K. Rowat

NURSING PAPERS
PERSPECTIVES EN NURSING

Fashioning the Future

L'évaluation du fonctionnement de la famille
en matière de santé

Evaluation of Family Functioning:
Development and Validation of a Scale
which Measures Family Competence in Matters of Health

Cognitive Dissonance: Denial, Negative Self Concepts
and the Alcoholic Stereotype

Accreditation Review: Strategies, Costs, and Benefits

Nontraditional Clinical Sites
in Baccalaureate Nursing Education

Fall/Automne 1984 **Volume 16, No. 3**

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

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.

ADVERTISEMENTS: Full page display ad $300; half page display ad $175.

BACK ISSUES: are available at $6 per copy or $24/year. Xerox copies of articles are available at 25¢ per page or a minimum of $3.00 per article.

To ensure prompt service when you write to us about your subscription, please include the address label from your *Nursing Papers* mailing envelope.

NURSING PAPERS/PERSPECTIVES EN NURSING est une publication trimestrielle de l'École des sciences infirmières de l'université McGill, 3506, rue University, Montréal, Québec, H3A 2A7. 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.

ABONNEMENTS: Institutions (ce qui comprend les hôpitaux, les écoles, les bibliothèques et les agences): 22$ pour une année; 40$ pour deux ans. Abonnements individuels: 16$ pour une année; 30$ pour deux ans. Veuillez compter 5$ de plus par année pour les envois par avion outremer.

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

ANCIENS NUMÉROS: 6$ le numéro ou 24$ par année. On peut se procurer des photocopies d'articles pour 25¢ la page ou 3,00$ minimum par article.

Pour accélérer le service dans toute correspondance relative à votre abonnement, veuillez inclure l'étiquette de l'enveloppe dans laquelle vous sont envoyées les *Perspectives en nursing.*

Dépôt légal — 1er trimestre 1974.
Bibliothèque Nationale du Québec.

NURSING PAPERS
PERSPECTIVES EN NURSING

Volume 16, No. 3
Fall/Automne, 1984

CONTENTS — TABLE DES MATIÈRES

EDITORIAL

In assuming the responsibility of editorship of *Nursing Papers*, I am commiting myself to a major challenge, a challenge which must be shared by all nurse researchers in Canada. More than ever we need a refereed journal of research in order to remain in the mainstream of academic and nursing scholarship. *Nursing Papers* has served and will continue to serve this need. However, in times of economic restraint, the publication of a journal presents a substantial financial burden. *Nursing Papers* is not self-supporting by its subscriptions, and solving the deficit problem has been accomplished in the past by recruiting sponsored issues from other universities. While this approach has worked well, it also creates organizational and time-lapse problems. Some accepted papers are put on hold for long periods and authors understandably become annoyed. New solutions must be found in order to finance the journal and assure a well-run refereed process.

In addition to monetary concerns, the cost of excellence must also be addressed. Research in nursing has changed dramatically over the past 10 to 15 years both in quantity and quality. The level of scientific enquiry has advanced. An in-depth analysis of these changes is now underway in order to provide a basis for ensuring the quality of papers published. Standards of excellence must be maintained and reflect current trends in nursing research.

In order to build on the already established foundation of *Nursing Papers*, a number of developments must be considered. The challenge of continued development is currently being addressed and proposals will be reported as they are refined. An editorial board has been appointed and will meet regularly throughout the next three years. I look forward to working with Peggy-Anne Field, Marian McGee and Marie-France Thibaudeau, associate editors of *Nursing Papers*, as together we plan for the future.

We wish to express our sincere appreciation to Dr. Moyra Allen who has acted as editor of the journal since 1969. In her enthusiastic and energetic work she has left us a solid legacy upon which to continue. In addition, we wish to thank Dr. Peggy Anne Field for her important role in promoting and supporting the journal. The universities which have sponsored several issues of *Nursing Papers* and CAUSN which in policy and financial aid has contributed to the success of the journal also deserve special thanks. Finally, we wish to acknowledge the Canadian Nurses Association for its encouragement and foresight

as outlined in its recent publication *The Research Imperative for Nursing in Canada: A 5-Year Plan Towards Year 2000* (1984). This show of Canadian support for *Nursing Papers* will certainly help to promote the journal to new levels of scholarship and distribution. We look forward to the future success of all nurse researchers and the publication of their work in *Nursing Papers*.

Mary Ellen Jeans

ERRATUM

Summer 1984 issue (Vol. 16, No. 2) "Codes and Coping: A Nursing Tribute to Northrop Frye" by Rebecca Hagey.

p. 19, 6th line should read: not really be put into words and therefore has to suffice in metaphoric . . .

p. 21, 28th line should read: it does not matter . . .

p. 26, 8th line should read: . . . units or polities with . . .
6th line from bottom should read:. . . are not particulate representations of a single value or thought . . .

ÉDITORIAL

En assumant la responsabilité de rédactrice en chef de *Perspectives en nursing*, je m'engage à relever un défi de taille, un défi qui doit être partagé par tous les chercheurs infirmiers au Canada. Plus que jamais, nous avons besoin d'une revue spécialisée en recherche et dotée d'un comité de lecture afin de demeurer dans le courant principal de la vie universitaire et infirmière. *Perpectives en nursing* a joué ce rôle dans le passé et entend poursuivre sa vocation. Toutefois, à une époque de restrictions économiques, la publication d'une revue spécialisée constitue une charge financière importante. *Perspectives en nursing* ne peut subvenir à ses besoins uniquement par ses abonnements; dans le passé on a résolu le problème du déficit budgétaire en invitant des universités à commanditer certains numéros. Bien que fort satisfaisante, cette démarche a créé des problèmes d'organisation et d'échéancier. Certains articles, une fois acceptés, ont dû être mis en veilleuse pendant de longues périodes; leurs auteurs, à juste titre, en ont été contrariés. Nous devons donc trouver de nouvelles solutions de financement et assurer à la revue une démarche de révision bien rodée.

En plus de nos préoccupations budgétaires, nous devons nous pencher aussi sur le coût de l'excellence. Les recherches en sciences infirmières ont évolué d'une façon spectaculaire au cours des 10 à 15 dernières années, tant sur le plan de la quantité que sur celui de la qualité. La qualité de l'interrogation scientifique a progressé. Une analyse approfondie de ces changements est actuellement en cours afin d'établir une base qui permettra d'assurer la qualité des articles publiés. Les normes d'exellence doivent être maintenues et elles doivent refléter les tendances actuelles des recherches en sciences infirmières.

Pour consolider les bases déjà bien établies de *Perspectives en nursing*, il faut envisager un certain nombre d'actions progressives. On se penche actuellement sur le défi que pose la recherche du progrès; on fera part aux lecteurs de diverses propositions au fur et à mesure de leur mise au point. Un conseil de rédaction a été constitué et il se réunira régulièrement au cours des trois prochaines années. Je me réjouis déjà de travailler avec Mesdames Peggy-Anne Field, Marian McGee et Marie-France Thibaudeau, rédactrices adjointes, dans le cadre de notre planification de l'avenir de *Perpectives en nursing*.

Nous tenons à exprimer nos sincères remerciements à Mme Moyra Allen, rédactrice en chef de la revue depuis 1969. Par son travail enthousiaste et énergique, elle nous a laissé une base solide sur laquelle nous pourrons bâtir l'avenir de notre revue. En outre, nous tenons à

remercier Mme Peggy-Anne Field de son rôle important dans la promotion de la revue. Les universités qui ont commandité plusieurs numéros de *Perspectives en nursing*, et l'Association canadienne des écoles universitaires de nursing qui a contribué au succès de notre revue par son appui sur le plan politique et financier, méritent également toute notre reconnaissance. Enfin, nous exprimons notre gratitude à l'Association des infirmières et infirmiers du Canada pour son encouragement et sa vision avertie, comme en témoigne sa publication récente: *Les impératifs de la recherche infirmière au Canada: un plan quinquennal vers l'an 2000* (1984). Cette manifestation d'un appui canadien à *Perspectives en nursing* contribuera certainement à élever la revue vers de nouveaux sommets d'excellence et à étendre sa diffusion. Nous nous réjouissons déjà des succès futurs de tous les chercheurs infirmiers et de la publication de leurs travaux dans *Perspectives en nursing*.

Mary Ellen Jeans

NURSING RESEARCH: SCIENCE FOR QUALITY CARE
TENTH NATIONAL NURSING RESEARCH CONFERENCE

April 9-11, 1985, Toronto, ON

Information: Hattie Shea
Nursing Research Conference Secretariat
University of Toronto, Faculty of Nursing
50 St. George Street
Toronto, ON M5S 1A1

TRIBUTE TO MOYRA ALLEN
EDITOR, NURSING PAPERS 1969-1984

In April 1969 the first issue of *Nursing Papers* appeared, the result of the vision and forethought of Dr. Moyra Allen. This first issue was a slim volume of 16 pages containing two articles, both related to nursing education. One addressed the issue of learning to nurse patients in labour; the second evaluative research in nursing education. Both articles reflected Dr. Allen's goals for the paper.

In the first editorial Dr. Allen spoke of the need for facilitative communication among university schools of nursing in Canada and saw this as the major purpose of the new journal. While it had its origin at McGill University, from the beginning papers were solicited from nurse scholars across Canada. Dr. Allen identified the purpose of the journal as being "to provide a medium for assessing problems, for posing questions and for describing ideas and plans of actions by persons concerned with nursing education in our universities."

One of the major concerns of those who produced *Nursing Papers* was financing. The alumni of McGill School of Nursing provided consistent support as did National CAUSN. The regions of CAUSN added their financial contributions. Western Region CAUSN made a subscription to the journal a part of the annual membership fee. This example was followed by the Atlantic region. In these ways the universities supported Dr. Allen's belief in the need for a scholarly journal in Canada.

Her goal of making *Nursing Papers* national in nature took its first step forward when in July 1972 the University of Western Ontario sponsored an issue. The papers were written by faculty members of the university, and Western Ontario also provided financial sponsorship. The following year the University of Toronto sponsored an issue and in the Winter of 1976-77 all the papers were published in French as the Université de Montréal took its turn. Today articles are published in French or English, with an abstract in the alternate language being provided in the same issue. The journal has truly become a reflection of Canadian scholarship.

Dr. Allen was seen at most National CAUSN meetings over the years promoting *Nursing Papers* and soliciting articles and subscriptions. Each university had an Ambassador (later called an Editorial Representative). The function of the ambassadors was to publicize the existence of *Nursing Papers* and to encourage faculty interest. Since 1978 the names of the Editorial Representatives and of the members of the Review Board have been published so readers can recognize the representative in their university.

The content of the journal has also changed over the years. When Dr. Allen sought a Canada Council Grant in 1977 the request was turned down as less than half the articles were related to research. In the Fall issue of 1981 the journal turned the corner when over half of the articles were research based. The primary emphasis on research has increased since that time. Another interesting feature has been the responses to articles. These are solicited critiques. The purpose of the critiques is to identify the strengths and weakenesses of a particular piece of research. This approach helps in the development of improved research methodology.

As the research content has increased so have the subscriptions. The mailing list shows that the journal is being purchased by hospitals, health agencies and diploma schools of nursing as well as by university libraries and individual nurses in Canada and abroad.

For 15 years Dr. Allen has guided *Nursing Papers* as its Editor. She had a vision which she made into a reality. She guided the journal through its childhood into its adolescence. For two years, during a period when The University of Alberta co-sponsored the publication, I had the privilege of working with her as co-editor. She was willing to listen and to accept new ideas. She taught me a great deal about scholarly writing and publication. While Dr. Allen has made many contributions to Canadian nursing, the establishment of *Nursing Papers*, as a medium for the exchange of ideas, is among the major contributions for scholars in university schools of nursing. The journal will miss her vision and her dedication to scholarly excellence, but she has provided us with a solid base from which we can continue to build toward a widely circulated and accepted journal. For this we thank you, Moyra. The journal will miss your wisdom and enthusiasm, but its continued development will the memorial to the work that you have begun.

Peggy-Anne Field

Peggy-Anne Field, R.N., Ph.D., is professor, Faculty of Nursing, The University of Alberta, Edmonton.

HOMMAGE À MOYRA ALLEN

Ce texte constitue un hommage au Docteur Moyra Allen, pour la valeur de sa contribution éclairée et soutenue à l'avancement des sciences infirmières.

Parmi ses nombreuses initiatives professionnelles durant sa longue et dévouée carrière, j'insiste de façon toute spéciale sur la création de notre revue *Nursing Papers/Perspectives en nursing* dont le premier numéro paraissait en 1969. Depuis ce temps, en sa qualité de rédactrice en chef, Madame Allen a su oeuvrer avec beaucoup de compétence à l'essor constant de la revue.

Docteur Allen, j'écris cette page face à tous les numéros de *Perspectives en nursing* jusqu'à maintenant. Vous avez favorisé l'expression de tant de questions stimulantes, de nouvelles pistes de réflexions, de débats, de controverses, de diffusion de résultats de recherches dans les domaines de la pratique, la formation et l'administration en sciences infirmières! Comme vous devez être fière du calibre de la revue en constante et ascendante évolution malgré les diverses contraintes!

Dans sa recherche d'excellence, le monde infirmier de l'écriture universitaire au Canada, tant francophone qu'anglophone, vous doit et vous exprime sa profonde gratitude pour ce forum d'expression académique que lui permet votre initiative majeure dans notre contexte.

Veuillez accepter, Madame Allen, de la part de *Nursing Papers/Perspectives en nursing* (et je me permets de souligner la voix de l'Université de Montréal) l'expression de nos voeux les meilleurs à l'occasion de votre départ dans un nouveau tournant de vie.

Recevez le sens profond de cet hommage écrit sincèrement, sens qui s'emplifie lorsqu'il dépasse la limite des mots.

Julienne Provost

Julienne Provost, inf., M.Sc.(A), est professeur agrégée, Faculté des sciences infirmières, et représentante de la rédaction de *Perspectives en nursing* pour l'Université de Montréal, QC.

LETTER

Research problems: Objectivity

The purpose of the following analysis of the article "Issues in Coping Research" (L. Joan Brailey, *Nursing Papers*, Spring 1984, Vol. 16, No. 1) is not intended as a criticism of its content. Instead, it is to provide a different perspective of the difficulties that are inherent in socio-behavioral research.

Initially, the very selection of a research problem requires the strictest of scrutiny. Presently, the nursing profession is so caught up in a web of enthusiasm with research that a deceptive dimension is present of what research can and cannot do. Partly, perhaps because of the "halo" which has permeated research nowadays and partly because of the unconscious belief that it is a panacea for all problems. Nurses at times attempt to investigate phenomena or things which are simply incapable of being studied through objective scientific approaches (Hochbaum, 1960).

Most experienced dissertation chairpersons will tell you that many doctoral students believe that a topic or area of interest they have identified for investigation is of great significance because very little research has been directed in that area. Most often, however, the reason for that belief is simply because the students have not carried out a thorough search of the relevant literature. If in fact such an observation by the students is accurate, then the question of why the topic or area has not been investigated is raised and analysed. Rarely, the reason for this would be an oversight by hungry investigators; it would probably be because the variable(s) cannot properly and adequately be scientifically controlled.

Let us now examine the three research issues which Brailey has identified:

1. To study coping effectiveness, accurate data of how individuals cope with stress of daily living must be obtained. Stress and coping with stress have in fact been extensively investigated (Alexander, 1950; Kutash & Schlesinger, 1980; Mahl, 1953; Saranson & Spielberger, 1979; Selye, 1956, 1976, 1980). Brailey proceeds to explain four different methods of data collection about coping strategies and their advantages and disadvantages. According to Dickstein (1977), the possibility of inaccurate self-perception is related to the nature of the self and this raises an interesting question. If the behavior of individuals is partly determined by their subjective self-impressions, it follows that complete understanding would require

knowledge of how individuals view themselves as well as having an objective evaluation of their ability. Behavior may be more readily predictable from knowledge of others' attribution to them.

2. Investigators must be able to delineate clearly the function of coping in order to establish its effectiveness. A basic characteristic of human development is the common desire every person has to keep feelings of uncertainty at a minimum so that the self-concept is not threatened. The entire process of human growth and development is a progressive series of adaptation in which anxiety plays an important role and acts as a symptom of stress which is a normal, adaptive, and recurring event in daily living and cannot be avoided. A stress-free environment is a non-conducive one for growth. It is hard to understand why Brailey considers that the function of coping needs to be investigated.

3. Once the functions of coping strategies usually employed have been established, researchers "must decide on ways to measure the efficacy of strategies used in fulfilling the stated functions." Sound research rests to a significant extent on the objectivity of the researcher and this is not always easy to maintain. This objectivity is threatened when the object of the investigation is people, something so closely related to the investigator's own basic motivations and needs (Hochbaum, 1960). Therefore, although data collection methodology is an integral part of research, its importance does not precede that of sample selection. Coping mechanisms of daily living by individuals vary as apples do, especially when the population of North American society is so diverse because of multi- and transculturalism. Generalization of research findings will be very limited, even questionable. For example, subjects' coping repertoires and their effectiveness could be genetically, socio-economically, developmentally, psychologically, and environmentally dependent. Data obtained must take all these variables into account and that is not an easy matter. I am not of course referring to statistical manipulation through the use of ANCOVA or other tests.

In conclusion, perhaps the reason why Brailey's belief that research in the processes of coping with daily stresses is limited is probably because they cannot be very objectively investigated.

Mohamed H. Rajabally, R.N., Ph.D., Lecturer, School of Nursing, Okanagan College, Kelowna, BC

REFERENCES

Alexander, C. (1950). *Psychosomatic medicine: Its principles and application.* New York: Norton.

Dickstein, E. (1977). Self and self-esteem: Theoretical foundations and their implications for research. *Human Development, 75,* 129-140.

Hochbaum, M. (1980). The nurse in research. *Nursing Outlook, 8,* 193-195.

Kutash, I. J., & Schlesinger, L. B. (1980). *Handbook on stress and anxiety.* San Francisco: Jossey-Bass.

Mahl, G. F. (1953). Physiological changes during chronic fear. *Annals of New York Academy of Science, 56,* 8.

Saranson, I. G., & Spielberger, C. D. (1979). *Stress and anxiety* (Vol. 6). New York: Halsted.

Selye, H. (1956). *The stress of life.* New York: McGraw-Hill.

Selye, H. (1976). *Stress in health and disease.* New York: Butterworth.

Selye, H. (1980). *Selye's guide to stress research* (Vol. 1). New York: Van Nostrad Reinhold.

FASHIONING THE FUTURE *

Verna Huffman Splane

The committee planning this Conference of the Canadian Association of University Schools of Nursing, in choosing the theme, Fashioning the Future, made two assumptions. One was that the human race has a future. The second was that human beings in general and nurse educators in particular can do something significant in fashioning it or at least those parts of it that concern us most: the health delivery system, the role of nursing within it and, most specifically, the responsibilities of the nurse educator.

How justified was the assumption that the human race has a future? The rise and fall of civilizations, Arnold Toynbee taught us, is the most persistent theme over the entire course of history (Toynbee, 1947). Even before the explosion of the atomic bomb in 1945, this century had surpassed all others in the toppling of empires, governments, kings and presidents and in the devastation and savagery of its wars and its genocidal massacres. What reasons, then, are there to suppose that, with an atomic, or rather a nuclear, arsenal burgeoning yearly in magnitude and menace, the human race has anything more than the ghost of a chance to survive through this decade, or the next or the next?

The reasons are hard to come by. If humanity manages to escape nuclear annihilation, is not the most likely alternative the Orwellian world of total oppression of mind and body? (Orwell, 1954). A third and all-but-present threat is that of engulfment in the Tofflerian Third Wave of computer dominance (Toffler, 1981).

These and an array of other apocalyptic scenarios could be paraded to establish that humanity has either no future or one of such subjugation to seemingly uncontrollable forces as to make nonsense of the notion that it can be rationally and benignly fashioned.

Verna Huffman Splane, B.Sc. (Columbia), M.P.H. (Michigan), LL.D. (Queens), was the first Principal Nursing Officer of National Health and Welfare, Canada and was, for eight years, a vice-president of the International Council of Nurses. She is on the board of a number of national and international agencies, including International Social Service. In academic year 1982-83 she initiated a course on health care systems that included international and national nursing concerns for the Master's Program, School of Nursing, University of British Columbia.

* The keynote address to the Canadian Conference of University Schools of Nursing, University of British Columbia, Vancouver, 1983.

Affirming the Future

Yet these prophecies of doomsday death, Orwellian oppression and computer domination must be rejected. Despite the earlier references to the ever present nuclear peril and the historic record of social disintegration and collapsing civilizations, there are and always have been grounds for hope. History records not only human meanness but human greatness, not only hate but also love. It provides a basis for a faith that, through whatever forces are at work in the universe and in human society, the human race will survive and human beings will not give in indefinitely to forces that deprive them of the exercise of human rights and freedoms, including the right to fashion the institutions on which their daily well-being depends.

Clearly this is not the place to spell out the historical case for this assertion, the assertion that humanity in general, and our tiny portion of it in particular, can proceed to address the future with a determined confidence.

If our task is to look at the future, and if the surest guide to the future is a perceptive reading of the past, there is merit in looking back through half a century and identifying developments and trends within the period that will carry forward significantly into any imaginable future.

Before embarking on that retrospective journey let me indicate the general lines on which this paper is proceeding. I propose, first, to discuss developments from the past both internationally and nationally that have relevance to the topic and, second, to comment on the current health care system in Canada. The comments will raise many questions about nursing and nursing education in the coming decades.

The Last Half Century, Internationally

No one in 1933 could have foretold the nature and magnitude of the events and developments that were to occur internationally, nationally and in all manner of our institutions, including the institution of health and the role of nursing in it.

The world in 1933 was in the depths of a depression in many ways like ours of 1983, with high unemployment and deep economic dislocations. Two new and very different figures were emerging on the international scene where they would remain until their deaths some 12 turbulent years later. Hitler became Chancellor of Germany and opened the first Nazi concentration camp with all that implied for the

subjugation of people. Roosevelt was inaugurated as President of the United States and, in contrast, within the year established the Tennessee Valley Authority, signalling thereby to the world a conviction that needs renewing in 1983, that governments need not cower helplessly before what are marketed as the immutable laws of conservative economics. The remainder of the 1930s were seven lean years in a world that could neither end the depression nor arrest the drift to war and to holocaust.

