masculine, Androgynous, Undifferentiated and Feminine Women

	Masculine		Androgynous		Undifferentiated		Feminine		
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	F Ratio
Achievement	14.63	2.48	14.83	2.71	14.38	2.83	13.94	2.45	.63
Affiliation	14.89	2.31	16.29	2.27	15.75	1.75	16.50	2.20	2.30
Aggression	7.16	4.09	5.50	2.28	4.75	1.98	3.81	1.75	6.70***
Autonomy	9.63	3.55	7.92	2.63	8.13	3.44	5.81	2.57	7.22***
Dominance	12.68	4.14	11.63	3.33	9.88	3.94	7.41	3.27	10.89***
Endurance	14.32	3.07	12.46	2.95	11.88	2.53	11.72	3.34	2.95*
Exhibition	10.95	4.31	11.13	3.49	9.13	3.18	7.97	3.78	4.12**
Harmavoidance	6.79	4.06	10.21	4.26	10.00	3.02	12.63	4.36	7.85***
Impulsivity	11.11	3.46	10.08	3.84	10.13	3.94	8.19	3.54	2.87*
Nurturance	14.79	1.84	15.92	2.50	15.25	1.49	15.63	2.52	.93
Order	10.26	3.60	10.92	3.27	10.38	3.29	11.97	3.18	1.29
Play	10.47	2.70	11.71	3.10	9.63	2.72	11.25	2.60	1.47
Social Recognition	7.95	4.33	9.21	3.32	7.50	1.77	10.72	3.84	3.08*
Understanding	15.95	2.42	14.42	2.78	16.13	1.64	13.72	2.44	4.25**

n=83
df=3,79

p=.05
critical F=2.72

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

tended to have non-professional job experience than other women. There was no significant difference in the academic achievement of these four groups of women.

DISCUSSION

Although personality variables did discriminate between traditional and nontraditional women, with four variables showing a significant difference between them, it was also learned that these two groups did not significantly differ on some of the competency related traits. Women in medicine were significantly higher than women in nursing on Endurance and Understanding. It is interesting to note that women in nursing were higher than the normative sample of college women on both Endurance and Understanding (Jackson, 1974) and yet, in this sample, were significantly below women in medicine on these traits. Although Endurance is required in nursing, and has been identified as a characteristic of nurses (Bailey & Claus, 1969; Webb & Herman, 1978), it appears that women in medicine are particularly persistent and determined. This result lends support to Rossi's (1965) contention that successful achievement, particularly in the sciences, requires persistence and apartness from others. It concurs with Cartwright's (1972) findings that women in medicine are particularly persevering.

The description of the high scorer on Understanding (Jackson, 1974) is "wants to understand many areas of knowledge; values synthesis of ideas, verifiable generalization, logical thought, particularly when directed at satisfying intellectual curiosity." Although scientific knowledge is required in both professions, it appears that women in medicine are particularly enquiring, investigative and intellectual. This is consistent with the findings of Tangri (1972) and Lemkau (1979) that women in nontraditional careers have a high degree of intellectual capacity. One might question whether individuals who chose to enter medicine originally had higher levels of Endurance and Understanding, or whether these traits have been developed to a higher level in the educational process of medical school.

Women in nursing were significantly higher than women in medicine on Play and Social Recognition. Although women in nursing were not high on these traits, medical students were low relative to female norms (Jackson, 1974). As the scales on the PRF are bipolar, a low score on Play is consistent with a high score on Endurance and Understanding. Perhaps limited time for recreation in medical school contributes to a lower Play score for these women.

Social Recognition may be considered a stereotypic feminine trait. A low score on this trait reflects an autonomous, independent personality. This coincides with the literature pertaining to women in nontraditional careers and, in particular, women in medicine. Tangri (1972) and Lemkau (1979) reported that women in nontraditional careers were unconventional, independent, and autonomous. Women in medicine were found to report both more and less support from society for their decision to enter medicine (Cartwright, 1972; Kutner & Brogan, 1980; McCormick, 1979). In dealing with the nonsupportive elements, it appears that women who choose nontraditional careers must be able to accept criticism and remain strong and independent in their decision.