The 1940s, however, notwithstanding all the devastation of World War II, witnessed the regeneration of the human will and capacity for fashioning the future. The United Nations was born and the Charter of Human Rights adopted; the latter expressed humanity's finest aspirations and ideals, the former, together with its specialized agencies, offered structures for positive endeavours toward human well-being.

Among the range of international developments since the 1940s, four merit special attention: First, the birth of new sovereign nations from old colonial empires, raising the number of countries in the United Nations from 50 in 1945 to 157 in 1983; second, the vastly expanded world potential for producing and distributing wealth in the form of goods; third, the vastly increased potential for providing human services; fourth, the failure of the world's political and economic structures to utilize those potentials for social justice and human development.

The persistence and enormity of that failure, and particularly its effect on those new nations in the developing world, can be illustrated in many ways. One of the most telling for those of us whose professional commitments combine education and health is the international indicator of relative well-being, the Physical Quality of Life Index (North-South Institute, 1978). Combining data on life expectancy, infant mortality and literacy, the Physical Quality of Life Index, indexed on a scale from 0 to 100, shows a world of rich northern industrialized nations with indexes in the 80s and 90s and of poor underdeveloped nations, largely in the southern hemisphere, with indexes in the 20s, 30s and 40s.

Although the indications seem to stand as a testament of unjustifiable failure of our instruments of international action and of the exploitive policies of the multi-national corporations they harbour, the story of the North-South relationship must not be depicted in wholly negative terms. Great, commendable and partially successful efforts have been made by the United Nations and its associated agencies to grapple with the socio-economic problems of underdevelopment. Noteworthy among them is the success of the World Health

Organization in the reduction, and in some instances the eradication, of communicable disease (although WHO's mandate goes well beyond the prevention of disease, as indicated later in this paper). Similar comments can be made about the multi-lateral and bilateral programs of developed countries such as Canada. Though these have often been misdirected, wasteful and sometimes harmful, they have had a positive impact on many Third World countries and those who seek to fashion the future must retain them and increase their effectiveness.

In the 1970s, two significant statements of purpose with implications for health and health personnel were made in the international community. The first was the Declaration of the Group of 77 (developing nations) made some 10 years ago to the General Assembly of United Nations. The Group demanded a New International Economic Order (NIEO). This challenge was a response from developing countries and new sovereign states to the failure of the programs of the United Nations and the industrialized countries to expedite solutions to the socio-economic problems of the Third World, notably the persistance of acute poverty and the deprivations that go with it. It was a concept aimed at establishing a more equitable balance of the world's goods and services between the developed and developing countries.

The reactions of developed countries to the New International Economic Order has been less than enthusiastic, although it has been completely endorsed by WHO. The Biennial Report of the Director General on the Work of WHO 1976-77 (WHO 1978b) indicates support for the aspirations expressed in the NIEO concept and states that WHO programs from that date will be developed with a concern for the role of health in promoting social and economic development. The acceptance of health as an integral part of development is described in this Report as "a major stride in the direction of international social justice" (WHO, 1978b, pp. x). The Report stresses that the determinants of health do not lie solely, or even primarily in the field of health.

The second statement of purpose reflecting a new direction in the international field was proclaimed through the Declaration of Alma Ata, in 1978, from the International Conference on Primary Health Care sponsored jointly by WHO and the United Nations International Children's Emergency Fund (UNICEF). The global objective in this development was stated as "the attainment by all of the peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." (WHO, 1978b, pp. 5). "Primary health care is the key to attaining this goal . . ." (WHO, 1978a, pp. 17).

International developments during the recent past which have significance for health and health care systems can be found in the movements of ideas and peoples across international frontiers. The ideas include new concepts and practices which depart from the traditional Western concept of health and medical models and reflect those of other regions and more ancient cultures. Of equal significance is the movement of people, immigrants and refugees, transforming the ethnic composition of populations, such as Canada's. The refugee movement, which has every appearance of becoming a permanent phenomenon, will have a continuing and profound effect on population profiles and on health services throughout the world as the movement continues to grow.

Let me turn my comments on international developments in the last half century into two specific proposals as areas for consideration by nurse educators intent upon fashioning the future. First, is the need for courses that deal with international health and international nursing. Such courses have, I believe, to deal with the kinds of socio-political concepts identified in this paper. It is only on the basis of some knowledge of international development and of factors that have been furthering and retarding it that students will comprehend and promote the international goals and objectives specific to the health field. In this I am referring to the broad range of health and health related matters that are vital to human survival with particular reference to the WHO initiated objective to achieve health for all by the year 2000.

My second proposal relates to the need for programs which prepare nurses to provide transcultural health care. As the population in our country becomes increasingly multicultural, the need for health personnel who understand different cultural values, beliefs and practices becomes more imperative. Canadian nurses have written with great sensitivity on their recognition of this needed change in nursing education (Davies & Yoshida, 1981).

These proposals for changes in Canadian nursing education flow directly from developments in the international field in the recent past and illustrate the importance of recognizing their significance in future planning at the national level.

The Last Half Century, Nationally

When we look at national developments of the last half century, we need first to recognize the primacy of political and economic factors as they influence the future. Let me first comment on the economic factors, in which I include where and by whom macro-economic decisions are made. Economic factors over most of the period have been

favourable to Canada. By being strategically placed in the great trading area of the northern hemisphere, by becoming good at some economic activities and competent in others and by finding markets for and selling off our natural resources, Canada has grown rapidly. All international comparisons testify that most Canadians have been able to enjoy a high standard of living.

For a while at least, during that period good political decisions, from a social point of view, were made; they were good because of the emphasis placed on human service programs, programs which ensured that people would never suffer again as they had in the depression of the 1930s. This was the purpose of the great wartime social documents, such as the Haegerty Report, the Marsh Report and the Green Book Proposals that formed the basis for post-war planning in health and social welfare (Taylor, 1978). These documents expressed the national will to build the kind of comprehensive nationwide social security system that the industrialized states of Western Europe had put in place long since.

What made the creation of a Canadian social security system possible was, in the best sense, politics. Canadian governments, through most of the period, could count on popular support for continuing the process toward comprehensive and adequate social security programs. Until recently, those who proposed extensions and improvements in such programs could challenge opponents to put the matter to a political, that is an electoral, test. The great testing ground of the national will on social security was, of course, in the field of health.

In his book *Health Insurance and Canadian Public Policy,* Dr. Malcolm Taylor (1978) recounts the high drama in the key steps leading to the acceptance and implementation of the federal health insurance proposals. Beginning with the Green Book Proposals for Health Insurance in 1945, based on the work and recommendations of two national committees, Taylor identifies the building blocks, strategies and negotiations that put the national program in place. The National Health Grant Programs of 1948 assisted the provinces in establishing the foundations for facilities and personnel in preparation for health insurance; the Hospital and Diagnostic Services Act implemented in 1958 made hospital care available to all without financial barrier; the Report of the Royal Commission on Health Services of 1964 recommended a comprehensive health care program for all Canadians; and finally the National Medical Care Act implemented in 1967 made physician services available to all Canadians through an insured system. Key political figures in this momentous national development, and the roles each of them played, are identified by Taylor.

The role of the nursing profession in the development of the health care system has yet to be written. Although the profession is not likely to be identified as a key figure in the events, the record will show nursing input in almost all of the significant national health insurance developments of the last 50 years. Nursing's participation was initiated by the Canadian Nurses Association with the formation of a Committee on National Health Insurance in 1934. Through briefs, appearances before national governmental committees and consultations with senior government officials, nurse representatives have made known the views of the profession and its support for the public insurance principle.

In 1947, a delegation from the Canadian Nurses Association met with the Minister of National Health and Welfare requesting the formation of a Division of Nursing within that Department; previous to 1947 the Department had no nursing position in its complement. Although the proposal was rejected then, it did contribute to the establishment, over the next 10 years, of senior federal nursing positions to provide consultant services to the Department of National Health and Welfare and to the provinces in the developmental stages of the health care system. Significant to nursing was the appointment of a nurse to the Hall Commission in 1961, the Commission which produced the Charter of Health for Canadians (1964).

Throughout this period, the record shows that the CNA has represented nurses well. A comparison of Association briefs to the first Hall Commission in 1962 (CNA, 1962) and the second one in 1980 (CNA, 1980) reflects increased sophistication and skill in articulating nursing views as well as a decided change in perspective. The earlier brief contained 24 recommendations, 21 of which related to nursing. Its one specific reference to the health care system was in these terms: "No recommendations are made to the overall organization of health services and financing [which] are subjects for government and legislation" (CNA, 1962, pp. ii). The 1980 brief, in contrast, includes eight recommendations focusing on the health care system in terms of legislation, federal-provincial relationships, health care research and health education. This document was described by Justice Hall as one of the best briefs received by the Commission and worthy of the closest attention from all levels of government.

National nursing leadership in the period under review has progressed in various ways, moving from a reactive to a proactive role, in seeking input to policy decisions on national health, and advancing from a limited nursing viewpoint to a health system perspective. It demonstrates increasing competence in functioning in the broader field of national affairs.

Between 1967 and 1977 Canada's health system, though incomplete and flawed in certain ways, functioned in essential harmony with the principles of the Charter of Health for Canadians formulated in the Report of the Royal Commission on Health Services (Hall, 1964). Under the conditional shared cost provisions of federal legislation the provinces were required to adhere to the principles of accessibility, universality, comprehensiveness, portability and public administration.

For a variety of reasons, including declining economic growth which prompted federal financial authorities to wish to move away from open-ended shared cost programs together with the pressure of some provinces to be freed of federal constraints, a decision was made in 1977 to place the funding of health and post-secondary education on a block funding basis, a decision that was formalized that year in the federal Established Programs Financing Act. It was not long before a number of provinces began to abandon their undertaking to adhere to the principles that had prevailed under earlier arrangements. By 1980, extra billing by physicians and the imposition of extra charges for various health services had sufficiently eroded the health system to prompt the appointment of a second Hall Commission. The report of its findings and recommendations affirming the earlier principles and condemning extra billing have not arrested the deterioration of the system (Hall, 1980).

By the beginning of the 1980s there was no doubt that the health care system in Canada was in the process of change, real and potential change, through pressure from forces within and without governments. The system was subject to the constraints of an economic recession, the impact of a technological revolution, and the demands of a health-oriented population. Further, it was undermined by medical and commercial interests and was vulnerable as a political issue in the federal-provincial struggle over the division of powers.

Other changes began to appear in the health care field. Opposition to the medicalization of society, exemplified by Ivan Illich's *Medical Nemesis* (1975), appeared in the mid 1970s, followed by the emergence of new patterns of care initiated by the women's movement and consumer groups. The holistic health movement appeared, emphasizing an appreciation of the whole person and reaffirming the importance of the mind and spirit in health and healing. There was a rediscovery of the significance of the environment and *New Perspectives on the Health of Canadians* (Lalonde, 1974) gave lifestyle a new importance. New categories of personnel appeared as part of traditional health teams and the concept of health itself came under review and redefinition.

As we moved into the 1980s the most significant change was the continuing deterioration, referred to earlier, in the national health insurance system. This began toward the end of the last decade, with an increasingly relaxed attitude in the provincial governments to the basic principles of accessibility and universality.

In response to calls for remedial action to arrest the erosion of the system and to recommendations of a Parliamentary Task Force on Federal Provincial Fiscal Arrangements (Government of Canada, 1981) the federal Minister of National Health and Welfare proceeded in May of 1982 to propose to the provinces a basis for federal-provincial collaboration to be incorporated in new legislation to be called the Canada Health Act. The proposed Act would combine the Hospital Insurance and Diagnostic Services Act and the National Medical Care Act into one piece of legislation and, in the words of the Minister would seek "to assure 100 percent universal entitlement to basic health insurance in Canada without financial or other barriers" (Bégin, 1982b). However, this position is being strenuously attacked by medical associations, by the allied insurance industry and by most provinces.

Let me identify some of the issues. Speaking before the Canadian and American Public Health Associations meeting together in Montreal in November 1982, Monique Bégin, the Minister of National Health and Welfare, described the complexities involved in deciding on future courses of action for health within the federal-provincial structure. In response to her rhetorical question, "Where, then, are we going?" she described the alternatives for a choice of direction, their potential impact on the health of Canadians and the problems inherent in their implementation. The Minister pointed out that, in times of economic growth, the development of alternatives had been encouraged with funding from federal and provincial governments. This initiative had resulted in many imaginative programs which allowed a wider choice of health care for providers, consumers, and policy makers (Bégin, 1982a). Nursing examples of these are well documented by the Canadian Nurses Association in its 1980 brief (CNA, 1980) "Putting 'Health' into Health Care."

Madame Bégin identified a number of alternatives but focused particularly on the proposal "to use the nurse as the point of first contact and the doctor as the final point of referral" (1982a, pp. 3-4). Acknowledging the potential in this proposal for more efficient and effective resource allocation, she identified two conditions necessary to implement it: the support of both senior levels of government, and the support of other provider groups and consumers.

In expanding on these proposals, the Minister identified two major problems. First, increasing nurse utilization would affect the current growing supply of physicians in the country by virtue of reducing the role of physicians. The Minister stated that the opposition of the medical associations to such change has been expressed publicly in a variety of ways and that such opposition creates political difficulty in facilitating this change. Second, in the absence of a strong ground swell of public support for utilizing the nurse in an alternative role, she pointed out that it would be extremely difficult to carry it through. As indicated, the Canada Health Act proposal is strongly opposed by the Canadian Medical Association. The CMA favours its own privatization scheme, which would move Canada away from universality and return Canadians to the two-tier system which we had up to the late 1960s. This would divide Canadians again into those who could pay for services and those who could not. Other opposition comes from the insurance companies and from provincial governments on the basis, in the first instance, of the profit motive, and in the second, that it represents a violation of provincial rights.

The nursing profession, through CNA, has declared its position on the proposed Act in a brief to the Minister of National Health and Welfare (CNA, 1982). It expresses support for the proposals in the areas of universality, comprehensiveness, portability and the maintenance of standards in the system. It affirms, however, its earlier position that the proposed legislation should provide nursing services in an extended role as an entry, and perhaps the most cost-effective entry, to the system (1980). The Minister's comments of November 1982 identifying problems associated with the CNA proposal bear careful examination. Madame Bégin indicated that to implement the proposal that the nurse be an entry to the health care system would require the support of four separate groups: the federal government, the provincial government, the other health care providers, and the consumers, or public.

The current status of support from the four groups can be summarized as follows: The federal minister's expressed public interest in the proposal might be interpreted as a positive reaction from the senior level of government; the position of provincial governments remains unclear; among other health providers there is some support from organizations such as the Canadian Health Coalition while, according to the Minister, there is declared opposition from the medical profession; from the public, there is relative silence. That score shows tentative support from one group; no reading on the second; a divided position in the third, including opposition from the major medical providers; and limited response from the fourth.

What significance can be drawn from that reaction? My attempt to analyze it has raised questions which I believe must be answered by nurses themselves. The first relates to the public. How can the public's silence be interpreted? Is it lack of information or lack of interest? If it is the former, why does the public not know of the proposal? Who should have told them? Since it is a nursing proposal that would affect how the public enters the health system, is it the responsibility of members of the nursing profession to interpret it?

This line of reasoning leads to the question of how well informed and committed to the idea are nurses themselves. Is the profession united on this issue? To gain support for any major change requires interpretation by an informed and committed membership working individually and collectively at all levels. If lack of unity or commitment exists within nursing itself, then the priority becomes the development of strategies to correct that situation. Among the already committed, what new initiatives can be taken by nurse practitioners, nurse educators and nurse administrators? Can they, and should they, promote and facilitate progress toward involving membership in supporting the proposal to make the nurse an entrance point into the system?

With regard to the attitude of provincial governments, what additional measures should be taken in the political arena to achieve support from this level of government which is responsible for the health care system in its own province? Finally, the opposition from the medical profession, with which nurses have traditionally had the closest ties, gives cause for concern. The two professions, medicine and nursing, are already at odds on the basic issues of universality and accessibility in the health care system. Despite these divergent views are there new approaches that should be made to achieve understanding, if not agreement, on positions to ensure that future working relationships do not jeopardize the provision of health care to people?

Notwithstanding our desire to have support of the medical profession in this struggle to see nursing more fully and appropriately utilized in the provision of health care, it is important to recognize where the real power on public issues resides. On at least two previous occasions involving major national issues, the Health and Diagnostic Services Act of 1958 and the National Medical Care Act of 1966, it was political will, the voice of the people, which determined the outcome in those struggles rather than the views of the medical profession or the commercial interests, both of which opposed the legislation. Using those precedents as a guide, the nursing profession must develop new strategies to gain public support for its proposals — strategies that should involve membership at every level.

Conclusion

The purpose of this paper is to provide a broad framework for charting the future for nursing education in Canada. It will be apparent that I have dealt only with certain broad policy issues, internationally and nationally. There are other questions of immense importance: entry to the practice of nursing; new and extended ways of maximizing the technological and information systems to provide continuing education and baccalaureate programs beyond the university setting; the impact of technological change on future students and faculty; and the moral and ethical aspects related to high technology. These examples could be described as among the professional, technological and ethical imperatives of both today and tomorrow.

Without diminishing their importance let me end on the note with which I began. I would describe it as an expression of faith — faith that we can have a future and that we can play a part in fashioning it. But it is a contingent or conditional faith. It holds that humanity's future depends on the nature of our perspectives and understandings. It holds further that we, as educators in the health field have special responsibilities and opportunities to undergird our teaching and research with a continuing appreciation and understanding of the kind of global and national issues this paper has touched on.

What I aspire for this conference are fruitful deliberations as we seek to fashion a future, a future in which such global objectives as health for all people by the year 2000 may, in fact, be attained. A future in which we, in Canada, have developed to the optimum, the role that nursing can play in a health care system that truly honours the principles set out in the Charter of Health for Canadians.

REFERENCES

Bégin, M. (1982a). *Notes for an address by the Honourable Monique Bégin to the American Public Health Association and Canadian Public Health Association, Montreal, Quebec, November 15, 1982.* Ottawa: Office of the Minister.

Bégin, M. (1982b). *Opening statement by the Honourable Monique Bégin, Minister of National Health and Welfare to Conference of Federal Provincial Ministers of Health. Ottawa, May 26, 1982.* Ottawa: Office of the Minister, p. 13.

Canadian Nurses Association. (1982, August). A brief to the Honourable Monique Bégin, Minister of National Health and Welfare, on the Federal Proposals for A Canada Health Act. Ottawa: Canadian Nurses Association.

Canadian Nurses Association. (1980). Putting "health" into the health care. Submission to *Health Services Review '79.* Ottawa: Canadian Nurses Association, pp. 15.

Canadian Nurses Association. (1962). *Statement to the Royal Commission on Health Services.* Ottawa: Canadian Nurses Association.

Davies, M., & Yoshida, M. (1981). A model for cultural assessment of the new immigrant. *The Canadian Nurse, 77*(3). Note: This issue features four other articles on Canada's multicultural health needs.

Government of Canada. (1981). *Fiscal Federalism in Canada: Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements.* Ottawa: Queen's Printer.

Hall, E. M. (1980). Canada's National-Provincial Health Program for the 1980's. *Health Services Review '79.* Ottawa: National Health and Welfare.

Hall, E. M. (1964). *The Report of the Royal Commission on Health Services,* Vol. 1. Ottawa: Queen's Printer.

Illich, I. (1975). *Medical Nemesis.* Toronto: McClelland and Stewart.

Lalonde, M. (1974). *A new perspective on the health of Canadians: A working document.* Ottawa: Government of Canada.

North-South Institute. (1978). *North South Encounter: The third world and Canadian performance.* Ottawa: Runge Press, 182-189.

Orwell, G. (1954). *Nineteen eighty-four.* London: Penguin Books.

Taylor, M. G. (1978). *Health Insurance and Canadian public policy.* Montreal: McGill-Queen's University Press. (Reference to The Haegerty Report, p. 18; The Marsh Report, p. 21; the Green Book Proposals, p. 1, pp. 52-53).

Toffler, A. (1981). *The third wave.* London: Pan Books.

Toynbee, A. J. (1947). *A study of history.* Abridgement of Volumes I-IV by D. C. Somerwell. London: Oxford University Press.

World Health Organization. (1978a) *Primary health care: Report of the international conference on primary health care, Alma Ata, USSR, 6-12 September 1978.* Geneva: World Health Organization.

World Health Organization. (1978b). *The work of WHO 1976-77: Official Records No. 243.* Geneva: World Health Organization.

RÉSUMÉ

Modeler l'avenir

L'auteur suppose que les forces positives qui animent les affaires du monde ne sanctionnent en fin de compte ni l'anéantissement du globe ni l'assujettissement orwellien. S'appuyant sur cette confiance, l'auteur fait valoir que les êtres humains et notamment les personnes auxquelles l'article s'adresse — infirmières et éducateurs — peuvent faire face à l'avenir, confiants jusqu'à un certain point, d'être en mesure de le modeler ou de l'influencer de façon significative. Cette donnée dépend toutefois des perspectives et de la compréhension qu'ils acquerront ainsi que de l'effort rationnel et soutenu qu'ils mettront à faire progresser leurs objectifs et rayonner leurs valeurs.

Pour illustrer ce que sous-entend la réalisation des perspectives requises et l'acquisition des connaissances en vue d'une action efficace, l'article tire des exemples de la scène internationale et nationale de l'histoire de l'humanité au cours des 50 dernières années. Les exemples se rapportent en grande partie aux facteurs socio-économiques et culturels qui ont influencé le développement des systèmes de soins de santé et le rôle que les infirmières y ont joué.

Sur la scène internationale, l'article évoque les politiques et les événements qui ont amené plus de 100 pays en développement à demander un nouvel ordre économique international, dont l'objectif central est de réduire ou, idéalement, d'éliminer la pauvreté. La pauvreté massive, comme le souligne l'article, est l'obstacle principal à la réalisation de l'objectif des Nations unies qui vise la santé pour tous d'ici l'an 2 000.

Parlant des forces accumulées contre les politiques de santé rationnelles et humaines, tant sur le plan national qu'international, l'auteur conclut que les éducateurs dans le domaine de la santé doivent baser leur enseignement et leurs recherches sur le genre de problèmes planétaires et nationaux qu'aborde l'article.

L'ÉVALUATION DU FONCTIONNEMENT DE LA FAMILLE EN MATIÈRE DE SANTÉ (E.F.F.)

Marie-France Thibaudeau • Mary Reidy • Marielle St-Félix-Beauger

L'échelle d'Évaluation du fonctionnement de la famille en matière de santé (E.F.F.) a été construit dans le but d'aider les infirmières en santé communautaire à structurer leurs observations des familles qu'elles soignent et à les guider dans leur évaluation des comportements familiaux. Bien que les auteurs se soient inspirés du "Family Coping Index" (Freeman et Lowe, 1962), l'échelle E.F.F. a été construite, validée et utilisée dans le cadre d'un projet de recherche (Thibaudeau, Reidy, D'Amours, et Frappier, 1983) auprès de familles défavorisées, pour diagnostiquer le fonctionnement de la famille en matière de santé et planifier les soins de l'infirmière. Elle a aussi été utilisée pour mesurer périodiquement le changement global et le changement de certains aspects spécifiques du fonctionnement de la famille en matière de santé. Cet article présente les grandes lignes du cadre théorique de l'échelle et du guide d'évaluation, les étapes de validation de ces outils et les résultats de diverses analyses statistiques.

Définition des concepts

Le terme "santé" est utilisé ici dans un sens très large. Il recouvre les concepts de bien-être physique, psychologique et social, d'absence de maladie, de satisfaction des besoins fondamentaux, de comportements relatifs à la prévention de la maladie et à la promotion de la santé, d'utilisation adéquate des ressources de santé et de bien-être, de salubrité de l'environnement et d'habileté à résoudre des problèmes de santé, de même que la capacité de faire face aux exigences constantes et aux crises de la vie et la faculté de s'actualiser à travers un rôle social utile.

Marie-France Thibaudeau, inf. M.Sc.N., est doyenne et professeur titulaire, Mary Reidy, inf., M.Sc.(App.), est professeur adjoint, Faculté des sciences infirmières Université de Montréal, et Marielle St-Félix-Beauger, inf., M.N., est infirmière clinicienne de médecine familiale, Hôpital du Sacré-Coeur, Montréal.

Les auteurs remercient Santé et Bien-être social Canada pour l'aide reçue.

La famille est un groupe composé d'un ou deux parents unis par les liens du mariage ou une relation stable et d'un ou de plusieurs enfants. Ce groupe a une identité propre. Les personnes qui le composent vivent sous le même toit; elles sont en relation les unes avec les autres à travers leurs rôles familiaux et elles partagent la même culture. La famille est un système ouvert, dans un environnement qui lui fournit des ressources; elle contribue au développement et à l'équilibre de cet environnement par ses fonctions de reproduction, de socialisation, d'éducation et d'économie.

Le fonctionnement de la famille est défini en termes d'interaction et de cohésion à l'intérieur de celle-ci, en termes d'habileté, comme groupe, à répondre aux besoins physiques, psychologiques et sociaux de ses membres, de capacité à faire face aux situations stressantes de la vie et de participation à la vie communautaire. Le fonctionnement peut aussi être défini en termes de compétence à remplir adéquatement les rôles que la société lui assigne; il s'agit également de la responsabilité que les membres assument pour eux-mêmes et pour la famille selon leur âge et leurs capacités.

Le cadre théorique

La famille est l'objet d'études de diverses disciplines qui la perçoivent à travers des lunettes propres à chacune et qui leur permettent de l'observer, de la décrire et de l'analyser. Dans sa recension des techniques d'évaluation de la famille, Strauss (1978) rapporte une grande diversité dans les cadres conceptuels sur le fonctionnement de la famille et dans les guides, inventaires et méthodes pour évaluer la famille, le couple et les interactions parents-enfants.

Plusieurs auteurs ont élaboré des instruments de mesure intéressants mais qui ne concordaient pas avec notre cadre théorique (au début de l'étude en 1976), ou qui n'avaient pas été suffisamment validés pour être utilisés dans un projet de recherche (Boardman, Lyzanski, et Cottrell, 1975; Brown et Rutter, 1966; Epstein, Bishop, et Levin, 1978; Geismar, 1964; Moos, Insel, et Humphrey, 1974; Pless et Satterwhite, 1975).

Les auteurs en sciences infirmières utilisent, de façon générale, deux grandes orientations dans l'analyse de la famille: la méthode structurale fonctionnelle, étroitement reliée à la théorie des systèmes (Friedman, 1981; Minuchin, 1974) et l'approche interactionnelle couramment utilisée en thérapie familiale (Haley, 1971; Jackson, 1968; Satir, 1967). Nous avons adopté une approche éclectique et construit notre propre modèle à partir de concepts de diverses orientations à l'intérieur d'un cadre systémique et du "Family Coping Index" élaboré

par Freeman et Lowe (1962) en collaboration avec le VNA Richmond. Cet index est basé sur le concept de besoin en soins infirmiers et il peut être utilisé pour des évaluations périodiques. Les catégories de soins ou de difficultés avec lesquels la famille doit composer sont au nombre de neuf: (a) indépendance physique; (b) compétence thérapeutique; (c) compétence émotionnelle; (d) connaissance de la condition de santé; (e) application des principes d'hygiène; (f) attitude envers la santé; (g) vie familiale; (h) environnement physique; (i) utilisation des services communautaires.

Nous nous sommes largement inspirées de cet outil, surtout de sa structure. Nous avons utilisé certaines catégories; nous en avons supprimé quelques unes et en avons ajouté d'autres. Nous avons modifié dans une large mesure le contenu des critères. Aussi, notre guide est en essence différent de celui de Freeman et Lowe.

L'état actuel et le raffinement de notre échelle est tributaire de nombreux auteurs tels que David (1980), Kelman (1965), Lazarus (1980), Pratt (1976) et Robinson (1971), autant au niveau de la définition des concepts globaux tels que la famille, qu'au niveau des concepts spécifiques tels que les comportements de santé, le *coping*, les modes de vie, les attitudes face à la santé.

Nous nous sommes aussi largement inspirées des caractéristiques de la famille normale et en santé décrites par Lewis, Beavers, Gossett, et Phillips (1976): (a) la communication entre les membres; (b) l'unité des parents; (c) la flexibilité dans les rôles; (d) l'habileté à fonctionner en présence de stress psychologique; (e) le rôle fondamental de la mère comme premier membre à souffrir de la désorganisation familiale; (f) la maladie physique comme critère de fonctionnement.

En résumé, nous avons adopté une approche éclectique, adaptant certaines notions tirées de différents auteurs ou écoles de pensée. Cette approche nous a permis d'abord de mettre l'accent sur les dimensions de la santé qui sont parties intégrantes de la vie quotidienne de la famille et qui sont pertinentes au champ d'action de l'infirmière et ensuite, d'élaborer un cadre théorique suffisamment complet.

Echelle du fonctionnement de la famille

L'échelle E.F.F. comporte neuf dimensions relatives à divers aspects du fonctionnement de la famille. Le schéma qui suit présente ces dimensions:

Dimensions du fonctionnement de la famille

A. Connaissance en matière de santé.
B. Habileté à résoudre des problèmes de santé et à prévenir des complications.

C. Habitudes de santé et application des principes d'hygiène.
D. Attitudes envers la santé, les services et les travailleurs de la santé.
E. Capacité de faire face aux situations stressantes (coping).
F. Modes de vie familiale.
G. Action sur l'environnement physique.
H. La connaissance et l'utilisation des services de santé et de bien-être.
I. Participation à la vie communautaire.

Dans la version préliminaire de l'E.F.F., chaque dimension est évaluée sur une échelle de 1 à 5. Le chiffre 1 correspond au niveau le plus bas et le chiffre 5 se rapporte à une très grande compétence. Une description non exhaustive est donnée pour chaque niveau et pour chaque dimension pour aider l'infirmière à situer correctement la famille. Ces descriptions ne sont qu'un guide et l'infirmière doit évaluer les différents comportements et manifestations relatifs à chaque dimension. Pour compléter son évaluation, l'infirmière décrit en termes opérationnels et concrets sous la colonne "commentaires," les comportements de la famille qui lui ont permis de la classer à un niveau donné et ce, pour chacune des dimensions.

Les infirmières qui ont utilisé la version finale de l'E.F.F. n'ont pas trouvé l'échelle en cinq points suffisamment précise. C'est pourquoi, on leur a permis de placer leurs familles sur des points intercalés entre chacun des cinq niveaux définis. Les échelles des catégories sont donc passées de cinq à neuf points (voir l'annexe A). Le score total de l'E.F.F. peut donc varier de 9 à 81 points avec un point médian théorique de 45. Un score élevé indique un haut niveau de compétence; un score peu élevé indique un bas niveau de compétence.

Le schéma suivant représente la version finale de l'échelle de chaque catégorie.

1	2	3	4	5	6	7	8	9
(Niveau défini)		(Niveau défini)		(Niveau défini)		(Niveau défini)		(Niveau défini)
Bas niveau de compétence				Niveau moyen de compétence				Haut niveau de compétence

Etapes du processus de validation

Pour être utile comme instrument de recherche, l'échelle d'évaluation familiale doit être valide et fidèle. Elle doit aussi répondre à ces critères si elle est utilisée pour des fins cliniques, quoique le critère de fidélité relatif à l'exclusivité des dimensions soit moins important. Nous avons donc poursuivi différentes étapes pour nous assurer de la

validité et de la fidélité de l'outil. Les premières étapes sont présentées dans l'étude de St-Félix-Beauger (1978), complétée cependant avant que les infirmières commencent le soin expérimental.

Dans un premier temps, 9 infirmières spécialistes ont étudié l'outil et le guide sur le plan de leur contenu, de la structure et de la pertinence d'utiliser cet outil de façon régulière dans des services de santé communautaire. Quelques modifications furent apportées à l'outil.

Dans un deuxième temps, 12 infirmières de trois CLSC et d'un département de santé communautaire ont choisi, parmi leurs familles, une famille qui fonctionnait bien et une qui fonctionnait mal. Elles ont fait une évaluation globale des deux familles choisies sur une échelle de cinq points et ont donné les raisons de leur évaluation. Ensuite, elles ont utilisé la première version de l'échelle selon les spécifications données dans un guide qui accompagne l'échelle. Un mois plus tard, elles ont refait l'évaluation des mêmes familles.

Dans un troisième temps, nous avons refait une autre collecte de données auprès de 8 infirmières seniors d'un service de santé urbain. Elles ont évalué, au total, 100 familles qu'elles assistaient et réévalué, après un délai d'un mois, 85 de ces familles.

L'analyse des données de cette deuxième collecte nous a donné les résultats suivants:

1. un accord élevé (85%) entre les deux juges qui ont analysé la concordance entre la cote attribuée dans une dimension et les commentaires qui justifient cette cote (validité);

2. une corrélation de 0,86 (r de Pearson) entre l'évaluation globale de la famille faite par l'infirmière au début de l'étude et le score à l'échelle E.F.F. (validité);

3. une corrélation de 0,95 (r de Pearson) entre les deux évaluations de l'E.F.F. à un mois d'intervalle (fidélité);

4. la dimension "capacité de faire face aux situations de stress" reste toujours plus basse que toutes les autres;

5. l'analyse des courbes de fréquence démontre que trois dimensions, le *coping*, les modes de vie familiale, et l'action sur l'environnement physique, ont créé plus de difficultés aux infirmières que les autres;

6. l'analyse d'un questionnaire complémentaire, remis aux infirmières qui ont utilisé l'E.F.F., démontre qu'elles ont apprécié l'outil et que son utilisation les a aidées à structurer leurs observations et à planifier leurs soins.

L'étude de St-Félix-Beauger (1978) démontre de plus que certaines conditions sont requises pour que l'infirmière en santé communautaire utilise adéquatement l'E.F.F. Il est primordial que l'infirmière comprenne la structure et la dynamique de la famille et possède l'habileté à observer et à communiquer efficacement de façon à aider ses clients à clarifier le sens de leurs comportements. De plus, l'infirmière doit être capable d'établir des relations entre les événements et les comportements qui semblent significatifs, de façon à les regrouper sous la dimension appropriée de l'E.F.F.

Les différents niveaux de l'E.F.F. ont été raffinés à partir des résultats de ces analyses (voir exemple en annexe B). Ainsi, la version finale utilisée dans le projet auprès des familles défavorisées (Thibaudeau et coll., 1983) diffère légèrement de la version originale.

La quatrième étape a consisté à effectuer des analyses avec les données recueillies lors de notre projet auprès des familles défavorisées. Premièrement, nous avons effectué une analyse d'items pour éprouver la consistance interne. Le coefficient alpha de Cronbach demeure élevé et ce, même lorsque les groupes expérimental et témoin sont traités séparément (Gr. exp., $N = 45, \alpha = 0{,}8214$; Gr. Tém., $N = 38, \alpha = 0{,}8605$; Gr. combinés, $N = 83, \alpha = 0{,}8593$). Dans les trois cas, le retrait de l'un ou l'autre des items ne provoque pas une augmentation sensible d'alpha.

Ensuite, une analyse de composante principale a été effectuée avec 225 évaluations de façon à examiner l'unidimensionnalité de l'échelle. Avec la méthode sans rotation (facteur principal — sans rotation), le premier facteur regroupe les neuf dimensions de l'échelle avec une valeur de 0,65 ou plus et il explique 62,7% de la variance. Les autres facteurs ne sont pas indépendants les uns des autres et n'expliquent que des proportions additionnelles minimes de la variance. Nous présentons la liste des valeurs pour chacune des dimensions:

Dimension	Facteur (Coefficient factoriel)
A	0,79
B	0,86
C	0,83
D	0,85
E	0,80
F	0,78
G	0,79
H	0,75
I	0,65
% de variance	62.7%

Les facteurs sont des "construits" ou variables hypothétiques que l'on croit mesurés par l'échelle (ou un groupe d'échelles). L'analyse factorielle en composante principale, tout comme les analyses factorielles, est une méthode utilisée pour déterminer le nombre et la nature de ces variables. Les résultats présentés ci-devant suggèrent fortement qu'une seule structure serait sous-jacente aux neuf dimensions de l'E.F.F. Ceci signifie que l'E.F.F. doit être considérée comme une mesure globale de la compétence de la famille en matière de santé.

Relations entre l'E.F.F. et d'autres instruments de mesure et variables

Nous avons étudié les relations entre l'E.F.F. et d'autres variables, mesurées au cours du projet dans le but de nous assurer davantage de la validité des concepts de l'échelle. Trois variables sont reliées à la santé de la mère ou à son habileté en matière de santé; ces dernières montrent des corrélations significatives (r de Pearson) autant avec les scores individuels des dimensions qu'avec le score total de l'échelle E.F.F. Les instruments utilisés et les variables mesurées sont les suivants:

INSTRUMENTS	VARIABLES MESURÉES
General Health Questionnaire (GHQ)	Stress vécu par la mère
Echelle de tension	Tension vécue par la mère (complémentaire au GHQ, symptômes spécifiques à cette population)
Foyer de contrôle de Levenson	Croyances:
— Interne (I)	— un contrôle intrinsèque sur les événements
— Puissance des autres (P)	— un contrôle par d'autres personnes plus puissantes que soi
— Hasard (C)	— les événements se produisent par hasard
Situations hypothétiques	Habileté de la mère à résoudre des problèmes de santé

Fonctionnement social

— Intensité des interactions dans le réseau social	— Interactions sociales avec la famille, les amis, les voisins, etc.
— Intensité de la participation sociale	— Fréquence ou degré de participation dans les groupes sociaux

Les coefficients de corrélation et de probabilité sont donnés au Tableau 1. Il appert que le score total de l'E.F.F. est en corrélation négative avec l'échelle de Hasard de Levenson et en corrélation positive avec les situations hypothétiques et l'intensité des interactions dans le réseau social.

De plus, des relations significatives (r de Pearson) apparaissent aussi entre les dimensions de l'E.F.F. et les instruments utilisés pour évaluer la santé des mères ou de la famille. Six des neuf dimensions montrent des corrélations positives ($p \leqslant 0,05$) avec les situations hypothétiques (habileté de la mère à résoudre les problèmes de santé). Ainsi elles présentent un coefficient de corrélation de 0,2065 avec la dimension "Mode de vie familiale," de 0,4006 avec la dimension "Action sur l'environnement." Les trois autres dimensions "Capacité de faire face aux situations stressantes," "Connaissance et utilisation des ressources de la communauté" et "Participation à la vie communautaire" ont aussi des relations significatives avec cette variable ($p \leqslant 0,10$).

Qu'est-ce que tout cela signifie sur le plan clinique? Les différents aspects du fonctionnement de la famille en relation avec la santé de la mère sont reliés et, d'une certaine façon, peuvent être vus selon l'habileté de la mère à résoudre les problèmes de santé.

Chacune des sous-échelles "Interne" et "Puissance des autres" de l'échelle de Foyer de contrôle de Levenson est en corrélation significative ($p \leqslant 0,05$) et positive avec une seule dimension de l'E.F.F., soit respectivement "Action sur l'environnement" et "Connaissances en matière de santé et de maladie." Cependant, la sous-échelle "Hasard" est en corrélation négative ($p \leqslant 0,05$) avec toutes les dimensions, exception faite de la dimension "Connaissance et utilisation des ressources de la communauté."

Les instruments utilisés pour mesurer l'interaction sociale et la tension montrent aussi des corrélations positives avec plusieurs de ces dimensions. Il est intéressant de noter la corrélation négative ($p = 0,093$) entre l'échelle de Goldberg (GHQ) qui mesure le stress vécu par la mère et la "Capacité de la famille à faire face aux situations stressantes."

Tableau 1

Coefficients (r) de Pearson et niveaux de signification entre les dimensions et le score global de l'EFF et d'autres variables relatives à la santé des membres de la famille.

Echelles	Dimensions									Score global EFF
	A Connaiss.	B Habileté	C Habitudes	D Attitudes	E Coping	F Mode de vie	G Environn.	H Services	I Pert.soc.	
Goldberg (N = 82)					-0,1833[a]		0,2140*			
de tension (N = 82)			0,2390*				0,2376*			
Levenson: I							0,1206*			
(N = 207) P	-0,1303*							0,1844[a]		
C	-0,2693***	-0,1927**	-0,1561**	-0,1250**	-0,2060**	-0,1981**	-0,1901**		-0,1689**	-0,2218**
Sit. hypoth. (N = 82)	0,3908***	0,3434***	0,2985**	0,2681**	0,1870[a]	0,2065*	0,4006***	0,1839[a]	0,2020[a]	0,4064***
Fonction soc. (N = 82)										
-interaction du réseau			0,2462*					0,3797***	0,4263***	0,2939***
-intensité particip.									0,2189*	

a p = 0,10
* p = 0,05
** p = 0,01
*** p = 0,001

Bien qu'aucune relation significative n'ait été trouvée entre le score global de l'E.F.F. et les mesures utilisées dans ce projet pour évaluer la santé des enfants d'âge pré-scolaire et scolaire, quelques relations significatives mais faibles apparaissent entre les dimensions spécifiques et certains de ces tests. Ainsi, l'échelle de Glidewell (Évaluation par la mère des problèmes de santé des enfants d'âge scolaire) et l'échelle des Comportements des enfants en matière de santé (Évaluation par la mère des problèmes de santé des enfants d'âge pré-scolaire) présentent des coefficients de corrélations négatives avec les scores de la famille à la dimension "Mode de vie familiale," soit respectivement $-0,2292$, $p = 0,078$ et $-0,1879$, $p = 0,095$.

Deux autres corrélations positives apparaissent entre la dimension "Connaissance et utilisation des ressources de la communauté" et (a) l'échelle de Butler (Évaluation par le professeur de la santé des enfants — concept positif) et (b) Observation du comportement des enfants âgés de 2-5 ans (Évaluation des problèmes par l'infirmière).

De plus, la compétence de la famille telle qu'elle est mesurée par l'E.F.F., est reliée au niveau de scolarité de la mère. Elle discrimine, en effet, les familles dont les mères ont une scolarité de niveau primaire ($N = 40$) de celles dont les mères ont une scolarité de niveau secondaire. (Prim. $\overline{X} = 29,35$; Second. $\overline{X} = 34,6$; différence significative entre les moyennes, $p = 0,01$). Elle discrimine aussi entre les familles qui reçoivent des prestations de bien-être social depuis moins de deux ans ($N = 31$), et celles qui en reçoivent depuis deux ans ou plus ($N = 35$) au moment de l'évaluation (moins de deux ans, $\overline{X} = 35,66$; deux ans ou plus $\overline{X} = 29,9$; différence significative entre les moyennes, $p = 0,4$).

Le type de la famille (un parent / deux parents), l'âge des parents, la source de revenu, la condition générale de la maison ne sont pas associés de façon significative avec le niveau de l'E.F.F. Il appert donc que les mères dont la famille fonctionne bien en matière de santé ont tendance à présenter un niveau de scolarité plus élevé, alors que la compétence des familles qui dépendent de l'aide sociale se détériore avec le temps.

Fonctionnement des familles défavorisées

Comme mentionné précédemment, l'échelle E.F.F. a été développée pour les fins d'un projet de recherche sur les familles défavorisées. Ce projet repose sur un protocole de recherche type quasi-expérimental (45 familles expérimentales et 38 familles témoins). Les familles expérimentales bénéficient de soins à domicile donnés par des infirmières entraînées à utiliser un modèle spécifiquement conçu pour ce projet.

Avant que débute l'intervention (Temps 1), le groupe témoin présente des scores significativement plus élevés ($\overline{X} = 30,5$, $p \leqslant 0,05$) que le groupe expérimental ($\overline{X} = 24,9$). A la fin de la période d'intervention (Temps 2), cette relation est inversée, le groupe expérimental présentant les scores les plus élevés. L'augmentation du score moyen durant la période expérimentale s'avère significative (Temps 2, groupe expérimental, $\overline{X} = 42,4$; groupe témoin, $\overline{X} = 30,3$). Le groupe témoin ne présente que peu de changement.

Il faut noter que les moyennes des groupes n'atteignent jamais le point médian (45) de l'échelle, au T_1 comme au T_2. Aucune famille du groupe expérimental au T_1, trois familles expérimentales au T_2 et deux familles du groupe témoin aux T_1 et T_2 présentent un score égal ou supérieur au point central de l'E.F.F. (qui, par définition, représente le niveau moyen ou acceptable de fonctionnement de la famille). D'autre part, lors du pré-test, un groupe de familles de niveau socio-économique moyen et présentant des problèmes sociaux et de santé relativement moins importants, obtinrent un score moyen supérieur au point médian. (La version de l'échelle utilisée dans le pré-test était cotée sur cinq points avec un point central global de 27; la moyenne des scores de ce groupe était de 30,6).