The personality profile of the women in nursing in this study supports the belief that the personality characteristics of women entering nursing today are different from those of 10 and 20 years ago. Relative to the women in the normative female college sample (Jackson, 1974), women in nursing were higher on the competency traits of Achievement, Dominance, Endurance and Understanding and lower on Social Recognition. In spite of the fact that women in nursing are becoming more competency oriented, the results of this study indicate that women in medicine are still significantly more persistent, work oriented, independent and intellectual than women in nursing. These are the traits identified by Atkinson and Raynor (1974) and McClelland (1971) as typifying the high achiever.

Although there were higher numbers of masculine women in medicine and higher numbers of feminine women in nursing, there were similar numbers of androgynous women in the two professions. This supports the suggestion of Yanico, Hardin, and McLaughlin (1978) that women with an androgynous self-concept are as likely to choose a traditional as a nontraditional field, and that sex typed individuals are likely to choose a career that is compatible with their sex role self-concept.

The results of this study suggest that androgynous women do have more flexibility in choosing a career. Optimum freedom to develop one's potential through work would likely be enhanced if individuals were helped to develop androgynous self-concepts. This lends support to authors who suggest that women must be encouraged to expand their self-concepts to include masculine qualities, along with their feminine qualities, if they are to be helped to make and implement career-related decisions (Birk & Tanney, 1977; Hawley, 1978; Moreland, 1979).

The result of the age variable in this study supports the findings of Cartwright (1972) and Kutner and Brogan (1980) that women who

decide to enter medicine are older and have more life experience than do women who choose more traditional careers.

The marital status variable showed that more medical students than nursing students are married. This occurs with several authors who reported that support from a spouse or boyfriend is a significant factor in nontraditional career choice or achievement motivation among women (Alper, 1974; Kutner & Brogan, 1980; Tangri, 1972). It suggests that once the conflict surrounding the role of wife, and perhaps mother, has been resolved, women are freer to make a commitment to a nontraditional career.

The job experience variable in this study showed that women in medicine had more professional job experience than did women in nursing. This finding is in agreement with authors who reported that women in medicine have frequently left other jobs with which they were dissatisfied (Cartwright, 1972; Kutner & Brogan, 1980). They suggest that improved career counselling for women might help to prevent them from making career choices that are not in keeping with their interests and abilities.

Although a degree was not required for entry into medical school at the University of Calgary, it is acknowledged that a degree would enhance one's acceptability into this faculty. Information from the medical school reveals that 58 (76%) of the 76 female medical students have degrees. This information suggests that academic self-esteem is a factor which influences career motivation and the selection of a nontraditional career.

Personality variables measured by the PRF discriminated among masculine, androgynous, undifferentiated, and feminine women. The a priori analyses supported the hypothesis of masculine women being significantly higher than feminine women on all of the competency related traits but Achievement. Androgynous women were found to be significantly higher than feminine women on Aggression, Autonomy, Dominance, and Exhibition. This result suggests that Endurance and Understanding are the significant components in the masculine orientation that draw women into medicine, and perhaps other nontraditional careers. Androgynous women, who were higher than feminine women on the competency traits of Aggression, Autonomy, Dominance and Exhibition, are seen to choose either medicine or nursing as a career. It is concluded from this study that androgynous women are not the same as masculine women on all of the competency related traits.

This study does not reveal any significant information about the undifferentiated female. From the mean scores (Table 3), it is seen that

undifferentiated women tended to be more like feminine women on Aggression and Endurance and more like masculine women on Autonomy, Social Recognition and Understanding. However, post hoc Scheffé analyses did not yield any significant differences between the groups on these variables. If Dominance and Exhibition are a reflection of self-esteem, then this study does not support the authors who suggest that undifferentiated individuals have lower self-esteem than androgynous and masculine individuals (Bem, 1977; Harris & Schwab, 1979; Pyke, 1980).

The results of this research tend to support the conclusions of Pyke (1980) that androgyny does not bear any statistically significant relationship to demographic variables. However, the proportionately higher numbers of feminine women in the unmarried and non-professional job status suggest that a closer examination of these variables and their relationship to androgyny might be worthwhile.