Le point médian théorique de chacune des neuf dimensions est 5. Les deux seules dimensions pour lesquelles les scores des groupes s'approchent du point médian sont l' "Action sur l'environnement physique" (4,03) T_2 et la "Connaissance et utilisation des ressources de la communauté" (4,13) T_2. La dimension "Capacité de faire face aux situations stressantes" est celle qui présente le score le moins élevé et ce, pour chacun des deux groupes, au T_1 comme au T_2.

Chaque dimension représente un aspect de la compétence de la famille. Bien que nous concluons que la compétence des familles du groupe expérimental augmente au cours de l'application du modèle, est-ce que cette augmentation de l'habileté varie d'une dimension à l'autre? L'examen des scores de chaque dimension pour le groupe expérimental peut sans doute nous fournir la réponse (les différences pour le groupe témoin s'avèrent trop minimes). Par exemple, nous constatons que les dimensions relatives au degré d'action sur l'environnement et au niveau de connaissance et d'utilisation des ressources communautaires de santé et de bien-être présentent les scores les plus élevés (comparativement aux sept autres dimensions, au T_1 comme au T_2). D'autre part, les deux types de compétence qui augmentent le plus sont celles qui présentent les scores les moins élevés au T_1, soit "Capacité de faire face aux situations stressantes" et "Connaissance en matière de santé et de maladie."

Nous observons donc une tendance générale des positions relatives des groupes expérimental et témoin au T_1 à s'inverser au T_2; la moyenne des scores du premier groupe augmente de façon significative alors que celle du second demeure stable ou diminue légèrement.

Discussion

Pour construire l'échelle E.F.F., nous nous sommes inspirées de l'index "Family Coping" et nous avons élaboré un cadre conceptuel, en utilisant une approche éclectique de façon à produire un instrument qui soit le reflet de nos préoccupations cliniques, qui soit utilisable par des infirmières professionnelles et suffisamment fidèle pour mesurer le changement. Fondamentalement, nous voulions mesurer la compétence familiale à travers neuf ensembles de comportements. Les résultats des analyses statistiques, le coefficient alpha et l'analyse de composante principale nous laissent croire à l'unidimensionnalité de l'échelle. De plus, les corrélations positives entre la variable "habileté des mères à résoudre des problèmes de santé" et l'échelle globale, et huit des dimensions de l'E.F.F. concourent à assurer la validité de critères de l'outil.

Une grande partie des analyses ont été faites avec des familles défavorisées qui éprouvaient beaucoup de difficultés à composer avec les exigences de la vie quotidienne. Dans toutes les catégories de l'échelle, on obtient des scores bas. La grande pauvreté de ces familles semble déterminer l'ensemble de leur vie. Les scores obtenus sont donc le reflet de ce phénomène. En d'autres mots, tous les sujets se situent, au début de l'étude, à une extrémité de la courbe normale. Aurions-nous observé de plus grandes variations d'une catégorie à l'autre chez des familles "ordinaires" ou des familles de milieux plus aisés? Il serait intéressant de poursuivre l'étude avec une plus grande variété de familles, soit des familles de milieux socio-économiques variés et plus de familles biparentales. Les résultats obtenus par l'analyse multivariée et les questions qu'ils soulèvent indiquent qu'il faut raffiner le modèle de prédiction du fonctionnement de la famille.

Une des limites de l'échelle est son manque de précision. Aussi, il pourrait être utile d'élaborer des sous-échelles pour chaque dimension. Toutefois, en augmentant la complexité de l'échelle, on accroîtra probablement les difficultés d'utilisation. Les limites de l'outil semblent d'ailleurs plus liées aux conditions d'utilisation qu'à l'outil même.

L'utilisation adéquate de l'échelle dépend, dans une large mesure, de l'habileté de l'infirmière à observer une famille, à comprendre le sens

des interactions entre les membres de la famille, à communiquer efficacement et directement avec la famille de façon à clarifier la perception que cette dernière entretient de sa situation et de ses problèmes; en d'autres mots, l'infirmière doit avoir une grande compréhension de la dynamique et de la structure familiale. Elle doit aussi pouvoir déterminer quels comportements appartiennent à la même classe de comportements sinon la condition d'exclusivité entre les catégories n'est plus assurée.

Une des limites que nous avons rencontrées lors de la validation de l'échelle se rapporte à la difficulté de faire évaluer la même famille par deux infirmières ou une infirmière et une travailleuse sociale qui connaissent la famille et qui ont observé des interactions entre les membres de la famille récemment. Si l'on considère la pénurie de main d'oeuvre dans les services communautaires, il semble peu utile de proposer de poursuivre l'étude dans ce sens.

En conclusion, il semble qu'en dépit de certaines limites, l'E.F.F. soit un outil fidèle qui possède un niveau acceptable de validité de critères et de différenciation. Son utilité comme instrument clinique et sa valeur comme instrument de recherche ont été en partie démontrées. L'usage répété de l'outil pourra confirmer les résultats obtenus.

RÉFÉRENCES

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

Brown, G. W., & Rutter, M. (1966). Measurement of family activities and relationships: A methodological study. *Human Relations, 19,* 241-263.

David, H. P. (1980). Healthy family coping: Transnational perspectives. In L. A. Bond & J. C. Rosen (Eds.), *Competence and coping during adulthood*. Hanover, NH: University Press of New England.

Epstein, N. B., Bishop, D. S., & Levin, S. (1978). The McMaster model of family functioning. *Journal of Marriage and Family Counselling, 4*(4), 19-31.

Freeman, R. B., & Lowe, M. (1962). A method for appraising family public health nursing needs. *American Journal of Public Health, 53*(1), 47-52.

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

Geismar, L. L. (1964). *Understanding the multiproblem family*. New York: Association Press.

Haley, J. (Ed.) (1971). *Changing families*. New York: Grune & Stratton.

Jackson, D. (Ed.). (1968). *Communication, family and marriage*. Palo Alto: Science and Behavior Books.

Kelman, H. C. (1965). Compliance, identification and internalization: Three processes of attitude change. In A. Proshansky & B. Saidenberg (Eds.), *Basic studies in social psychology*. New York: Holt, Rinehart & Winston.

Lazarus, R. S. (1980). The stress and coping strategies. In L. A. Bond & J. C. Rosen (Eds.), *Competence and coping during adulthood*. Hanover, NH: University Press of New England.

Lewis, J. M., Beavers, R. W., Gosset, J. I., & Phillips, V. A. (1976). *No single thread*. New York: Brunner/Mazel.

Minuchin, S. (1974). Family and family therapy. Cambridge, MA: Harvard University Press.

Moos, R. H., Insel, P. M., & Humphrey, B. (1974). *Family, work and group environment scales*. Palo Alto: Consulting Psychologists Press.

Pless, I. B., & Satterwhite, B. B. (1973). A measure of family functioning and its application. *Social Science and Medicine, 7*, 613-621.

Pratt, L. (1976). *Family structure and effective health behavior: The energized family*. Boston: Houghton Mifflin.

Robinson, D. (1971). *The process of becoming ill*. London: Routledge and Kegan Paul.

St-Félix-Beauger, M. (1978). Validation d'une échellle d'évaluation du fonctionnement de la famille en matière de santé. Mémoire de maîtrise inédit, Université de Montréal.

Satir, V. (1967). *Conjoint family therapy*. Palo Alto: Science and Behavior Books.

Strauss, M. A. (1978). *Family measurement techniques*. Abstracts of Published Instruments 1935-1974. Minneapolis: University of Minnesota Press.

Thibaudeau, M.-F., Reidy, M., D'Amours, F., & Frappier, G. (1983). *Soins infirmiers aux familles défavorisées*. Rapport de recherche. Faculté des sciences infirmières, Université de Montréal.

ABSTRACT

Evaluation of Family Functioning Scale (EFF)

The Evaluation of Family Functioning Scale (EFF) is a measure of family functioning in relation to health matters. It was developed primarily to help the community nurse assess the families whom she serves. While the authors were inspired in large part by the Family Coping Index (Freeman et Lowe, 1962), the actual EFF was developed, validated and used in a research project (Thibaudeau, 1983) with disadvantaged families in order to make a diagnosis of the functioning of the family, and to plan nursing care. It was used regularly over time to measure change globally and with respect to certain health care functions. The scale consists of nine dimensions, each of which are measured on a nine point graphic scale. The validation process is reported (i.e. concomitance between measures, test-retest reliability, internal consistency and principal component analyses, etc.) and the limitations of the scale are discussed.

Annexe A

Échelle du fonctionnement de la famille

Nom de famille: _____ Date: _____

Infirmière: _____ Agence: _____

Domaine et niveau de compétence (fonctionnement familial)	Commentaires
A. Connaissance en matière de santé-maladie 1 2 3 4 5 6 7 8 9	
B. Habileté en matière de santé-maladie 1 2 3 4 5 6 7 8 9	
C. Habitudes de vie et application des principes d'hygiène 1 2 3 4 5 6 7 8 9	
D. Attitudes envers la santé et les services 1 2 3 4 5 6 7 8 9	
E. "Coping" (capacité de faire face au stress) 1 2 3 4 5 6 7 8 9	
F. Modes de vie familiale 1 2 3 4 5 6 7 8 9	
G. Action sur l'environnement physique 1 2 3 4 5 6 7 8 9	
H. Connaissance et utilisation des ressources de la collectivité 1 2 3 4 5 6 7 8 9	
I. Participation sociale 1 2 3 4 5 6 7 8 9	

Annexe B

Dimension B: habileté à résoudre les problèmes de santé et à prévenir les complications

L'habileté se manifeste de deux façons: (a) par l'identification de la condition et de sa gravité à la suite d'observations et par la prise de décision sur les façons d'éliminer le problème ou d'améliorer la condition; (b) par les actes posés pour résoudre le problème, protéger l'entourage et prévenir les complications. Ces actes peuvent être de nature spécifique telle que donner des médicaments pour une infection, isoler l'enfant pour prévenir la contagion, aider dans ses devoirs un enfant qui a un problème de lecture, ou de nature générale telle que des mesures d'hygiène générale et de réconfort.

NIVEAU 1. La famille est nettement incapable d'identifier la gravité de la situation et de donner les soins appropriés ou d'exécuter des prescriptions médicales en toute sécurité. Elle manifeste des comportements de négligence ou de laisser-faire dans l'observation et le soin des membres de la famille ou bien elle a recours constamment à un service d'urgence pour des banalités.

NIVEAU 2. La famille peut identifier une condition aiguë et manifeste (ex., troubles respiratoires), mais elle ne peut poser des actes appropriés autres que de recourir à un professionnel de la santé. Elle peut savoir prendre la T° mais elle ne sait pas en interpréter les degrés. Ou bien elle sait poser un certain nombre d'actes spécifiques mais néglige les mesures d'ordre général. Elle est surtout portée à négliger les problèmes de nature psycho-sociale.

NIVEAU 3. La famille répond partiellement aux besoins de ses membres ou elle donne des soins à certains et en néglige d'autres. Elle fait des observations et pose des actions appropriées pour les conditions les plus habituelles. Elle peut exécuter des traitements mais tend à négliger la prévention des complications.

NIVEAU 4. La famille identifie les conditions usuelles et sait comment intervenir. Elle ne fait appel aux services de santé que si nécessaire. Elle protège les autres membres de la famille contre la contagion. Elle porte une certaine attention aux problèmes de nature psychologique. Elle donne les soins spécifiques appropriés et un certain nombre de soins généraux.

NIVEAU 5. La famille fait des observations pertinentes et identifie correctement la gravité de la condition. Elle pose des actes appropriés du point de vue des soins spécifiques et des soins généraux. Elle sait quand faire appel aux agences de santé. Tous les membres participent à la solution du problème selon leur âge et leur capacité. Elle porte beaucoup d'attention aux problèmes de nature psychologique.

EVALUATION OF FAMILY FUNCTIONING: DEVELOPMENT AND VALIDATION OF A SCALE WHICH MEASURES FAMILY COMPETENCE IN MATTERS OF HEALTH (EFF)

Mary Reidy • Marie-France Thibaudeau

The Evaluation of Family Functioning Scale (EFF) is a measure of family functioning in relation to health matters. It was developed primarily to help the community nurse assess the families whom she serves. While the authors were inspired in large part by the Family Coping Index (Freeman & Lowe, 1962), the actual EFF was developed, validated and used in a research project (Thibaudeau, Reidy, D'Amours, & Frappier, 1983) with disadvantaged families in order to make a diagnosis of the functioning of the family, and to plan nursing care. It was used regularly over time to measure change globally and with respect to certain health care functions .

Definition of Terms

The word health, as it is used here, has a broad meaning. It refers to physical, psychological and social well-being, the absence of illness, the appropriate utilization of health and welfare resources, the salubrity of the environment, and the practice of health behaviours relating to the prevention of illness and accidents, solution of health problems, the meeting of basic health needs (rest, etc.). The concept of health also includes the capacity to cope with the constant exigencies and crises of life and the ability to move toward self-actualization in a useful social role.

Mary Reidy, Inf., M.Sc.(App.), is assistant professor, and Marie-France Thibaudeau, Inf., M.S.N., is dean and professor, Faculté des sciences infirmières, Université de Montréal.

The authors wish to thank Health and Welfare Canada for financial aid received.

The family is defined as a group which consists of one or two parents, united by the bonds of marriage or a stable relationship, and of a child or children. These people live together, they are related to each other in familial roles and share the same culture. The family is a subsystem of society to which it contributes by its reproductive, social, educative and economic functions; the family must both rely on it for support and in turn contribute to it.

Family functioning refers, in the context of this evaluation, to the interaction and cohesion within the family, to the ability of the family group to satisfy the physical, psychological and social needs of its members, to their capacity to face the stress situations of life and to their participation in community life. Such functioning can also be seen in terms of competence to fill those roles assigned to them by society; it is equally concerned with the responsibility assumed by each family member for himself and for the family (according to his age and abilities).

The Theoretical Framework

The family is the object of study of many different disciplines which in turn observe, describe and analyse it according to their own light.

In his review of methods to evaluate the family, Strauss (1978) presents various types of theoretical frameworks, guides, inventories, interview schedules to measure the couple, the parent-child relationships, the family or other subsystem of the family. Many authors from various disciplines had developed interesting tools which were not concordant with our framework or were not sufficiently tested to be utilized in a research project (Boardman, Lyzanski, & Cottrell, 1975; Brown & Rutter, 1966; Epstein, Bishop, & Levin, 1978; Geismar, 1964; Moos, Insel, & Humphrey, 1974; Pless & Satterwhite, 1975).

Authors in nursing who write about family functioning generally employ two main approaches to family analysis: the structural-functional approach closely related to systems theory (Friedman, 1981; Minuchin, 1974), or the interactional approach often used in family therapy (Haley, 1971; Jackson, 1968; Satir, 1967). We have, however, adopted an eclectic approach and have constructed our instrument, with a theoretical base composed of various orientations, with the "Family Coping Index" (Freeman & Lowe, 1962) as a starting point. This index developed by Friedman in collaboration with the Richmond VNA, is based on the concept of need for nursing care. It can be used for periodic evaluation of the family in terms of the following nine categories of care or difficulties encountered by the family (a) physical independence; (b) therapeutic competence;

(c) emotional competence; (d) knowledge of health conditions; (e) application of principles of hygiene; (f) attitude toward health; (g) family life; (h) physical environment; (i) use of community services.

We were greatly inspired by this instrument, particularly by its structure. We have retained most of the categories; removing some and adding others, we have also modified to a great extent the content of the criteria proper to each category. Finally, our evaluation guide is essentially different from that of Freeman & Lowe.

The refinement of our scale was dependent on numerous authors such as David (1980); Kelman (1965); Lazarus (1980); Pratt (1976); Robinson (1971). The work of these authors contributed both at a general level of conceptualization, for example concerning family dynamics, or at a more specific level such as health behaviours, coping, way of life or attitudes toward health. We turned also to Lewis, Beavers, Gossett, & Phillips (1976) who underlined the characteristics of the normal healthy family: (a) communication between members; (b) parental unity; (c) flexibility of role; (d) the ability to function in the presence of psychological stress; (e) the fundamental role of the mother to be the first to suffer from family disorganization; and (f) physical illness as a criterion of functioning.

It may be seen, from this short review (Thibaudeau et al., 1983, for a more detailed presentation), that we have adopted an eclectic approach, adapting certain notions from various authors or schools of thought, in order to be able to place the accent on those health dimensions which are part of the family's daily life, and to permit the elaboration of a broad theoretical base.

The Family Functioning Scale (EFF)

The EFF like the original index developed by Freeman and Lowe (1962) was composed of nine dimensions relating to various aspects of family functioning, which was judged in terms of the competence of the family to care for its health at that moment of its existence. These dimensions are as follows:

Dimensions of Family Functioning

A. Knowledge of health and illness.
B. Ability to solve health problems and prevent complications.
C. Health habits.
D. Attitudes toward health and health services.
E. Ability to cope with stressful situations.

F. Family life patterns.
G. Action on the physical environment.
H. Knowledge and utilization of community health and welfare resources.
I. Participation in community life.

Each dimension was evaluated in the preliminary version of the EFF by a scale of 1 to 5. The number 1 corresponds to the lowest level, and 5 to the highest level of competence. The description of each of the five levels, provided to help the nurse locate the family correctly on the scale, is not considered exhaustive. These descriptions are presented only as a guide and the nurse, in using the scale, must weigh the various behaviours relative to each category. In completing the evaluation, the nurse also describes in operational and concrete terms under the column "comments," the behaviours of the family which permitted her to scale it at a given level within each dimension.

However, the nurses using the scale did not find the five point scale sufficiently precise. For this reason, they were permitted to "place" their families on the midpoints between each of the five defined levels. The final version of the scale was in this way expanded from five to nine points (see Appendix A) allowing the total possible score to range from 9 to 81 (midpoint 45). A higher score indicates a higher level of competence; a lower score a lower level of competence.

The following schema represents the final version of the scale.

1	2	3	4	5	6	7	8	9
(Level defined)		(Level defined)		(Level defined)		(Level defined		(Level defined)
Low level of competence				Medium level of competence				High level of competence

Steps in the Validation Process

To be useful as a research tool, a family evaluation scale must be valid and reliable. It must also possess these characteristics if it is to be used for clinical purposes, even though internal reliability relative to the exclusivity of the dimensions is perhaps less important. The study of St-Félix Beauger (1978) reports, in detail, the steps taken to assure such reliability and validity. This study was completed with a different sample of public health nurses before the actual research with the disadvantaged families was undertaken.

First, for purposes of content validity, nine nurse experts studied the EFF in terms of its content, structure, relevance and appropriateness for regular use in a community health service. Several modifications, in terms of content and wording, resulted from this in-depth study.

Next, to assess concurrent validity, 12 nurses from three CLSC's (Community Local Service Centres) and one Community Health Department chose from among the families they followed, one which functioned well and one which functioned badly. Each nurse first evaluated her families globally on a graphic scale of one to five points, and then justified the evaluation, in some detail; she then used the preliminary version of the EFF. Test-retest validity was assured by repeating both types of evaluation (graphic scale and EFF) one month later. Further, she also collected data from eight senior public health nurses of an urban health service. They evaluated 100 of the families they were following, and repeated this evaluation with 85 of these families at the end of one month.

The analyses of these data yielded the following results:

1. a high level of agreement (85%) between the two judges who judged the concomitance between the two scales (Graphic Scale and EFF) and the comments which justified the assigned score (validity);

2. a correlation of 0.86% (Pearson r) between the nurses' global assessment of the families and their score on the EFF (validity);

3. a correlation of 0.95% (Pearson r) between the two sets of scores on the EFF completed one month apart (test, re-test reliability);

4. the dimension "Ability to cope with stressful situations" consistently scored the lowest of all the dimensions;

5. analyses of the frequency distributions indicated that the nurses consistently experienced greatest difficulty in assessing clients on three dimensions: "Coping," "Family patterns" and "Action on the physical environment";

6. analyses of a complementary questionnaire completed by the nurses using the EFF indicated that they liked to use the tool and found it to be most helpful in structuring their observations and in planning their care.

The study of St-Félix-Beauger (1978) also demonstrated that certain conditions are important for the appropriate utilization of the EFF by the nurse in community health. Of first importance is the understanding of family dynamics and structure and the ability to observe and to communicate effectively while helping clients clarify the meaning of

their behaviour. Further, the nurse must establish relationships between events and behaviours which are significant in order to interpret them in terms of the appropriate dimension of the EFF.

The description of the levels of the EFF (see Appendix B for example) was refined as a result of the analyses of the nurses' comments. However, the resulting final version used in the project with the disadvantaged families (Thibaudeau et al., 1983) differed little from the preliminary version.

Further analyses were carried out on data taken from our project with the disadvantaged families. First, an item analysis (as a measure of internal consistency) was carried out. The Cronbach alpha remained consistently high when the experimental and control groups were treated separately. (α: Gr Exp. = 0.8214, N = 45; α: Gr. Con. = 0.8605, N = 38, or combined α: 0.8593, N = 83). Further, the deletion of any one of the items (dimensions) did not result in any marked improvement in the level of α in any one of these three cases.

Next, a principal component analysis was carried out with 225 evaluations in order to examine the unidimensionality of the scale.

In a non rotated solution (using principal factor, no iterations), the first factor included all nine dimensions with factor loadings of 0.65 or more, and explained 62.7% of the variance. The remaining factors were not independent and explained only small additional proportions of the variation.

Dimension	Factor Loading
A	.79
B	.86
C	.83
D	.85
E	.80
F	.78
G	.79
H	.75
I	.65
% of variance	62.7

Factors are hypothetical constructs or variables that are assumed to underline a scale (or set of scales). Principal component analysis, like factor analysis, is a method used to determine the number and nature of these variables. The results just presented strongly suggest that there is a single construct underlying the nine dimensions of the EFF; that is to say it may be treated as a global measure of family competence in matters of health.

Relationship with other Measures and Variables

The relationships between the EFF and other variables, measured during the course of the project, were investigated. Three of these related to the mother's health or health ability; these correlated (Pearson r) significantly with either individual dimensions or total score of the EFF. The instruments used and variables measured were as follows:

INSTRUMENTS	VARIABLES MEASURED
Goldberg (GHQ)	Stress experienced by mother
Tension Scale	Tension experienced by mother (complement to GHQ, symptoms specific to this population)
Levenson's Locus of Control — Internal (I) — Powerful others (P) — Chance (C)	Belief in: — internal control of events — control by other — events occurring by chance
Hypothetical situations	Mother's ability to solve health problems
Social Functioning — Intensity of Social Network	— social interaction with relatives, friends, neighbours, etc.
— Intensity of social participation	— the frequency or degree of participation in social groups

The correlation coefficients and probabilities can be found in Table 1, where it may be seen that the total score of the EFF correlated negatively with Levenson's Chance Scale, and positively with the Hypothetical Situations and the Intensity of the Social Network.

Further, significant relationships (Pearson r) were also found between the dimensions of the EFF and the instruments used to evaluate some aspects of maternal or family health. Six of the nine dimensions correlated ($p \leqslant 0.05$) with the scale (Hypothetical Situations) which measured the mother's ability to solve health problems. These correlations ranged from 0.2065 for the dimension "Family life patterns," to 0.4006 for the dimension "Action on the physical environment." The other three dimensions "Ability to cope with stressful situations," "Knowledge and utilization of community resources," and "Social participation," were associated with the

Table 1

Pearson Correlation Coefficients (r), and Significance Levels, between the Dimensions and Total Score of the EFF and other Variables Related to the Health of Family Members.

Scales		Dimensions									Total score EFF
		A Knowledge	B Ability	C Habits	D Attitudes	E Coping	F Life pattern	G Environment	H H.serv.	I Part. social	
Goldberg (N = 82)						-0.1833[a]		0.2140 *			
Tension (N = 82)				0.2390 *				0.2376 *			
Levenson: (N = 82)	I							0.1206 *			
	P	-0.1303 *							0.1844		
	C	-0.2693***	-0.1927 **	-0.1561 **	-0.1250 *	-0.2060 **	-0.1981 **	-0.1901 **		-0.1689 **	-0.2218 **
Hyp. sit. (N = 82)		0.3908***	0.3434***	0.2985 **	0.2681 **	0.1870[a]	0.2065 *	0.4006***	0.1839	0.2020	0.4064***
Soc. funct. (N = 82)											
Soc.network				0.2462 *					0.3797***	0.4263***	0.2939***
Soc. part.										0.2189 *	

a $p \leq 0.10$
* $p \leq 0.05$
** $p \leq 0.01$
*** $p \leq 0.001$

Hypothetical Situations but only with a p 0.10. In clinical terms, what does this mean? The various aspects of a family's functioning in relation to health matters are related to and, to some extent, can be predicted by the mother's ability to solve health problems.

Levenson's Locus of Control (Internal and Powerful Others) were each significantly ($p \leqslant 0.05$) and positively correlated with only one of the dimensions of the EFF, (Internal with "Effect on the physical environment," and Powerful Others with "Knowledge of health and illness"). However, the Chance Scale was negatively related ($p \leqslant 0.05$) to all but the dimension "Knowledge and utilization of community resources."

The instruments used to measure social interaction and tension also show positive correlation with several of these dimensions. It is interesting to note, however, there is a negative ($p = 0.093$) correlation between the Goldberg Scale (GHQ) which measures stress of the mother and the family's "Ability to cope with stress."

While significant relationships were not found between the global score of the EFF and the tests used to evaluate the health of school and pre-school children in this project, some (weak) significant relationships were found between several of the dimensions and certain of these tests. Both Glidewell's scale (Mother's evaluation of health problems in the school child) and the Health behaviour of children scale (Mother's evaluation of health problems in the pre-school child) correlated negatively with the family's scores on "Patterns of family life." The former r was equal to -0.2292, $p = 0.078$, the latter r was -0.1879, $p = 0.095$.

A second pair of (weak) significant correlations occurred between the dimension "Knowledge and utilization of community resources" and both the Butler Scale (teacher evaluation of child's health — as a positive concept), and the Observation of the behaviour of the 2-5 year old child (nurse's evaluation of problems). The former correlation was 0.2456, $p = 0.056$, the latter -0.2098, $p = 0.062$.

Further, family competence as measured by the EFF was found to be related to the education level of the mother. It seems to discriminate between families with mothers who have only primary ($N = 40$) as compared to secondary ($N = 44$) level education (Prim. $\bar{x} = 29.35$; second. $\bar{x} = 34.6$; sig. diff. between the two $\bar{x}$, $p = 0.01$). It also discriminates between families who have been on welfare for less than two years ($N = 31$), and those who have been on welfare for two years or more ($N = 35$) at the time of the evaluation (less than two years, $\bar{x} = 35.66$; two years or more, $\bar{x} = 29.9$; sig. diff. between the

two $\bar{x}$, $p = 0.4$). Type of family (one parent/two parents), age of the parents, source of revenue, general condition of the home are not significantly associated with the level of EFF. It would seem then that the family which functions well in health matters tends to have a mother with a higher level of education but at the same time the family's competence has a tendency to deteriorate the longer the family is on welfare.

Functioning of Disadvantaged Families

As mentioned earlier, the EFF was developed for use in a research project with disadvantaged families. This was a project with a quasi-experimental design (45 experimental, 38 comparative families). The experimental families were cared for, in their homes, by nurses prepared to apply a model specifically designed for the project.

It was found that before the nursing intervention began (Time 1), the comparative group ($\bar{x} = 30.5$) scored significantly ($p \leqslant 0.05$) higher than the experimental group ($\bar{x} = 24.9$). By the end of the period of nursing intervention (Time 2), the relationship was reversed in that the score of the latter group was then higher. This increase in the mean score, during the experimental period, was significant (Time 2, experimental group $\bar{x} = 42.4$, comparative group $\bar{x} = 30.3$). The comparative group of families changed little over time.

While we do not pretend to have established standards, it should be noted that the mean of neither group, at both T_1 and T_2, even approaches the midpoint (45) of the scale. None of the experimental families at T_1, three at T_2, and two of the control families at both T_1 and T_2 had mean scores at or above the midpoint of the EFF (which may be seen by definition as a medium or acceptable level of family functioning). However, in a pretest, a group of middle class families with relatively fewer health and social problems did have a mean score above the midpoint. (The version of the scale used in this pretest was scored in terms of 5 points with a midpoint of 27; the mean score for the group was 30.6).

The theoretical midpoint on each of the nine dimensions falls at 5. The closest either group comes to this midpoint is with scores of 4.03, 4.13 T_2 respectively on the dimensions, "Action on the physical environment," and "Knowledge and utilization of community resources." The dimension on which both groups of families scored the lowest, at both T_1 and T_2 was that of "Ability to cope with stressful situations."

Each dimension represents an aspect of family competence. While it may be concluded that the competence of the families of the experimental group did increase over the course of the application of the model, did this increase in ability vary from one dimension to another? The answer to this question may be found by examining the scores by dimension for the experimental group (the differences for the comparative group tend consistently to be too small). It may be seen, for example, that the dimensions which relate to the level of "Action on the physical environment" and their level of "Knowledge and utilization of community health and welfare resources," have the highest scores (as compared to the other seven dimensions) at both T_1 and T_2. On the other hand, the two types of competence which improved most over time were two of the lowest at T_1, "Ability to cope with stressful situations" and "Knowledge of health and illness."

It would seem then that the general tendency between T_1 and T_2 is a reversal of the relative positions of the experimental and comparative groups resulting from a significant increase in the $\bar{x}$ scores of the former and the stability or slight diminution over time in scores of the latter.

Discussion

In constructing the EFF scale, we began with the "Family Coping Index" and then went on to develop an appropriate conceptual framework. In using this eclectic approach, we were able to produce an instrument which reflected our clinical approach and which was both useful for the professional nurse and sufficiently reliable in order to measure change. Essentially, we wished to measure change in terms of nine types of behaviour. However, the results of our statistical analysis, the alpha coefficient and principal component analyses allowed us to treat the scale as unidimensional. Further, positive correlations betwen the scale, the ability of the mother to resolve health problems, and both the global scale and eight of the dimensions of the EFF to some extent support the concurrent validity of the tool.

We have, therefore, considered the EFF as a global measure of family competence, in which competence is defined as the ability of the family to satisfy the physical, psychological and social needs of its members, to face stressful situations and to participate in community life.

Other analyses were also carried out with the data from disadvantaged families who were experiencing difficulty in meeting the exigencies of daily life. While we found that the scale did discriminate between different types of families, we obtained low scores on all

dimensions of the scale. It would seem that the extreme poverty of these families overshadows the rest of their lives. In other words, all the scores of these families tend to be located at one end of the normal curve. Would we notice greater variation from one dimension to another in "normal" families or in families in more comfortable circumstances? It would be interesting to study groups of families of a more diversified nature, whether families from a different socio-economic milieu or more bi-parental families. At the same time, however, questions such as these, as well as results already obtained through multivariate analyses based on a multiple regression model have led us to believe that the next, immediate step in the development of the EFF is to refine a predictive model using the data we already have on hand.

One of the limitations of the EFF is related to its level of precision. It would perhaps, be useful to elaborate sub-scales for each dimension. However, in increasing the complexity of a scale, one also increases the difficulty in using it. The limitations of this scale, it seems, are more closely related to the conditions under which it is used, than to the scale itself.

Appropriate utilization depends in large measure on the ability of the nurse to observe a family, to understand the interaction between its members, to communicate directly and effectively with the family in a way which will clarify her perception of the situation. In other words, the nurse must be able to comprehend the dynamics and structure of the family. She must also be able to determine which behaviours belong to which dimension of the scale if the condition of exclusivity between dimensions is to be assured.

One of the limitations, in terms of the development of the scale, is related to the difficulty of having the same family evaluated by two health workers, whether two nurses or a nurse and a social worker, who know the family and who have observed the interaction between family members during the same period of time. When one considers the lack of personnel in community health, it seems, perhaps, of little use to contemplate further such measures of reliability.

In conclusion it would seem that, with some limitations, the EFF is internally reliable and possesses a certain degree of concurrent and discriminatory validity. It has been shown to be useful both as a clinical and a research tool.

REFERENCES

The Reference List for the English version is the same as that of the French version. See page 38.

RÉSUMÉ

L'évaluation du fonctionnement de la famille en matière de santé (E.F.F.)

L'échelle d'Évaluation du fonctionnement de la famille en matière de santé (E.F.F.) a été construite dans le but d'aider les infirmières en santé communautaire à structurer leurs observations des familles qu'elles soignent et à les guider dans leur évaluation des comportements familiaux. Bien que les auteurs se soient inspirés du "Family Coping Index" (Freeman & Lowe, 1962), l'échelle E.F.F. a été construite, validée et utilisée dans le cadre d'un projet de recherche (Thibaudeau, Reidy, D'Amours, et Frappier, 1983) auprès de familles défavorisées, pour diagnostiquer le fonctionnement de la famille en matière de santé et planifier les soins de l'infirmière. Elle a aussi été utilisée pour mesurer périodiquement le changement global et le changement de certains aspects spécifiques du fonctionnement de la famille en matière de santé. L'échelle comporte neuf dimensions chacune étant divisée en neuf unités de mesure. Le processus de validation est décrit (validité, concomitance, fidélité test-retest, consistance interne, et analyse des composantes principales, etc.), et les limites de l'échelle sont discutées.

Appendix A

Evaluation of Family Functioning Code Sheet

Name of family _____ Date _____

Nurse _____ Agency _____

	Areas of functioning	Comments
A.	Health-illness knowledge 1 2 3 4 5 6 7 8 9	
B.	Ability to solve health problems and to prevent complications 1 2 3 4 5 6 7 8 9	
C.	Health habits 1 2 3 4 5 6 7 8 9	
D.	Attitudes toward health and health services 1 2 3 4 5 6 7 8 9	
E.	Ability to cope with stressful situations 1 2 3 4 5 6 7 8 9	
F.	Family life patterns 1 2 3 4 5 6 7 8 9	
G.	Action on the physical environment 1 2 3 4 5 6 7 8 9	
H.	Knowledge and use of community resources 1 2 3 4 5 6 7 8 9	
I.	Participation in community life 1 2 3 4 5 6 7 8 9	

Appendix B

Dimension B: Ability to Solve Health Problems and to Prevent Complications

This ability manifests itself in two fashions: (a) by the identification of a condition and of the gravity of this condition following observation, and by making a decision which will resolve the problem or improve the condition; (b) by acting to resolve the problem, protect those in the surroundings and prevent complications. These acts can be of a specific nature, such as giving medication for an infection, the isolation of a child to prevent the spread of the infection, helping a child who had reading difficulties, or of a general nature such as general hygiene and comfort measures.

LEVEL 1. The family is clearly incapable of evaluating the gravity of a situation and of giving appropriate care. It manifests negligent or *laissez-faire* behaviour in its observation and care of family members, or else it constantly has recourse to an emergency service for trivialities.

LEVEL 3. The family can identify an acute or evident condition (i.e. respiratory problems) but cannot carry out appropriate action other than having recourse to a health professional. It knows how to take the temperature with a thermometer but it does not know how to interpret the "degrees". Or else, it knows how to carry out a number of specific actions but neglects measures of a general order. It tends, above all, to neglect problems of a psycho-social nature.

LEVEL 5. The family responds partially to the needs of its members, or cares for some and neglects others. It observes and acts appropriately for the condition which it encounters often. It can carry out treatments but tend to neglect the prevention of complications.

LEVEL 7. The family recognizes most common conditions and can intervene appropriately. It does not appeal to health services unless necessary. It protects other members of the family against contagion. It pays some attention to problems of a psychological nature. It can appropriately give certain specific types of care and can also, to some extent, carry out a more general plan of care.

LEVEL 9. The family makes pertinent observations and correctly evaluates the gravity of the situation. It acts appropriately from a point of view of both specific and general care. It can call upon health agencies for assistance when needed. All the members participate in solving health problems according to their age and their abilities. They pay a great deal of attention to problems of a psychological nature.

COGNITIVE DISSONANCE: DENIAL, SELF CONCEPTS AND THE ALCOHOLIC STEREOTYPE

Cheryl Forchuk

Alcoholism is a serious problem. In Ontario, 3.89% of the population who are 15 years of age or older are believed to be alcoholic (Marshman, 1978). The Lalonde (1974) report stated that in Canada "one quarter of all first male admissions to psychiatric hospitals are due to alcoholism" (p. 24). The report also related alcohol abuse to "motor vehicle accidents, poisonings, accidental fire deaths, cirrhosis of the liver and falls" (p. 24). Consequently, nurses will frequently encounter patients diagnosed as alcoholic.

In caring for patients diagnosed as alcoholic, two common problems are: denial of alcoholism (Moore & Buchanon, 1966) and negative self concepts (Heinemann, Moore, & Gurel, 1977; Quereshi & Soat, 1976). Nurses may find these problems frustrating and difficult to deal with. Common theoretical frameworks, such as viewing denial as a defence mechanism, are complex and offer few, if any, interventions for the nurse. A study was conducted to examine denial, negative self concepts and acceptance of the alcoholic stereotype within a theoretical framework of cognitive dissonance.

The Alcoholic Stereotype

Why is the term "alcoholic stereotype" used? A stereotype is an image of a minority group generally accepted within a culture or society. Simpson and Yinger (1972) state stereotypes have the following characteristics: highly exaggerated picture of a few characteristics, invented traits made reasonable by association with other traits that may have a kernel of truth, and failure to show how the majority share these traits. Traits are thought to be intrinsic or even self willed and have little possibility of change. (p. 53) Such a definition seems to apply to what is often called the "alcoholic personality."

The negative stereotype of the alcoholic assumes that the alcoholic is not worthwhile. Specific exaggerated traits depict the alcoholic as "uncontrolled, negligent, insensitive, irresponsible, self-centred,

Cheryl Forchuk, R.N., M.Sc.N., is clinical nurse specialist, Hamilton Psychiatric Hospital, Hamilton, ON.

careless, hostile, lazy, contentious or foolish" (Tamarin & Neumann, 1974, p. 316). They are also considered "bad" and "weak." Past studies have found that alcoholics themselves (Hoy, 1973; McCartney & O'Donnell, 1981; Pennock & Poudrier, 1978), health professionals (Chalfant, 1979; Cohen, Griffen, & Wiltz, 1982; Kilty, 1975; Sowa & Cutter, 1974; Wallston, Wallston, & DeVellis, 1976), community residents (Kilty, 1975, 1978), graduate students (Gay, 1981) and even 12 year old children (Isaacs, 1977), accept a stereotyped view of alcoholics and/or substance abusers generally.

Adaptation of Festinger's Theory of Cognitive Dissonance

Cognitive dissonance is a psychological theory developed by Festinger (1957). It alleges that if a person's cognitions (knowledges, opinions or beliefs) are inconsistent with one another, that person will be uncomfortable and will be motivated to make them more consistent.

Acceptance of the alcoholic stereotype indicates acceptance of the cognition "Alcoholics are not worthwhile." The treatment staff must encourage acceptance of the cognition "I am worthwhile" to improve the alcoholic's self concept. They must also encourage acceptance of the cognition "I am alcoholic" to overcome denial of alcoholism. Difficulty with these three cognitions is illustrated in Figure 1.

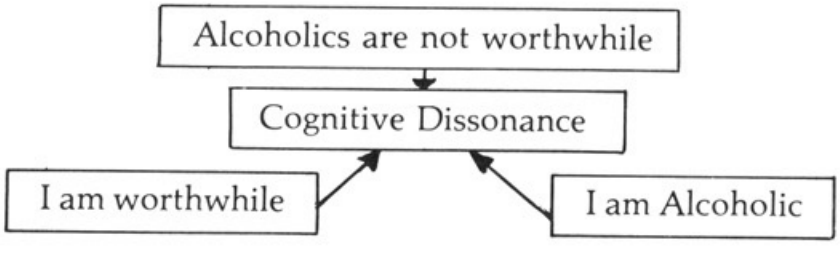

Figure 1. Dissonance with three cognitions.

Within this framework the alcoholic could resolve the dissonance by rejecting or altering one of the cognitions. He/she could (a) deny alcoholism; (b) accept a more negative self concept, or (c) reject the alcoholic strereotype. Those persons who accept their alcoholism and the negative stereotype would have a more negative self concept than if they rejected the stereotype. On the other hand, if the dissonance were reduced through denial, there would not be the same reason to suspect any relationship between self concept and acceptance of the stereotype because the dissonance would already be reduced. Without this motivating factor, the person's normal resistance to change would take precedence. Therefore the hypotheses are: (a) Among those accepting alcoholism or problem drinking there will be a positive

relationship between the "alcoholic" and "self" concepts, and (b) there will be no relationship between "alcoholic" and "self" concepts among those denying alcoholism.

Previous writers have suspected that alcoholics' conflicting feelings about themselves personally and alcoholics generally may cause conflict or cognitive dissonance. Pennock and Poudrier (1978) viewed denial as a means of reducing dissonance between the self and alcoholic concepts among subjects charged with drunken driving. They found an 11 week educational program resulted in subjects having a more positive alcoholic concept but not changing their self concept. Denial was not measured. In a discussion on "Alcoholism from the Inside Out" Wallace (1977) states "Because his actions when intoxicated are so markedly discrepant with his primary personality, the alcoholic experiences ever increasing identity confusion. In a sense, he is caught in a state of massive, painful cognitive dissonance. His private and most cherished beliefs about himself are constantly contradicted by the facts of his overt, intoxicated actions" (p. 11).

Method

The sample consisted of 116 male and female subjects from five in-patient or day-patient alcoholism programs in south-central Ontario, Canada. The ratio of psychiatric hospital-based programs to other hospital-based programs, the percentage of women in the sample and the age of the subjects were similar to those found in a provincial survey of all alcoholism programs in Ontario (Marshman, 1978), (see Table 1). Seventeen patient groups had been addressed to request volunteers for a group administered questionnaire. The potential subjects had been identified as "alcoholic" by the treatment program staff.

Table 1

Comparison of Study Sample to Marshman Report

	Study Sample	Marshman Report
Ratio of Psychiatric hospital based programs: Other hospital based programs:	2:2.8	2:3
Percentage of women in sample	14%	23%
Age	Median 31-40 Mode 41-50	Mean 39.5

Of the subjects, 52.1% were in their first week of treatment, 31.4% were in their second week, 9.9% were in their third week, 4.1% in their fourth week and 2.5% did not answer this question. The large number with shorter lengths of treatment reflects the investigator's attempts to include subjects as soon after admission as possible.

Eleven semantic differential scales were used to measure acceptance of the alcoholic stereotype and self concept. These scales are attitude measuring scales developed by Osgood, Suci and Tannenbaum in 1957. They have been used in many studies, including more than 80 which examined self concept (Wylie, 1974). However, since these scales were not developed specifically for measuring self concept, a supplementary scale, the Rosenberg Self Esteem Scale (1965), was also used. The correlation (Kendall's tau) between the Rosenberg Self Esteem Scale (RSES) and the self concept measurement on the semantic differential scales was .29 (p .001). This may reflect that the two instruments measure different aspects of the self concept. Since this study was more concerned with the parts of the self concept likely to be influenced by the alcoholic stereotype, rather than self esteem per se, the semantic differential results are the most important.

Semantic differential scales consist of adjective pairs. The subjects were asked to rate "alcoholics" and "myself" along seven point scales, for example:

sensitive ___ ___ ___ ___ ___ ___ ___ insensitive
1 2 3 4 5 6 7

The specific adjective pairs are included in Figure 2.

In addition, an item measuring denial was developed. This asked subjects to place themselves in one of three categories: (a) alcoholic, (b) problem drinker but not alcoholic, or (c) neither alcoholic nor problem drinker.

Results

Of the 116 subjects, 61% accepted their alcoholism, 28% having a problem with drinking but denied alcoholism, and 6% denied any problem with alcohol. The remaining 5% did not answer the item regarding denial. The differences in the sizes of these subgroups influenced the degree of relationship necessary to be statistically significant.

On semantic differential scales the "alcoholic" ratings were similar for all subgroups, but for semantic differential scale ratings of "myself" and RSES results, the self concept/self esteem improved with

increasing denial. Those who did not answer the denial item had the lowest scores. This is consistent with the cognitive dissonance theory, since if the dissonance were reduced through denial, a high self esteem could be maintained.

Both "alcoholics" and "myself" were rated more positively than anticipated, possibly because subjects avoided the extreme responses (valued at 1 or 7). Also the subjects had already been exposed to some treatment and had been in the company of a group of alcoholics. The relationship between self or alcoholic concept and length of treatment was not measured in this study but some past research revealed that self concept (Beckman, 1978; Burtle, Whitlock, & Franks, 1974) and alcoholic concept (Pennock & Poudrier, 1978) improved after treatment. Pennock and Poudrier (1978) found no improvement in self concept after treatment.