It is interesting to note that the demographic variables did not discriminate among women with a different sex role orientation, yet did discriminate between women in medicine and nursing. This suggests that role concept, which influences career choice in women, is in itself dependent on factors other than those which influence women in their career related decisions. It appears that much more information is required about the developmental influences of a sex role self-concept. It is clear that career choice in women is a much more complex process than the implementation of a self or role concept. Instead, it appears to be an interaction of personal and situational determinants at different developmental stages.

In summary, this study revealed that women who chose medicine as a career were older and had had more experience in the realm of work, marriage and education than women who chose nursing. Women in medicine tended to have a more masculine sex role orientation and were significantly higher on the personality traits of Endurance and Understanding, and significantly lower on Play and Social Recognition, than women in nursing. Sex role orientation was not significantly influenced by the composite of the demographic variables used in this study, but a negative relationship was found between feminine sex typing, and married and professional job status. Masculine and androgynous women were differentiated from feminine women on the competency related variables of Aggression, Autonomy, Dominance and Exhibition. Masculine women were also differentiated from feminine women on Endurance, Understanding, Harmavoidance and Social Recognition. It is concluded that androgyny is related to both stereotypic masculine and feminine personality traits, and possibly to marital status and job experience. It is not related to age or academic

achievement. It is also concluded that nontraditional career choice, in particular medicine, is the result of a complex interaction of demographic factors related to life situation, and personality traits related to perseverence, work orientation, independence and intellectual curiosity.

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RÉSUMÉ

Facteurs liés au choix professionnel des étudiantes en médecine et en sciences infirmières

Nous avons examiné les facteurs caractériels et démographiques chez les étudiantes qui avaient choisi une carrière traditionnelle (sciences infirmières) et une carrière non-traditionnelle (médecine). Notre échantillon comportait 45 étudiantes en sciences infirmières et 38 étudiantes en médecine. Nous avons relevé des différences marquées entre les deux groupes au niveau des facteurs caractériels et démographiques. Nous avons également constaté des différences en nous fondant sur des stéréotypes masculins et féminins.

A CONCEPTUALIZATION OF CONCEPT

Constance H. Becker

One of the prominent concerns of contemporary professional nursing is with the state of nursing theory. This concern runs the gamut: Does nursing theory exist? Can nursing develop a theory base? Where, and how, should nursing theory or theories develop? Each of these aspects of concern has its proponents and opponents. A very basic aspect of the concern over nursing theory, however, should be a concern with concepts used in basic nursing research. The concern should focus on such aspects of concepts as to how they are developed and defined, and implicity, why such a concern with concepts is necessary.

In order to understand something, for example, a concept, it is necessary that the "something" be taken apart and analyzed; thereby gaining a greater understanding of its place in the schema of other things. Unfortunately, the term concept has such a familiar sound to it that it is generally taken for granted; each and every user of the term fully comprehends the philosophic and scientific meanings of the term. In reality, however, what is comprehended by many users of the term is only a very loose meaning (Torres, 1980). Such a loose comprehension of the meaning of the terms is inadequate for the continued development of nursing theory. It is necessary to realize that if the concepts used are loose the potential contribution of the concepts to theory will be lost.

It follows, then, that for concepts to make the maximum contribution to theory they must be initially clarified and examined. Chinn & Jacobs (1978) see this examination of concepts as a poorly understood activity, one that is generally neglected. Therefore, it is necessary to examine the what and how of concept formulation for the subsequent knowledgeable use of concepts in the development of nursing theory. The present intent is to address a conceptualization of concept and to suggest the value of a perspective using micro concepts, rather than general — or macro — concepts, in nursing research and in the development of nursing theory.

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CHARACTERISTICS OF CONCEPTS

A characteristic of the term concept is the ambiguity of what is meant generically by the term. There are three characteristics to which the term can refer: 1) a property of things; 2) a relationship; or, 3) a context (Brodbeck, 1963). As an example of these differing characteristics Brodbeck uses the following example. The concept of "16" may refer to either $12+4$, or to 4^2. The former indicates relations, the latter, property. This example also illustrates another characteristic of a concept. That is, the meaning of a specific concept is based on convention and consensual agreement, and not on private meaning.