Profile analyses using the sign test were developed by plotting the means of each semantic differential scale adjective pair for both subject ratings of "alcoholics" and "myself" (see Figures 2, 3, 4, 5). The probability of these two profiles not crossing each other with 11 items is less than .001. In other words, this group of alcoholic subjects consistently rated "alcoholics" more negatively than "myself," the sole exception being those subjects not answering the denial item. The "alcoholics" profile and the "myself" profile appear quite similar in shape, particularly for those accepting their alcoholism. This could indicate that the alcoholic concept influences the self concept. Among those denying their alcoholism, there is a greater variation in the distance between the ratings of "myself" and "alcoholics".

The relationship between subjects' ratings of "alcoholics" and "myself" was examined on each individual scale at varying levels of denial. The bad-good scale (11.) was given particular focus since it was the most general and it was also clearly evaluative. Kendall's tau was .29 (p .01) for those accepting their alcoholism and .45 (p .001) for those only acknowledging a drinking problem. On the other hand, those denying any drinking problem had a very low and insignificant relationship (tau = .06). Several other adjective pairs revealed a similar pattern. For the subgroup who accepted their alcoholism, significant relationships were found on 6 of the 11 scales. For the "problem drinker only" subgroup, significant relationships were found on 7 of the 11 scales. The "problem drinker only" subgroup had stronger relationships on 8 out of the 11 items when compared to the "accepting alcoholism" subgroup. Only 2 significant relationships were found among those denying any problem with alcohol. Similarly, only 2 significant relationships were found among those not answering the denial item.

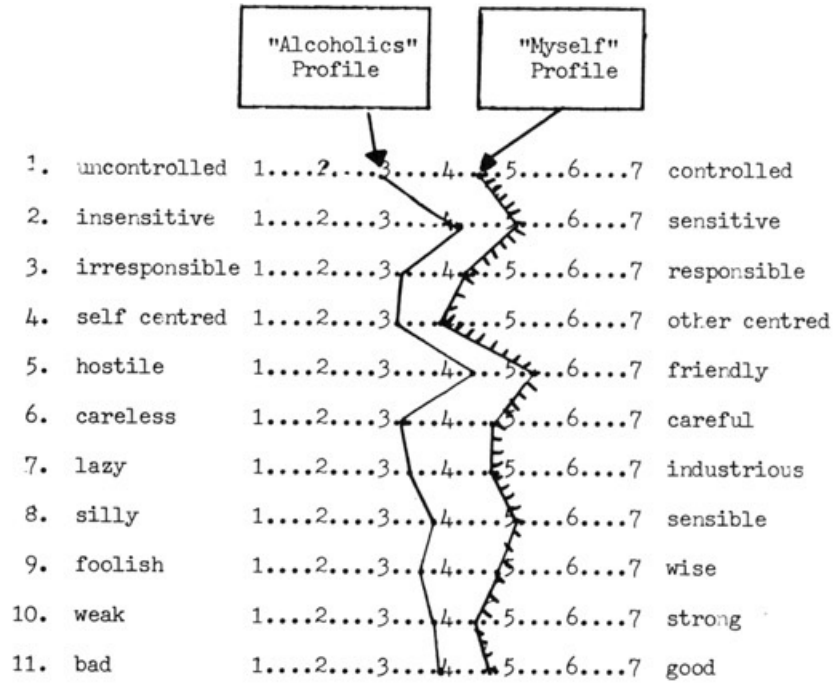

Figure 2. Profile analysis of means of semantic differential scale results for "Alcoholics" and "Myself" among those accepting their alcoholism.

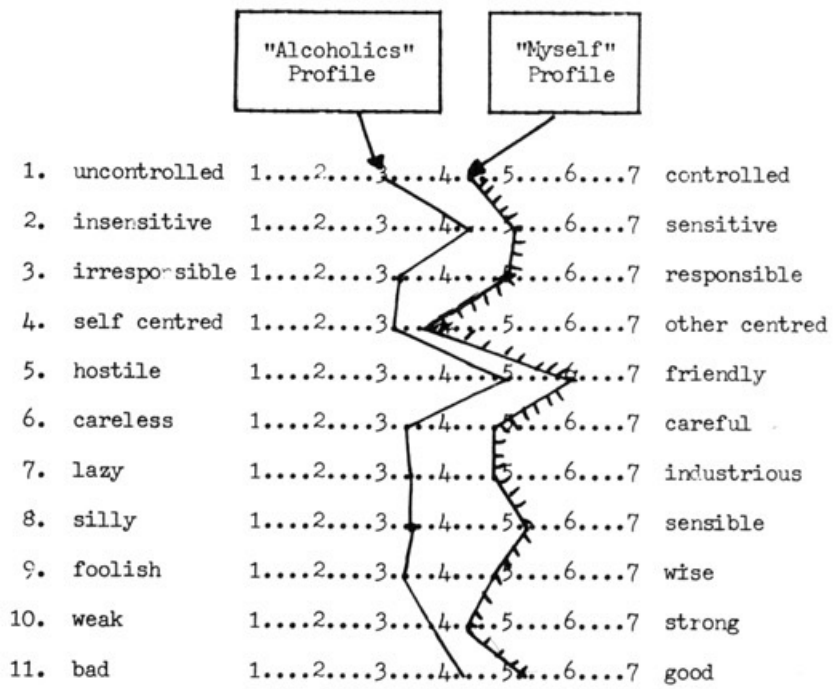

Figure 3. Profile analysis of means of semantic differential scale results of subjects acknowledging "Problem Drinking."

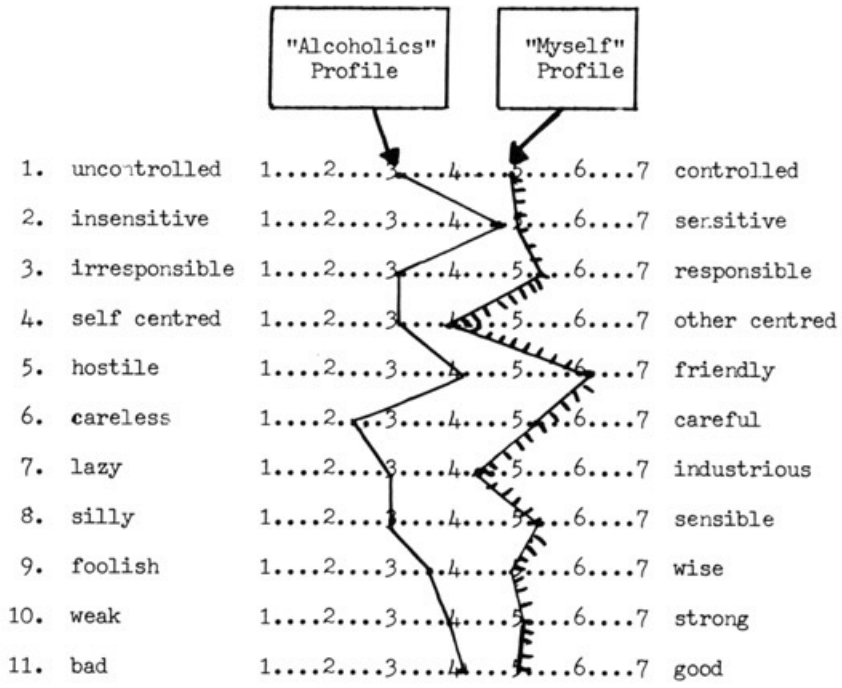

Figure 4. Profile analysis of means of semantic differential scale results of subjects denying alcoholism.

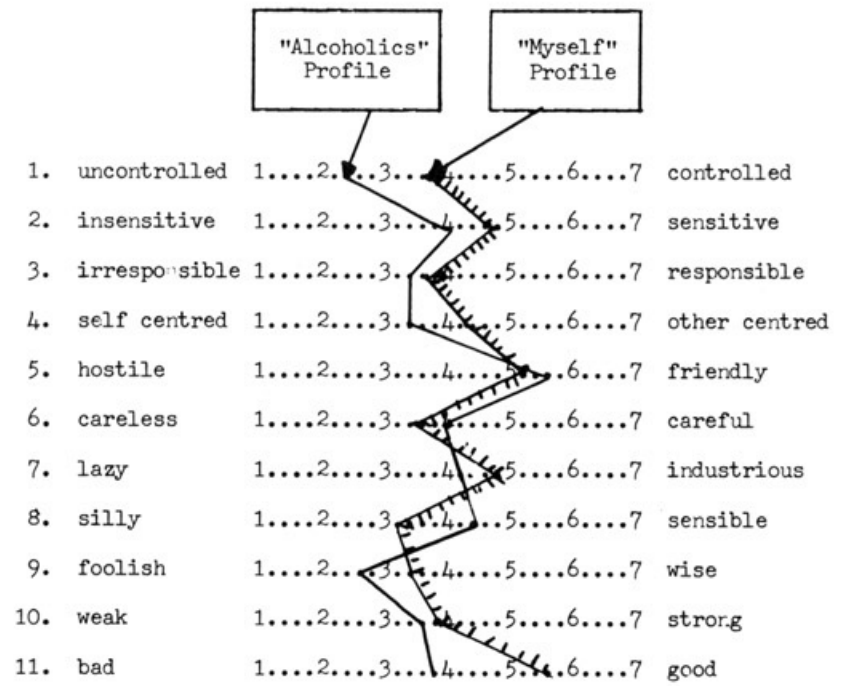

Figure 5. Profile analysis of semantic differential scale results of subjects not answering item re: Denial.

Among those accepting their alcoholism, with a possible range of 11 with the negative opinion to 77 with the most positive opinion, 6 subjects gave high totals for "myself" ($\leqslant$ 55) yet very low totals for "alcoholics" ($\leqslant$ 25). This only occurred among subjects who accepted their alcoholism.

Discussion

The results of the semantic differential scales were consistent with past studies which found that alcoholic subjects generally accepted the alcoholic stereotype (Hoy, 1973; Pennock & Poudrier, 1978; Powell, 1976) and that alcoholic subjects rated "alcoholics" more negatively than their self concepts (Pennock & Poudrier, 1978; Powell, 1976).

The relationships between the individual scale ratings of "alcoholics" and "myself" at varying levels of denial/acceptance of alcoholism support the theoretical framework of cognitive dissonance. Those subjects who accepted their alcoholism, or admitted to a problem with drinking, had significant relationships between their ratings of "alcoholics" and "myself." However, among those denying any problem with alcohol, no such relationship was found. This was anticipated since the dissonance would already be reduced through denial.

Six subjects who accepted their alcoholism had maintained a high self concept despite their acceptance of the alcoholic stereotype. Partington (1970) found that alcoholics may divide their self concepts into a "sober self" and "high self" ("high self" refers to the self while drinking). This could be an alternate method of reducing dissonance.

Unexpectedly, the highest correlations were found between "alcoholics" and "myself" among those subjects accepting a problem with alcohol, yet denying alcoholism. Why would their self concepts be closer to their concepts of alcoholics than was the case for those subjects who identified themselves as alcoholics? It appears the use of the more socially acceptable label, "problem drinker," does not avoid the influence of the stigma associated with "alcoholics." There are several possible reasons for this. It may be that avoiding a label such as alcoholic reinforces the stigma associated with it. It could be that since the problem drinker category represents only partial denial, the dissonance has not been reduced. More study is needed to understand the differences between alcoholics admitting only to problem drinking and those accepting the alcoholic label.

The results of those not answering the denial item seem quite different from the results of the other groups. Unfortunately, due to lack of further information no interpretations are made.

Implications for Nursing Practice

Cognitive dissonance may be an alternate framework to help understand the problems of denial and negative self concepts among patients diagnosed as alcoholic. A flow chart (Figure 6) has been developed to illustrate possible means of reducing the dissonance caused by the conflicting messages received by the alcoholic. This includes simply rejecting any of three messages (Routes 1, 3 and 4). It also includes (Route 5) the suggestion of Partington that alcoholics may split their self concept into "sober self" and "high self" to accommodate the alcoholic stereotype. Route 2 was included for those accepting a drinking problem but denying alcoholism. It would not be uncommon for an individual to change routes. Theoretically, if the treatment staff tried to overcome denial of alcoholism or improve the self concepts of alcoholic patients while still adhering to the stereotype, the patient would be returned to a state of cognitive dissonance.

When the stereotype is maintained, it may act as a fulcrum while the alcoholic seesaws between denial and a negative self concept. Reducing dissonance, without sacrificing a positive self concept or acceptance of alcoholism, occurs when the alcoholic either (a) rejects the stereotype (Route 3) or (b) splits his/her self concept and/or alcoholic concept (Route 5). The implication for the nurse would be health teaching and counselling to encourage rejection of the alcoholic stereotype. For example, with the patient who says "I am not alcoholic," the nurse could ask the patient how he/she sees alcoholics or how he/she might define alcoholism. Any misconception or negative attitude could then be discussed. This process might take place over a period of time.

Improving self concepts and overcoming denial are important treatment goals. Improving self concepts has been related to continued sobriety (Burtle, Whitlock, & Franks, 1974) and to alleviation of anxiety, depression and other indices of psychological distress (Beckman, 1978). Denial of alcoholism is a common treatment problem among patients diagnosed as alcoholic (Moore & Buchanon, 1966) that can be a barrier to entering treatment, and is also prognostically important (Kendall & Staton, 1966; Moore & Buchanon, 1966).

It is important for nurses to be aware of the potential influences of the alcoholic stereotype. It would also be important for nurses to be aware of their own feelings and assumptions about alcoholics.

Psychiatric nurses are certainly not the only nurses to encounter patients diagnosed as alcoholic. Perhaps if nurses in other areas, for

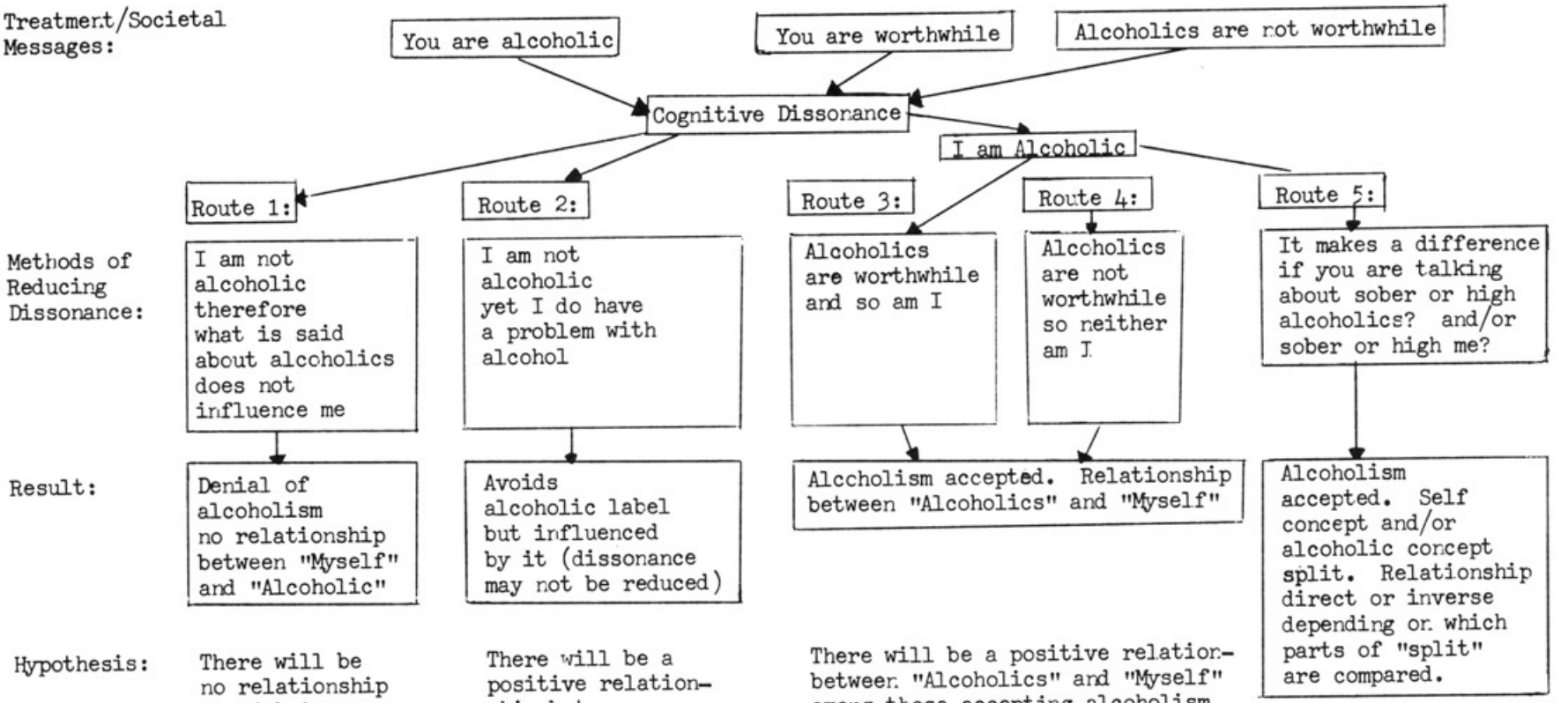

Figure 6. Routes for reducing dissonance.

example in medicine, surgery, community health and emergency, had more effective means of facilitating acceptance of alcoholism, more alcoholic patients would seek further treatment.

Suggestions for Future Study

1. Self concept, denial, and acceptance of the stereotype could be measured before and after a treatment program which challenged the stereotype.

2. The theoretical framework of cognitive dissonance could be tested among persons diagnosed as alcoholic in other settings such as Alcoholics Anonymous, out-patient treatment, jails, detoxification centres, general hospital wards, half-way houses, or non-specialized psychiatric wards.

3. A similar study could examine the families of alcoholic patients. How do their attitudes toward "alcoholics" affect their acceptance of the diagnosis and/or their concept of the identified alcoholic within their group?

4. A similar study could examine other diagnoses associated with stereotyping and stigma within a framework of cognitive dissonance. Examples could include "drug addicts," "schizophrenics," "psychiatric patients," and the "mentally retarded."

Summary

This study examined the relationship between the acceptance of the alcoholic stereotype and the self concepts of alcoholic patients at varying levels of denial/acceptance of alcoholism. The results have been consistent with those suggested by a theoretical framework of cognitive dissonance. On a practical level, this framework, if accepted, offers an alternative method of handling denial or negative self concept: challenging the alcoholic stereotype.

REFERENCES

Beckman, L. J. (1978). Self-esteem of women alcoholics. *Journal of Studies on Alcohol, 39*, 491-498.

Burtle, V., Whitlock, D., & Franks, V. (1974). Modification of low self esteem in women alcoholics: A behavioural treatment approach. *Psychotherapy: Theory, Research and Practice, 11*, 36-40.

Chalfant, H. P. (1979). Alcohol use and labelling the alcoholics: Factors in the classification of deviance. *British Journal on Alcohol and Alcoholism, 14*(2), 90-99.

Cohen, G., Griffen, P., & Wiltz, G. (1982). Stereotyping as a negative factor in substance abuse treatment. *The International Journal of the Addictions, 17,* 371-376.

Festinger, L. (1957). *A theory of cognitive dissonance.* New York: Row Peterson.

Gay, J. (1981). Self-perception as a concept of alcoholics and drug addicts. *Health Education, 12*(4), 13-14.

Heinemann, M., Moore, B., & Gurel, M. (1977). Need patterns related to treatment of alcoholism. *Communicating Nursing Research, 9,* 319-322.

Hoy, R. (1973). The meaning of alcoholism for alcoholics: A repertory grid study. British Journal of Social and Clinical Psychology, 12, 98-99.

Isaacs, M. (1977). Stereotyping by children of the effects of drinking on adults. *Journal of Studies on Alcohol, 38,* 913-921.

Kendall, R. E. and Staton, M. C. The fate of untreated alcoholics. *Quarterly Journal of Studies on Alcohol, 27,* 30-41.

Kilty, K. (1975). Attitudes towards alcohol and alcoholism among professionals and non-professionals. *Journal of Studies on Alcohol, 36,* 327-347.

Kilty, K. (1978). Some effects of type of group and sex on attitudes towards alcohol and alcoholism. *British Journal of Addictions, 73,* 11-17.

Lalonde, M. (1974). *A new perspective on the health of Canadians: A working document.* Ottawa: Department of National Health and Welfare.

Marshman, J. A. (Chairman) (1978, May). *Summary of the treatment of alcoholics: An Ontario perspective.* The report of the task force on treatment services for alcoholics. Toronto: Addiction Research Foundation.

McCartney, J., & O'Donnell, P. (1981). The perception of drinking roles by recovering problem drinkers. *Psychological Medicine, 11,* 747-754.

Moore, R., & Buchanon, T. (1966). State hospitals and alcoholism: A nationwide survey of treatment and results. *Quarterly Journal of Studies on Alcohol,* 27, 459-468.

Osgood, G., Suci, G., & Tannebaum, P. (1957). *The measurement of meaning.* Urbana: University of Illinois Press.

Partington, J. (1970). Dr. Jekyll and Mr. High: Multidimensional scaling of alcoholics self evaluation. *Journal of Abnormal Psychology, 75,* 131-138.

Pennock, M., & Poudrier, L. M. (1978). Overcoming denial: Changing the self concepts of drunken drivers. *Journal of Studies on Alcohol, 39,* 918-921.

Powell, B. (1976). Attitude changes in alcoholics following hospitalization. *Psychological Reports, 38,* 63-66.

Quereshi, M., & Soat, D. (1976). Perception of self and significant others by alcoholics and non-alcoholics. *Journal of Clinical Psychology, 32,* 189-194.

Rosenberg, M. *Society and the adolescent self image.* Princeton: Princeton University Press.

Simpson, G., & Yinger, J. (1972). *Racial and cultural minorities: An analysis of prejudice and discrimination* (4th ed.). New York: Harper & Row.

Sowa, P. A., & Cutter, H. S. (1974). Attitudes of hospital staff toward alcoholics and drug addicts. *Quarterly Journal of Studies on Alcohol, 35,* 210-214.

Tamarin, J., & Neumann, C. (1974). The alcoholic stereotype: Clinical reappraisal and implications for treatment. *American Journal of Psychoanalysis, 34,* 315-323.

Wallace, J. (1977). Alcoholism from the inside out: A phenomenological analysis. In N. Estes & M. Heinemann, (Eds.). *Alcoholism: Development, consequences and interventions.* St. Louis: Mosby.

Wallston, K. A., Wallston, Strudler B., & DeVellis, McEnvoy B. (1976). Effect of a negative stereotype on nurses' attitudes toward an alcoholic patient. *Journal of Studies on Alcohol, 37,* 659-665.