The conventional meaning of a concept has some latitude, however, depending upon the theory in which the concept is used. For example, the meaning of the concept of attachment has quite a different meaning in a theory dealing with maternal-infant interaction than it does in a theory dealing with psychotherapist-client interaction. The precise meaning of a concept is thus dependent upon the context in which it is employed.

Another characteristic of concepts is that they are neither true or false, valid or invalid. This point is at variance with the position of those who hold that concepts that may appropriately be said to be true or false are called propositions (Dickoff & James, 1975). The question of truth or non-truth has no place in either the delineation, analysis, or use of concepts in the development of theory. Theories are only models of reality and not reality itself, and therefore concepts are only models of reality and not reality itself. Concepts are elements in a theory; they make a contribution to the theory attempting to approximate reality. All error cannot be eliminated from conceptualizations of reality and since error is always present truth or non-truth cannot be said to be present.

Concepts can, however, be significant or not significant. Their appraised significance is dependent upon the frequency and the regularity with which the property, relation, or context of the perceived reality occurs. If the phenomena occur infrequently or in an unusual context, the concept is non-significant regardless of the goodness-of-fit of the concept with reality.

In an effort to deal with the ambiguity and confusion engendered by the term concept several authors have suggested that another term be used in any discussion of concept. Brodbeck (1963) suggests the word "term" be used; Hage (1972) uses the word "element" to point out the interrelationship of concepts with other essential parts of a theory.

The label of "unit" is employed by Dubin (1969) to avoid the general confusion that exists when concept is used 1) to mean those things out of which science attempts to make sense, or 2) to mean whole theories, or 3) to designate conceptual frameworks.

Although each of these three substitute words — term, element, unit — is neutral and well describes the functional characteristic of a concept, there seems to be little gain in introducing another word into the language of theory development; it is akin to using a private meaning for a specific concept rather than using a conventional meaning. It is more appropriate, and necessary, that the confusion which exists about the characteristics of concepts be resolved. This resolution can begin with a clearer understanding of how concepts arise.

Concepts arise in the mind of an individual as a result of attempts to make order out of that which is observed. How each person will specify a concept is a function of both a personal world view, and for the social scientist, a professional world view. The result of this specification of concept is made public in science by the way in which the research effort is designed. The result occurs because the concepts of interest selected by the investigator lay out the field of inquiry and prescribe the method of investigation. What, then, are the various modes of concept specification, hence analysis, that have been and are employed in the effort to approach knowledge and make order out of the perceived world?

Several modes of concept have been described by Edel (1979). These include: 1) *Socratic analysis* which imposes the criteria of generalness and essentialness. The criterion of generalness is more easily met than is essentialness as essentialness involves a value connotation that is subject to tradition and history. 2) Subscription to an *element analysis* mode indicates that the concept be broken into its component parts and the relationships among these parts be isolated. 3) Adhering to *genetic analysis* would delineate a concept on the basis of a consideration of how the concept evolved. 4) Application of the concept to the institutional and cultural norms extant in society is the process that is utilized in the *functional analysis* of a concept. 5) *Systems analysis* of concepts considers the global context in which a concept must be analyzed. 6) For *pragmatic analysis* the meaning of a concept is found in its practical consequences. 7) *Logical analysis* looks at the concept relative to the way the concept could be verified. 8) *Operational analysis* considers three things in the defining of a concept: operations as a necessary condition for meaning; where different operations are employed the concepts are different; and, the concept equates with its

operations. Finally, 9) *phenomenological analysis* looks for the meaning of the concept in the experience of the persons involved in the phenomenom. This brief listing of some of the major modes of concept definition points out the varied ways in which disciplines have attempted to define and analyze concepts.

The mode of analysis will be dependent upon the maturity of the particular discipline and the investigative aims of the discipline. It has been suggested by Edel (1979) that in those cases were such purposes or aims cannot be sharply drawn within the discipline, the definatory process regarding concepts could include an explanatory preamble. This preamble would substitute an explanation of problems and established knowledge for the tenuous pronouncement of meaning often found in many social science disciplines.