Wylie, R. (1974). *The Self Concept Vol. 1: A review of methodological considerations and measuring intruments,* Lincoln: University of Nebraska Press.

RÉSUMÉ

Discordance cognitive: dénégation, images négatives de soi et le stéréotype alcoolique

Des questionnaires ont été remplis par 116 sujets inscrits à des programmes de désintoxication de l'alcool. Les rapports entre l'image de soi et l'acceptation du stéréotype d'alcoolique ont été analysés à divers niveaux de dénégation/acceptation de l'alcoolisme. Parmi les sujets acceptant l'étiquette "d'alcoolique latent" ou "d'alcoolique," on a constaté respectivement 7 et 6 rapports entre les évaluations de "soi" et "d'alcoolique" sur 11 échelles différentielles sémantiques. Seulement deux de ces rapports importants ont été constatés chez les sujets niant tout problème d'alcool. Ces conclusions sont compatibles avec un cadre théorique de la discordance cognitive. Ce cadre, s'il est accepté, servirait de nouvelle mesure de soins face à la dénégation de l'alcoolisme ou à l'image négative de soi chez les patients que l'on a diagnostiqués comme alcooliques: il faut contester le stéréotype.

ACCREDITATION REVIEW: STRATEGIES, COSTS, AND BENEFITS

Elizabeth Kauffmann • Sharon Ogden Burke

Historic Overview

University schools of nursing in Ontario have been participating in a peer approval process since 1976. The Ontario Region of the Canadian Association University Schools of Nursing (ORCAUSN) formed an Accreditation Committee to develop and implement the approval process for Ontario in the belief that the profession should participate in the self-discipline of its members. This practice has implications for the educators of the profession, as well as for the practitioners.

CAUSN aspired to an accreditation program in 1972 by setting out a method to ensure quality in nursing education. Accreditation is viewed as the desirable and optimal attainment of standards (CAUSN, 1979). Approval has evolved to mean that the standards for measurement are at or near the minimum necessary to achieve an identified goal. Accreditation involves approval, but in most cases it includes standards for measurement which encompass a goal of excellence. Although Ontario has an Accreditation Committee, the title is anomalous since measurement and evaluation is actually limited to standards of approval.

The approval process provides some insurance to the public, the profession, the student body, the faculty of the school and the administration of the university that the nursing curriculum assessed is or is not meeting current minimum standards.

Prior to 1974 the College of Nurses of Ontario was responsible for approving all schools of nursing in Ontario. With the change to the Health Disciplines Act of 1974, the College no longer exercised this function, thus leaving nursing schools in the province without a systematic approval process.

Elizabeth Kauffmann, R.N., M.Ed., is assistant professor, and Sharon Ogden Burke, R.N., Ph.D., is associate professor, School of Nursing, Queen's University, Kingston, ON.

The authors wish to recognize Dr. Iola Smith's contribution to the preparation of the report and suggest that her experience as nurse educator and researcher was instrumental in providing worthwhile criticisms to the process.

University schools of nursing in Ontario currently receive approval through ORCAUSN's review process. In turn, ORCAUSN, on a voluntary basis, informs the College of Nurses of the status of a university program.

There are eight university schools of nursing in Ontario. Initially, a schedule was prepared whereby two schools of nursing per year would be required to submit an "intensive" report for the assessment of their programs. The remaining schools were required to submit relatively brief annual reports. Guidelines were prepared by the ORCAUSN Accreditation Committee for both the intensive report and the other annual reports. For each school the intensive review and reassessment for approval of their respective programs takes place every five years. In 1981-82 the last of the eight schools of nursing were scheduled for the initial intensive review. Queen's University School of Nursing was one of those schools.

This article does not address the philosophical elements of approval or accreditation, nor does it develop the faculty's beliefs regarding either process; it addresses the process rather than the content of approval from the perspective of an academic and professional task that has to be done. The essence of the task is self-evaluation and the method to achieve this developed by Queen's School of Nursing for its initial indepth review by ORCAUSN proved to be successful.

Early Planning

In order to meet the requirements of the Accreditation Committee, a body of specific and complete information must be submitted. As a beginning to the preparation of a report, the school had to decide: (a) when to begin assembling the information; (b) what information would be needed; (c) how to present the material; and (d) who would be responsible for preparing the report.

A variety of management strategies may be used to accomplish this end. In some schools or faculties, the Dean or other senior faculty may prepare the entire report. At Queen's the following strategy was used. The Dean delegated the responsibility of assembling the report to a standing committee, the Curriculum Steering Committee, which has general responsibility for philosophy, policy, and long-term planning in regard to curriculum issues. This committee began 14 months in advance of the due date to organize a schedule of activities and inform the Faculty Board (all members of faculty, representatives of the student body, and class presidents) of the anticipated work schedule.

Three entities who would work both independently and collaboratively were identified by the committee; these were, the faculty course teams, the committee, and the Dean. For purposes of continuity, the report itself was to be drafted by a single person.

Based on the work of Hawken and Reed (1978), the committee prepared a flow chart (Figure 1) for the approval process at Queen's. We used a 12-month period to prepare ourselves, whereas Hawken and Reed thought that 18 months was needed. Initially, one year seemed sufficient and we were able to meet the earlier deadlines; however, the final preparation of the report was rushed. Perhaps this final rush would still have taken place had we given ourselves more time.

Proposed Approval Timetable

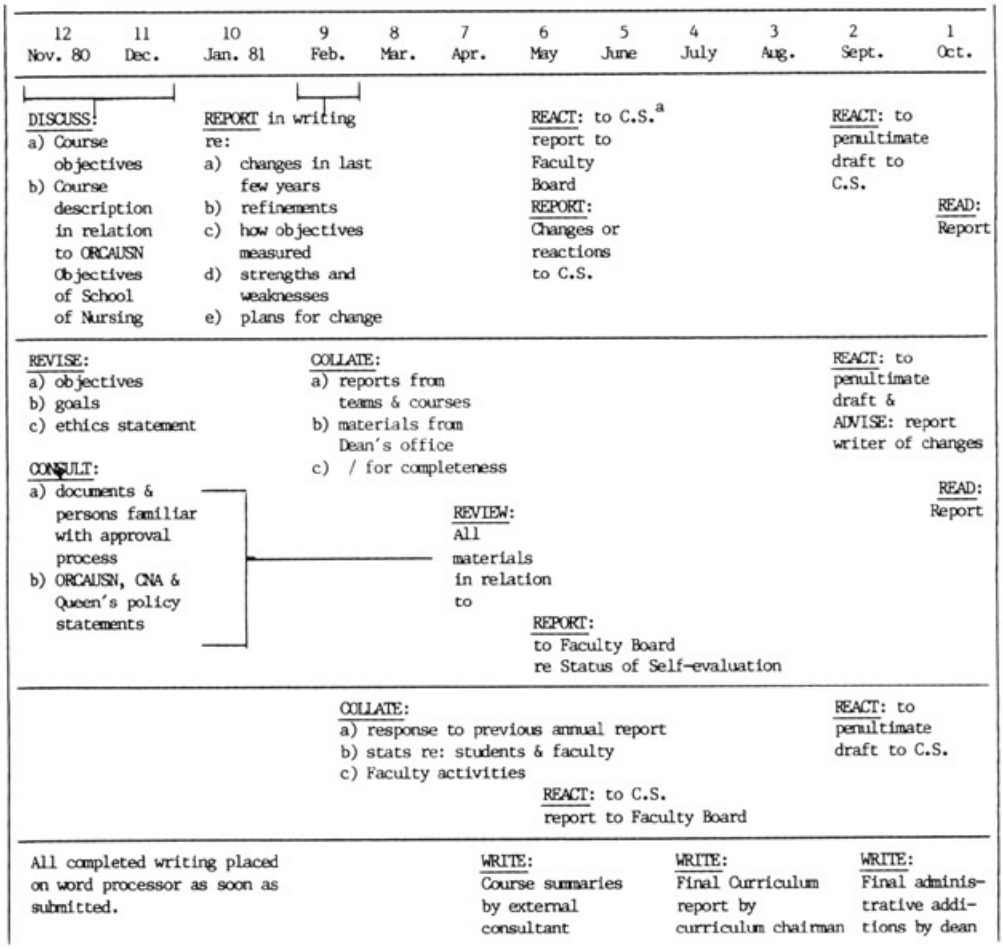

Figure 1. Flow chart used to direct and co-ordinate work on approval.
[a] Curriculum Steering Committee.

The flow chart was discussed at length at our Faculty Board meetings and approved with some modifications. This was an early step in involving everyone and soliciting cooperation from all participants in what we viewed as a self-evaluation process.

The flow chart presented here represents the actual timing of the events. A number of factors modified our initial timetable. For example, the time allocated for the activities from May to August was too brief, that is, it took longer to have the teaching teams review the material than was initially anticipated. Other factors which affected this schedule were summer holidays, availability of faculty time relative to other departmental responsibilities, and secretarial resources.

Approval Review in Ontario

The ORCAUSN guidelines for the approval process provided the overall direction for the content of the report. Queen's had submitted annual reports from 1977 to 1981, when the intensive review was scheduled to take place. However, although the ORCAUSN Accreditation Committee had favourably received our annual reports, the committee decided not to use them as the background information in support of our intensive review. The report for review would have to stand on its own.

Development of Report Content

With ORCAUSN statements and guidelines as a framework and our flow chart as a guide, faculty members began to collect information for our self-evaluation. While attention was primarily directed toward course objectives, learning experiences and evaluation methods, it was first necessary to present an overview of the entire curriculum and of each course. To compile all this information about each aspect of the curriculum would have resulted in a voluminous report and would have been an unwieldy task for the reviewers. The committee chose, therefore, to present all the main course objectives, with only samples of contributing objectives, related theory, clinical experience, and evaluation methods. For clarity, all supporting data were presented in table form, as illustrated in Figure 2.

Furthermore, the ORCAUSN directive that materials can be presented in any form considered most appropriate to the individual program, allowed us to create a format which we felt would reflect our curriculum most accurately. As a result, lengthy narrative was kept at a minimum, point form was used wherever possible and charts and grids were used extensively in the final report. This presentation

assisted the reviewers to gain a better understanding of the continuity as well as the increasing complexity of a program. Samples of our use of charts and grids are presented in Figures 2 and 3.

Maternal and Child Nursing: Examples of Course Objectives Related to Theory, Practice and Evaluation

Central Objectives	Specific Objectives	Content: Theory	Content: Practice	Methods of Evaluation
II The student will adapt and utilize the nursing process in giving family centered maternity and pediatric care.	2. Applies the nursing process satisfactorily during labour, and delivery to the family including: b) the monitoring of patient in labour, during delivery and in the immediate post-partum period.	Labour and delivery: normal and deviations from normal.	Participates in the care of patient (in labour, delivery and post-partum) and newborn (care, post-partum and discharge teaching.	- Anecdoted notes - Evaluation of clinical practice by means of a check list of behaviours. - written assignment Nursing Care Plans (2)
I The student will build on his/her knowledge of the physical, social and nursing sciences as they relate to obstetrics and pediatrics.	4. Will gain community visiting experience, with a young family. It is expected that the student: b) takes the responsibility of meeting the individual needs of their specific family by concentrating on: i) the adjustment of the family to crisis including a detailed assessment of parenting capabilities.	Developmental: Assessment of the newborn, infant. Nutrition.	3 home visits to families with a new baby or - preparing a child for in & out surgery	- Family folder - minimum of one supervised visit

Figure 2. Excerpt from a course summary table to illustrate format used.

Interface of ORCAUSN and Queen's Objectives

The program objectives had recently been reviewed, revised, and judged to be consistent with both the ORCAUSN statements on baccalaureate nursing and the individual nursing course objectives. These conclusions led to the generation of two grids. The first was the display of ORCAUSN's Statement on Baccalaureate Nursing on the side and Queen's program objectives on the top. The second grid showed the correlation between the Queen's program objectives and the supporting content in the nursing and required supporting course in our curriculum (Figure 3).

Initially, the ORCAUSN requirement of demonstrating increasing complexity in the curriculum was not readily apparent solely on the basis of our descriptive charts and summaries. The description of the curriculum and the rationale was clear, but a presentation of the manner in which we provided for increasing complexity throughout the

Summary of Program Objectives Addressed Within Individual Nursing Program Courses — As stated in Course Material (1980-1981)

KEY: The degree marks (o) imply that all passing students would have learning experience directly related to the particular program objective. They represent major foci of each course. The arrows (↓) signify comprehensive coverage of the program objectives.

PROGRAM OBJECTIVES (abbreviated form)	124	139	226	BIOLOGICAL & PHYSICAL SCIENCE	322	327	328	339	413	416	419	420
I Applies the Nursing Process			↓			↓	↓	↓		↓		↓
a) gathers data	o											
b) makes nursing diagnosis	o				o							
c) sets objectives												
d) establishes priorities												
e) designs a plan for intervention	o											
f) implements plan	o											
g) evaluates outcomes	o				o							
h) validates throughout		o			o							
i) organizes data in format		o	↓		o	↓	↓	↓		↓		↓
II Develops a broad base of knowledge		o	o							↓	o	
a) comprehends relevance to nursing	o		o		o	o	o		o		o	
b) applies knowledge to practice	o		o		o	o	o					
c) uses knowledge to human beings in reaction to crisis			o		o	o	o					
d) implements findings after critical appraisal					o				o			

Figure 3. Excerpt of chart used to present information on relationship of program objectives and course content.

program was not as apparent as we would have liked. Thus, one further type of grid was prepared to identify a thread throughout the four years of the program, illustrating the related objectives, kinds of learning experiences, and evaluation methods. This last format is not only useful for accreditation reports, but has been used for the continuing evaluation of various aspects of a program.

External Consultant

In order to examine our curriculum more objectively, it was decided to hire a researcher-writer who could provide an unbiased assessment and synthesis of the course materials. The person selected was Dr. Iola Smith, a nurse, educator and researcher. Her role evolved into more like that of an external reviewer.

Dr. Smith attended a one-day committee meeting where members presented their synthesis of course materials submitted by the course teachers, along with our interpretation of their fit with our program objectives. Playing the role of devil's advocate, Dr. Smith was able to point out gaps and lack of clarity in our materials.

From the course materials, Dr. Smith synthesized the key elements into a descriptive format which eventually came to be called the course summaries. See Figure 2 for an excerpt from one course summary. Each course summary contained: the course description, client focus, evaluation methods, key readings, a statement of how the course interfaced with other nursing courses; charts illustrating examples of course objectives and relationship to theory, practice and evaluation, strengths and weaknesses of the course, and plans for change. This objective review stimulated teaching teams to engage in an evaluation of their written material. Unexpectedly, this turned out to be one of the most positive outcomes of the review process. Dr. Smith's review and synthesis of our materials helped to identify weaknesses in describing the content of our courses. Thus, teaching teams were able to revise Dr. Smith's summaries to make them a succinct and accurate reflection of course content. These summaries can be useful for a presentation of our curriculum to a wider audience, for example, to students or the community.

Refining the Content

A major concern throughout the preparation of the report was to present a consise representation of our curriculum as it provides for attaining the program objectives, the university goals, and the ORCAUSN objectives. The committee received information from the teaching teams, professors, and Dr. Smith and then prepared selected materials for course summaries, charts, and grids. These were then sent back to the teachers and teams for critical appraisal in relation to accuracy and detail. The teaching teams then returned the drafts to the committee with suggestions for revisions. Revisions were made and again reviewed by the teaching teams. In the case of the course summaries, the review and revision was often done by the team leader and the cycle repeated two or three times before consensus was reached regarding the material to be placed in the final report. The Dean had the formidable task of writing the sections of the report that dealt with the introduction, history and resources of the university, follow-up of graduates and statistics.

Based on informal consultation with faculty members experienced with reviewing curricula, it was decided to select only a few exemplary student handouts, bibliographies, etc., for inclusion in the appendices. The body of the report was reserved for the presentation of the overall curriculum, while the appendices contained the supporting evidence. This approach was chosen to avoid a frequent problem observed by reviewers of reports containing either too much uncoordinated data or not enough supporting data on which to base an evaluation.

Word Processing

Extensive use was made of a word processing micro-computer system at the Queen's School of Nursing in preparing the report. The text was entered, revised, formatted, and the original copy produced on the hardware. We use the Q-TEXT word processing software programs, but many other systems, such as WORDSTAR, on an Apple, Pet or TRS-80 would work as well.

The word processor is particularly useful in the preparation of a report that goes through many drafts. Another advantage is that much of the information for the report was already on file within the computer and could be easily integrated into the report without the usual "cut, paste and retype." Examples of stored information we used are lists of faculty research projects and the School's five year plan.

The bulk of the report was typed into the processor by our support staff. However, minor corrections could have been easily made by anyone after the brief introduction to the system, using a self training manual (Q-TEXT, 1980).

Costs

We found the preparation of the 38-page report, plus 132 pages of appendices, very costly. The major costs were faculty time, support staff time, and printing. A conservative estimate of the cost of preparing the report is $7,772, 1981 dollars. The breakdown can be seen in Figure 4. This works out to about $45 per page!

	# people	Estimated Total # hours	Estimated[a] $
1. Individual Faculty members time including Dean	22	142	3,026
2. Committee time			
2.1 Curriculum Steering	4	14[b]	938
2.2 Teams, all courses	27	1-2[b]	527
2.3 Faculty Board	20	1[b]	260
2.4 Executive	6	1[b]	105
3. Support Staff time	2	175	1,397
4. Report writer	1	26	392
5. External reviewer[c]	1	5days	897
6. Printing	-	-	230
Total			7,772[d]

[a] At 1980-81 rates, includes fringe benefits
[b] Total hours in committees
[c] Includes some travel, accommodations, etc.
[d] Excludes all stationery, and supplies used in the many drafts.

Figure 4. Estimated costs of accreditation report production.

Conclusion

Based on our report, the school has been approved by ORCAUSN with their Committee's thanks for a "well organized and complete report." There were no requests for additional information. The reviewer stated that "The consise and well organized format of the report submitted by Queen's facilitated the review process" (ORCAUSN Accreditation Committee, 1982).

The primary benefit to the school and faculty was that the program had to be reviewed in a way that demanded careful scrutiny and justification of the curriculum by those who were involved with implementing it. The faculty members' understanding of how the curriculum provided for continuity, increasing complexity and congruency with ORCAUSN beliefs about baccalaureate nursing education was strengthened.

REFERENCES

CAUSN Committee on Accreditation. (1979). *Development of a method to promote growth and change in university schools of nursing and in nursing in general.* Ottawa: Canadian Association of University Schools of Nursing.

Hawken, P. L., & Reed, S. B. (1978). Preparing for accreditation, *Nursing Outlook, 26,* 761-765.

ORCAUSN. (1979). *Position statement on baccalaureate education in nursing.* Toronto: Ontario Region Canadian Association of University Schools of Nursing.

ORCAUSN. (1979). *Approval process for basic baccalaureate programmes in nursing.* Toronto: ORCAUSN.

ORCAUSN Accreditation Committee. (1982). *Report of the intensive review of Queen's University School of Nursing.* Toronto: ORCAUSN.

Q-TEXT Manual. (1980). Kingston: Queen's University.

RÉSUMÉ

L'agrément: stratégies, coûts et avantages

Pour obtenir l'approbation de l'Association canadienne des écoles universitaires de nursing (Ontario), les écoles de baccalauréat en sciences infirmières de l'Ontario doivent, tous les cinq ans, faire l'auto-évaluation de leur programme et en présenter le rapport au Comité d'agrément de l'association provinciale (ORCAUSN). Le présent article fait état des stratégies utilisées par les professeurs dans l'auto-évaluation de leur programme: plans de cours, consultant, traitement de textes; on y aborde également les coûts et les avantages de l'auto-évaluation.

RÉPLIQUE

Madeleine Clément

L'article des auteurs Kauffmann et Burke intitulé "L'agrément: stratégies, coûts, et avantages" porte, en réalité, sur la démarche suivie par l'École des sciences infirmières de l'Université Queen, pour obtenir l'approbation de son programme d'études par l'Association canadienne des écoles universitaires de nursing, région d'Ontario (ORCAUSN). En effet, depuis 1976, l'approbation des programmes d'études de sciences infirmières des universités ontariennes est faite par un Comité d'agrément qui relève de l'ACEUN régionale (ORCAUSN, 1983). De l'avis des auteurs, le Comité d'agrément d'Ontario dont il est question devrait plutôt s'appeler Comité d'approbation, du fait qu'il se réfère à des normes de qualifications minimales pour évaluer les programmes d'études. Cet article donne au lecteur l'occasion de différencier le processus d'agrément de celui d'approbation.

Le but du processus d'agrément est de favoriser la croissance et le développement optima des programmes d'études. L'agrément est un processus volontaire par lequel un organisme externe et non gouvernemental évalue un programme d'études et reconnaît qu'il répond à des normes d'excellence ou standards. Les normes dépassent les limites de la qualification minimale nécessaire à l'approbation d'un programme. Une école qui demande volontairement et reçoit d'un organisme externe l'agrément de son programme, fournit au public une "certaine" assurance de qualité et valorise son programme. Dans certains cas, un programme n'est éligible pour l'agrément que s'il est d'abord approuvé par l'organisme compétent (ACEUN, 1983). L'approbation d'un programme est obligatoire et relève d'un organisme établi en vertu d'une juridiction provinciale. Son but est de protéger les intérêts du public en garantissant que les normes minimales d'un programme sont respectées (ACEUN, 1983).

Stratégies, coûts et avantages

Les auteurs Kauffmann et Burke mettent en relief l'importance de l'auto-évaluation dans la démarche suivie par leur école, pour obtenir l'approbation du programme d'études. Bien que reconnaissant la valeur de l'auto-évaluation, il faut se rappeler que celle-ci fait partie du processus de revision inhérent au bon fonctionnement de tout programme d'études. Quant à l'agrément d'un programme, il repose à la fois sur l'auto-évaluation et sur l'évaluation faite par un organisme externe; c'est d'ailleurs cette évaluation externe qui donne de la crédibilité au programme agréé.

Madeleine Clément, inf., M.Nurs., est professeur agrégée, Faculté des sciences infirmières, Université de Montréal.

Le coût estimé pour la préparation du dossier d'approbation est exorbitant lorsqu'il est exprimé en dollars/page de texte dactylographié. Toutefois, si l'on considère que plus de la moitié du coût estimé consiste en temps faculté, et qu'une dimension importante de ce temps faculté consiste justement à faire l'évaluation du programme, le coût de revient de la préparation du dossier est plus modeste. Une façon de diminuer les coûts serait de faire appel à un organisme national capable de jumeler approbation et agrément de programme d'études; un tel organisme d'agrément desservirait un plus grand nombre d'écoles et de facultés et favoriserait la baisse des coûts de services pour chacune d'entre-elles.