It may be discomforting to acknowledge that concepts do have the characteristic of social values. The presence of social values is manifested when the scientists select and define those concepts in which they are interested. Thus, concepts relevant and significant to the discipline are selected but, as Nagel (1968) says, "so what?" Nagel takes the position that the thinking person is capable of conducting scientific inquiry by virtue of an interest in the concept; social values vis-à-vis concept selection are not of concern. It is in the explanation of the findings of the investigation of the concept that social values have no place. Subscription to the rigor of the scientific method is the check which helps avoid value biases in concept definition.

A final characteristic of concepts is that the label or name placed on the concept very often implies a sense or polarity, or dichotomy (Berthold, 1964). This sense of polarity leads to an inference that the obverse of the concept must exist. For example, adaption as a concept label leads to the logical inference that maladaption is a polar measurable phenomenon.

In summary, the knowledgeable and productive use of concepts in the process of theory development requires that: 1) concepts have intention; 2) concepts are seen as models of some aspect of reality; 3) the concepts selected are significant; 4) the mode of concept analysis dictates the method of investigation of the concept; 5) the value bias and semantic overtones are inherently present in the concepts selected for study; and, 6) concepts are subject to continual redefinition, analysis, and refinement.

MICRO AND MACRO CONCEPTS

It had been said earlier that concepts serve to lay out the field of inquiry and to prescribe the method of investigation. A reasonable

question to ask then is one regarding the scope of the field of inquiry laid out by concepts. The scope will be determined, in part, by the perspective of the field of concepts, either micro or macro.

Macro concepts are those concepts which are general in nature; for example, "man," "health." King (1968) held that concepts which are general in nature serve as a broad foundation and can lend flexibility in the process of structuring knowledge. I put forth the idea that, at this point in theory development in nursing, micro concepts rather than general, or macro concepts, may have the potential to contribute more to the structuring of nursing knowledge. Consider the following points.

A micro concept is less general in nature and deals with a more circumscribed phenomenon. Self-esteem is an example of a micro concept; it is much less general than the concept of personality, a general concept.

Another distinction which can be made between macro and micro concepts is one of the tightness or looseness of meaning which is allowed of the concept. Macro concepts, because of their generalness, have a loose flexibility of meaning. Micro concepts would not allow this looseness. The intention of macro concepts is to deal with the whole rather than parts and consequently a larger number of variables comprise the macro concept. This combination of flexibility of meaning and numerous variables can be problematic. And, the consequence could be that less would be learned about more.

In contrast perhaps more can be learned from less if micro concepts are employed. Since micro concepts deal with fewer variables the number of relationships among the variables is decreased. With a fewer number of variables and relationships it can be anticipated that the likelihood of spurious empirical findings is decreased.

No distinction, however, should be made regarding the need for maximum precision in operationalizing either macro or micro concepts. Precision of indices is a requirement for both. But, since micro concepts imply a tighter meaning the operationalization of the micro concept can more easily be made precise. Merton (1957) says that an index should stand, ideally, in a one-to-one correlation with what it signifies and that the difficulty of establishing this relation is one of the critical problems of science. I suggest that the difficulty could be employing micro rather than macro concepts.

The larger the knowledge base of a discipline the more likely it would be that macro concepts would be used in expanding that knowledge base. Less well established disciplines have a shorter tradition of knowledge and a smaller knowledge base. This may not

necessarily prevent a young discipline from laying claim to macro concepts. It does, however, raise the spectre of an edifice built upon a less than substantial foundation.

In addition to a smaller knowledge base, younger disciplines have a smaller cadre of scientists capable of undertaking the task of exploring macro concepts. This consideration may not deter scientists in young disciplines from investigating macro concepts. However, such investigative efforts may in effect spread the skills of a discipline too thin; the opportunity to take on the task of redefinition of concepts and the development of theory may be hampered. This should be a major consideration in those instances where the discipline is not able to make clear exactly what it is attempting to understand.

I think that a young discipline such as nursing will most quickly advance its knowledge if initially it selects to vigorously investigate micro concepts. Out of these rigorous efforts could arise clusters of micro concepts which, with further investigation of the relationships among them, would evolve into the macro concepts that explicate the discipline's theoretical foundations, tradition of knowledge, and scholarly experience.

SIGNIFICANCE FOR NURSING

Nursing is a young discipline but one with a long history of tradition and experience. As a young discipline it has to deal with and accept the fact that knowledge comes in degrees and various disciplines are at varied stages of development. Our scientific knowledge is less well developed than that of more established disciplines. In the early stages of the development of a discipline's theoretical knowledge it is only through trial-and-error that concepts begin to fit a logical and consistent framework to explain phenomena. From this will come developed frameworks which can be tested; out of these testings distinct nursing theories will evolve. The outcome of this continual reformulation and refinement will be the science of nursing.

At this point in time nursing must deal with the issue of concepts. What are the specific concepts of interest to nursing? The crux of this question is that the image of reality being dealt with, the concepts, be precise.

The importance of this precision of concepts has been pointed out by Batey (1977). Batey reviewed the research articles published in the past 25 years in *Nursing Research*. She concluded that the major limiting feature of published research reports, relative to yielding knowledge advancements, was a weakness of the conceptual phase.

These limiting weaknesses included: lack of clarity regarding the concepts which had guided the investigation; ambiguity as to the meanings of the concepts used — particularly those which would serve as variables in the empirical phase of the work; inadequate definitions of conceptual meanings; and, an absence of concept re-examination.

The misuse of concepts developed by other disciplines is another limitation to be avoided in nursing's attempts at concept use and theory development. There is no quarrel with nursing's use of concepts from other disciplines since the nature of scientific knowledge is cumulative. The quarrel would be with its inept use, and therefore limited contribution to knowledge.

In conclusion, the position is taken that micro concepts are, at this time, the most productive mode of inquiry for nursing theory development. This position is supported by the following considerations.

First, the intention characteristic of a micro concept can be more easily construed. *Second*, the conventional meaning of micro concept is less likely to be distorted and misconstrued. *Third*, the nurse scientist working with a micro concept would be able to identify the most appropriate mode of concept analysis more easily; as a result the field of inquiry is delineated and the method of investigation made clear. *Fourth*, micro concepts escape the polarity evoked by macro concepts: for example, the micro concept of "response to immediate life events" does not evoke the polarity inherent in the macro concept of "coping" and the explanation of investigative findings about a micro concept should be less vulnerable to social values since micro concepts elicit a lesser sense of polarity than do macro concepts.

Dubin (1969) cogently states that scientists should be selective in what they choose out of the experiential field for purposes of analysis and that they should deal with selected characteristics rather than with things as a whole. If the goal of nursing is to advance knowledge, the use of micro concepts, the selected aspects of reality, rather than the wholes, the macro concepts, will at this point in nursing's scientific history facilitate achievement of that goal.

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RÉSUMÉ

La notion de concept

Toute personne qui entreprend des recherches orientées vers le développement de la théorie des sciences infirmières doit avoir une idée précise de la notion de concept, à savoir, comment on formule les concepts et comment on les étudie. L'usage intelligent des concepts dans le développement de la théorie des sciences infirmières sous-entend certaines données: le concept choisi doit refléter l'intention de l'auteur, il doit être vu comme le modèle d'un certain aspect de la réalité, il doit être important et soumis à une analyse et à un perfectionnement continus. L'auteur affirme que les micro-concepts qui traitent de phénomènes plus circonscrits que les macro-concepts, ou concepts généraux, sont susceptibles de contribuer davantage à l'élaboration des connaissances en sciences infirmières que les concepts généraux. Les quatre caractéristiques spécifiques des micro-concepts qui sont appelées à faire progresser les connaissances en sciences infirmières sont les suivantes: l'intention de l'auteur, la signification, l'analyse et la non-polarité. La recherche rigoureuse de micro-concepts pertinents aux sciences infirmières doit mener à des recherches éventuelles sur des groupes de micro-concepts qui pourraient expliquer les fondements théoriques des sciences infirmières et de l'expérience universitaire.

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