Les auteurs concluent que l'auto-évaluation du programme a permis une revision minutieuse du curriculum et une meilleure compréhension de ce dernier. On peut supposer qu'une évaluation objective faite par un organisme externe tel un comité d'agrément, ajouterait aux avantages reliés à l'auto-évaluation.

RÉFÉRENCES

ACEUN. (1983). *L'agrément: critères et méthode pour les programmes de baccalauréat en sciences infirmières.* Ottawa: ACEUN. Document de travail.

ORCAUSN. (1983). *Preparation of submissions by baccalaureate nursing programs undergoing review for approval by the ORCAUSN. Accreditation Committee.* Toronto: ORCAUSN.

SUMMARY

The title of the article "Accreditation Review: Strategies, Costs, and Benefits" by Kauffmann and Burke implies a review of the accreditation procedure but the article, in fact, explains the auto-evaluation process used by the Queen's University School of Nursing in preparation for the five year approval of their program by ORCAUSN. The article obviates the need for a distinction between simple approval based on minimal provincial standards and national accreditation based on professional excellence. While the authors show the costs of approval to be exorbitant, their calculation includes faculty time devoted to auto-evaluation, an ongoing function of all programs. Appropriately corrected, the real costs are more modest. The authors conclude that auto-evaluation requires a careful scrutiny and justification of the curriculum which leads to a greater understanding of the program. An objective evaluation conducted by an external accreditation committee could provide greater insight and even greater understanding of the program.

NONTRADITIONAL CLINICAL SITES IN BACCALAUREATE NURSING EDUCATION

Miriam Joyce Stewart

Obtaining clinical sites for student experience is a major problem for nurse educators. A survey of 90 baccalaureate nursing schools revealed that 80 percent of clinical placements are concentrated in seven "traditional" settings: secondary-care agencies, homes, health departments, outpatient departments, tertiary-care settings, community health agencies, and schools (Graham & Gleit, 1981). Based on this finding, one could surmise that traditional placements incorporate in their philosophy, goals and objectives, a central focus on health care delivery and a clearly established nursing role.

Most faculty in schools of nursing have resisted change with regard to selection of clinical locales (Hawkins, 1980; White, Knollmueller & Yaksich, 1980). However, the goal of baccalaureate nursing education is to prepare a liberally educated individual to enter professional nursing practice in a variety of settings (Debeck, 1981; Kernen, 1979; Kramer, 1981; Thomas, 1979).

The School of Nursing of Dalhousie University, which adheres to this mainstream philosophy, is not unique in facing the inescapable fact that expanding enrolments ensure survival in an era of fiscal stringency. The evolutionary movement toward minimal baccalaureate preparation for the professional nurse will provide the impetus. However, the resultant increasing number of students requiring practical experience exceeds the capacity of conventional institutions to meet the demand. The accompanying inefficient trend of overloading certain agencies while avoiding others must be reversed.

Consequently, since 1977, our final year baccalaureate students have been allocated progressively to more "nontraditional" than traditional sites. The implementation strategies and impact of this five-year trial distribution of more than 200 students to 30 unique clinical settings are delineated.

Selecting Clinical Sites

The clinical curricular component of our school encompasses the "stress-adaptation" conceptual framework. The objectives of this fourth-year course emphasize the ability of the student to function as a client advocate, to facilitate the client's adaptive processes, to assume responsibility for personal growth and development, and to be accountable for individual interventions. The development of critical analytical thinking is the ultimate goal of this course.

Miriam Joyce Stewart, R.N., M.N., is associate professor, School of Nursing, Dalhousie University, Halifax, NS.

This paper was originally accepted for publication in January 1983.

Opportunities have to be provided for these senior students to adapt to communities and community groups, problem-solving, communication, teaching, change-process and leadership skills previously applied to individual and family-centred care. Therefore, traditional settings were explored. However, not all students could be readily accommodated by community-health agencies for an extended "reality-based" experience. Therefore, the search for clinical placements was initially expanded to include community settings with an obvious health component, such as physicians' offices; preventive medicine, prenatal, child guidance and drug clinics; family-medicine centres, and the Cancer Society. Later, nontraditional agencies with no readily apparent health focus, including social service departments, school guidance departments, and youth drop-in, day care and neighbourhood centres, were approached.

An alternative approach to the selection of nontraditional sites could have been geographic dispersal of the students. However, peer support and faculty guidance would have been less accessible. Furthermore, transportation, living accommodations, and timetable problems impeded consideration to this option.

The agencies selected met implicit criteria which evolved directly from the objectives of this clinical course. Specifically, they provided the opportunity for students to function independently and interdependently while focusing on the community as client. The assumption that traditional agencies tend to emphasize therapeutic and to a lesser extent preventive interventions, to the virtual exclusion of health-promotion activities, was not *initially* the primary determinant in site selection.

Students are placed in one of these settings for the equivalent of eight hours a week during their senior year. To develop initiative and responsibility for personal learning as well as to initiate the process of cutting the umbilical cord, instructors are rarely present while students are in the agency. Therefore, students learn to consult appropriately the agency staff (both nurses and nonnurses) as resource people. They develop individual projects that relate not only to the clinical course objectives, but also to the agency's goals and regulations. As these placements vary widely, so do the functions, roles and activities of the students.

Illustrations of the scope and diversity of these student experiences follow.

Neighbourhood Centre

Most staff members employed by this centre, located in the vicinity of a low-income housing development, are paraprofessional social workers and child-care workers. The flexible, loosely structured atmosphere meets the socialization and support needs of residents.

Following initial culture shock (Toffler, 1970) students became involved in incorporating health-related topics into a women's weekly discussion group; teaching preschoolers about hospitalization, safety and immunization; and leading after-school, latch key group programmes on babysitting and first aid. They concluded their experience by designing a comprehensive inservice programme on human sexuality. This addressed an acknowledged need of staff for preparation in relevant counselling and education techniques.

Youth Drop-in Centre

This particular centre serves transient and resident teenagers in a downtown area. Its location above a popular health-food store and the staff's casual dress create a homelike atmosphere for the adolescent target group.

Here, two nursing students developed group health education posters and programmes focusing on smoking, drugs, nutrition and family planning. These programmes were then implemented not only in the centre itself, but also in neighbourhood schools, libraries, and a mobile Youth Caravan.

Social Service Department

The stated objectives of this metropolitan agency revolve around the provision of family support, child protection, placement and counselling services, in addition to short-term financial assistance.

Through contacts with residents and professionals, students assessed the unbalanced nutritional intake as a priority problem. Working in direct collaboration with a social worker, a nutritionist, and a representative of the Senior Citizens' Council, they produced television programs, pamphlets, informational sessions and a cookbook for the single person on a restricted diet.

Multi-service Centre

A centre combining social, recreational and health-related services under one roof and linking others in the surrounding communities in a liaison system was opened recently, in a newly developed suburban community where transience and parenting and marital problems prevail. The home-nursing and public-health agencies, representing the largest proportion of community-health nurses in the area, are not located in the centre itself. Cooperation and collaboration are the key

operating principles of the centre. Multiple disciplines are co-ordinated by the executive director — a social worker.

Prior to the establishment of the centre, nursing students joined with social work students in developing an information registry of community and agency services in response to an expressed need of residents. Following the opening, the nursing students assessed community residents' reaction to, and awareness of, the services offered and produced innovative informative shopping mall displays. Furthermore, they made valuable contributions to board and committee meetings, ranging from interpretation of consumer perceived needs to shared evaluation of the group's process and progress.

YMCA

The medical clinic component of this recreational centre caters mainly to the needs of urban, middle-class residents. Ongoing programmes include fitness testing, prenatal and postnatal classes, cardiovascular risk assessment and recovery programmes, and stress testing.

Following an initial assessment of the agency and its clientele, one student conducted exercise classes and pulmonary function tests. This decision was based on a personally assessed need to learn approaches to lifestyle assessment and health promotion. Another, developing her teaching and group-process skills, helped coordinate a group for obese adolescent girls, developed a comprehensive report on the group's progress and formulated recommendations for the future. Students began to develop and demonstrate a role for the nurse in a structured setting in which only the physician, physical educator and nutritionist had clearly established functions. Hence, exciting new channels for nursing input had been discovered.

Student Insights and Accomplishments in Nontraditional Settings

Consider the experience of nursing students in the neighbourhood centre described. Initially, they had difficulty bridging the gap between their own middle-class, health-oriented values and those opposing views of the staff and clients. Accustomed to taking orders from instructors, head nurses and physicians and to wearing immaculate white uniforms, the students did not have specifically assigned duties and had to wear jeans to establish credibility.

Initially, students worked with the women's family-life group: they lectured on childhood diseases, nutrition and exercise — problems they assumed that this primarily middle-aged, overweight, single-parent group would be concerned about. However, they learned quickly that these women saw the centre as an escape from daily drudgery, a place to meet friends, have coffee and share concerns.

Students recognized the value of flexible, informal discussion sessions, incorporating films and role playing, and spontaneously addressing issues raised by members.

Further, students observed that attendance improved when group members themselves identified topics for discussion, and when they used outreach tactics such as advertising in a neighbourhood newsletter. Thus, problems as varied as living accommodations, religion, schooling, parenting, rape and family violence became the new diverse health-related foci of stimulating sessions.

The concept of individual rights was applied as students began to connect theories of poverty taught in the classroom to the feelings of powerlessness these women were experiencing. These graduating nurses came primarily from middle-class backgrounds that emphasized ambition and hard work as the sure road to success. Only practical experience showed them that this group, which they had labelled "indifferent" and "apathetic" by *their* standards, was responding defencelessly to barriers imposed by living conditions in this neighbourhood. This discovery was reinforced by home visits where the students were confronted with "cement playgrounds, littered garbage and homes in disrepair."

Students established contact with appropriate resource people, including clergy, housing authority personnel, family planning physicians and nurses, and crisis centre workers, as they acknowledged the futility of working in isolation when dealing with complex health issues. Thus, residents were introduced to potential health-related services available to them.

Advantages and Disadvantages of Use of Nontraditional Settings

The benefits accrued from using these diverse nontraditional sites for community-health clinical experience were numerous. Students

1. enlarged their perspective of the scope of health-care services and community resources and identified obstacles and gaps in the health-care-delivery system;

2. participated actively in interdisciplinary teams and learned the roles of many health-related professionals and paraprofessionals;

3. confronted their personal values and stereotyped attitudes;

4. through a process of contracting, involved consumers in the planning and evaluation of care, thus developing client advocacy skills;

5. practised group-leadership skills and merged individualistic approaches basic to nursing with aggregate strategies basic to community health;

6. provided valuable contributions to the community and agency as they negotiated and developed nursing functions and activities;

7. gained self-confidence and acted autonomously and responsibly; and

8. most significantly, reinforced and demonstrated their inherent belief that health is much more than a physical state — that its social, spiritual and psychological components must be intermingled in health-promotion interventions.

To summarize, the students learned how to facilitate the clients' efforts (whether individual, family or community) to assume independence and responsibility for health status. Maddison (1980) notes that the complexity of such professional-consumer relationships has been a neglected dimension of professional education. In these settings, students acquired and improved skills related to teamwork, communication, analytical problem-solving, self-evaluation and accountability. Epidemiological principles, systems theory, stress-adaptation concepts and the nursing process itself assumed new meaning as students applied them to communities and community groups. Finally, they gained proficiency in the application of change strategies. In short, the knowledge acquired and the skills mastered in a nontraditional milieu related directly to the objectives of this clinical course.

The vast majority of feedback from agency preceptors at the end of the academic session was favourable. However, it must be acknowledged that time and energy were expended and frustration and resistance encountered as nursing roles were integrated into nontraditional agencies. Some of the resistance that occurred appeared to be related to the traditional view of "legitimate" nursing functions held by some students and by staff in structured settings. Therapeutic "laying on of hands" and technical skills persisted as perceived practice needs. Nagging doubts, reflected in such phrases as "waste of time doing nonnursing activities" and "never be employed in such settings," surfaced in the initial phases of the experience. Further, the "go-to-it" attitude conveyed by staff in the more unstructured sites disconcerted students who craved explicit direction and who interpreted this as disinterest.

Agency staff in some volunteer- and other-discipline-run departments had to witness demonstration of a nursing role over a period of years in order to provide useful evaluation of student performance and to facilitate the entry process of new students. Initially, guidance counsellors, social workers, and medical practitioners did not comprehend or acknowledge the nursing skills of counselling and client education. As staff in these agencies changed, an intense orientation

session was a requisite element. Further, review for experienced preceptors was frequently necessary. Even public-health nurses visiting the schools in which students were working with guidance personnel, questioned their respective roles. Therefore, students developed collegial relationships with nurses in more traditional roles.

We found that placing students in pairs, holding weekly seminars to provide peer and faculty support, and encouraging ongoing communication between preceptors, faculty and students did much to overcome these obstacles. In this context, incentive for pursuing new avenues of role development, through formal inservice or continuing education programmes, appeared to be lacking in some agencies.

Discussion

Other nurse educators identify the use of voluntary health care agencies and associations, senior citizen and nursing homes, health departments, family practice, free clinics, ambulatory care units, public schools, planned parenthood groups, alcohol rehabilitation programmes, day care, expectant parent classes, and a campus health information centre as clinical learning laboratories in the community (Adams, 1980; Clark, 1977; Heggerty & Kidzma, 1980; Lawrence & Lawrence, 1980; Mezey & Chiamulera, 1980; Ruffing, 1979; Schenk, 1976; Sorgen, 1979). The majority of these could be considered traditional sites according to Graham and Gleit's (1981) typology, with one possible exception. In contrast to these authors' description of nurses employed full time within a particular educational institution, the school nursing functions tend to be subsumed within the official community health agency workload in this country.

Cox (1982) predicts that client needs will become increasingly diversified such that the *context* in which nurses will practise will inevitably change. She refers to the current shift from cure to care, a trend pinpointed by Lalonde (1974). Six years later, Hall (1980) supported the Canadian Nurses Association's (1980) contention that spending be directed toward primary prevention, health promotion and noninstitutionalized community-based points of entry. Yet, this adaptation of health service delivery demands different and creative orientations of manpower (Baumgart, 1982; Pender, 1982). Specific strategies to develop relevant knowledge and skills and to promote role transition (Kramer, 1974) are required. Hence, university schools of nursing must prepare for these altered roles and practice sites by reflecting these changes in the theoretical and clinical components of their curricula (Greaves, 1982; Smith, 1982).

Clinical agencies should be selected on the basis of characteristics which are directly related to these trends and objectives for clinical experience (White et al., 1980). Criteria might focus on opportunities for

continuity of relationships with staff and clients or for application of aggregate-level skills (Pridham & Hurie, 1980; William, 1977). Nevertheless, tradition, location, availability, access, numbers, competition, choice, attitudes and time do influence the selection process (Hawkins, 1980; Robischon, 1978; White et al., 1980). For example, some nursing faculty may cling to the belief that principles of public health nursing can only be learned in public health agencies, curriculum demands of other courses may constrict potential travelling time, and multiple learners representing nursing and other disciplines may be competing for the same agency.

In this experience, a gradual transition began with a cautious selection of agencies, whose aims and services were closely linked to the more traditional variety. Once it was established that these were indeed congruent with the goals of the baccalaureate programme, the search for clinical placements evolved to include less familiar sites. Freedom of choice, transfer of learning, development of problem-solving skills, role modelling, flexible teaching environment, and change strategies contributed to the positive outcomes of this venture.

Freedom of choice was a key factor in the success of this clinical programme. Although they did not choose their agency, students had opportunities to be creative and adaptive in functioning in a nursing role and were offered alternative yet comparable learning experiences. As White et al., (1980) and Robischon (1978) indicate, less traditional settings promote flexibility and variety, provide services to groups of people and are open to supporting expanded nursing functions. However, Roper (1976) cautions educators to remember that labels of settings do not necessarily reflect the type of experience to which students will be exposed and that clinical areas often provide unexpected nursing experience.

A second major premise underlying the selection of a multiplicity of varied settings in this experience was an inherent belief in the ability of senior level students to *transfer learning*. To promote transfer of learning and to stimulate the retrieval of previously learned intellectual skills, a variety of environmental contexts and cues must be provided. A range of probing questions, varied examples, and novel situations facilitate transfer to other experiences (Gagne, 1974; Huckabay, 1980). These strategies were applied to this experience with nontraditional sites. However, general principles must be comprehended before transfer can be expected, as Smith (1982) contends, interrelating curriculum design, process and content facilitates student learning. Thus, the accompanying theory course and preceding theoretical-clinical courses were applied and integrated.

Gagne (1974) relates transfer ability and creativity to *problem-solving* skills. Therefore, faculty teaching this clinical course invoked recall of relevant concepts and principles, assessed learner's entering behaviour, identified expected terminal performance, required varied demonstrations, and provided verbal directions without giving the solution. Analysis and synthesis were expected from these senior level students. Thus, the ability to relate ideas, to identify hierarchy of ideas, to organize content, to combine parts, to derive patterns and to make generalizations by identifying commonalities and differences were learning goals (Huckabay, 1980). Ketefian (1981) found that critical thinking was positively associated with moral reasoning and abililty to function optimally and independently in complex milieu. Therefore, students were asked to give and defend their opinions, they were challenged to make their own decisions and to articulate their judgement, and they were held responsible for identifying their learning needs, performance problems and roles.

The professional role is learned through interaction with people inside and outside the school (DeCecco, 1974). Changes over time, following employment, in role concepts and values have been attributed to *role models* encountered by new nursing graduates (Shuval & Adler, 1980). Social behaviour patterns are learned and attitudes established and modified through the combined influence of models and reinforcement (Bandura, 1977; Huckabay, 1980; Kramer, 1974). Three identified effects of this phenomenon are modelling, inhibiting or disinhibiting and eliciting (Maddison, 1980). In the experience with this fourth-year clinical course, a variety of models in a range of clinical settings were used and nursing staff role models were frequently unavailable. However, students developed an ability to discriminate values adhered to by staff and to be selective in absorbing values. Students dissatisfaction with teaching and supervision by agency staff was a continuing phenomenon. Therefore, it was essential that both faculty and preceptors recognize and acknowledge their own fallibility as models. The fact that nursing faculty were not present "on site" in this experience made innovative approaches to role modelling essential.

Huckabay (1980) contends that the teacher's primary function is to provide *environments* that promote the development of the individual learner and to produce given educational objectives. Decisions must be made about the educational value of the environment. Therefore, throughout this experience, faculty facilitated, counselled, evaluated, consulted and coordinated. They identified potential agencies, conducted preliminary negotiation and planning sessions with staff, guided

agency representatives in their supervisory role and incorporated preceptor input into student evaluations. Furthermore, they supported and guided students through extensive feedback in written assignments, individual interviews and weekly group problem-solving sessions. As Bandura (1977) recommends, nondirective, collegial relationships between faculty and students were the norm. Nevertheless, as faculty change there is an inherent risk that commitment to the nontraditional clinical locale may falter.

Smith (1982) proposes that a number of different loci can impose stressors on staff and students. Consequently, tolerance, supportiveness, flexibility, openness to new knowledge, motivational climate, educational preparation, and conceptual understanding (Greaves, 1982) were all prerequisite *change strategies*. This innovation required new skills, attitudes and value orientations in students and preceptors alike. In some cases, trust was difficult to establish and role conflicts occurred. Individual attitudes required as much attention as structural changes, as "normative re-educative" theory (Bennis, Benne, & Chin, 1969) dictates. Therefore, faculty acknowledge that agency personnel require formal recognition; for example, identification of preceptors in the university calendar, joint appointments and honoraria. Some faculty members have provided direct services to agencies in the form of client care and continuing education programmes. Finally, faculty members organized a "Community Experience Reporting Day" at the conclusion of the course, which emphasized the synthesis of students learning regarding role development and group level interventions. This gave students an opportunity to share information about approaches used and projects completed in these multiple settings and to express appreciation to preceptors.

Conclusion

It is somewhat ironic that a quest for community placements based primarily on necessity created a desirable alternative thrust in clinical experiences. These non health-focused settings in fact reinforced a healthy perspective that traditional agencies used in the past had not stressed. Students developed an expanded repertoire of behaviours and were afforded the opportunity to improvise. The success of the programme points to a need to continue and expand this approach. Potentially relevant placements currently being investigated include apartment dwellings predominantly rented by single parents and the elderly, boys' and girls' clubs, and informal neighbourhood aggregates or networks.

This experience demonstrated that collaboration with nontraditional agencies can be rewarding. Students encountered new dimensions of nursing and health services in these community-based agen-

cies. They learned to adapt theoretical principles and analytical approaches to holistic, client-centred care, regardless of the setting. Such flexibility is mandatory if nursing is to meet changing societal demands.

Appropriate learning opportunities abound when accompanied by comprehensive planning and careful guidance. The transition from role identification to programme commitment is a requisite element for students, preceptors and faculty alike. These developing learning laboratories should complement, not replace, the more conventional varieties. Further research is required to evaluate the long-term effects, if any, of student placement in nontraditional versus traditional sites on the retention of community health concepts and graduates' position selection and perseverance in the profession.

REFERENCES

Adams, D. E. (1980). Agency staff facilitate student learning. *Nursing Outlook, 28,* 382-385.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall.

Baumgart, A. J. (1982). Nursing for a new century — a future framework. *Journal of Advanced Nursing, 7,* 19-23.

Bennis, W. G., Benne, K. D., & Chin, R. (1969). *The planning of change,* 2nd. ed. New York: Holt, Rinehardt & Winston.

Canadian Nurses Association (1980). Putting health into health care. Submission to Health Services Review '79, Ottawa, C.N.A.

Clark, C. C. (1977). Learning to negotiate the system. *Nursing Outlook, 25,* 39-42.

Cox, C. (1982). Frontiers of nursing in the 21st century: Lessons from the past and present for future directions in nursing education. *International Journal of Nursing Studies, 19*(1), 1-9.

Debeck, V. (1981). The relationship between senior nursing students' ability to formulate nursing diagnoses and the curriculum model. *Advances in Nursing Science,* 3(3), 51-56.

DeCecco, J. P. (1974). *The psychology of learning and instruction: Educational psychology.* Englewood Cliff, NJ: Prentice Hall.

Gagne, R. M. (1974). *Essentials of learning for instruction.* Hinsdale, IL: Dryden Press.

Graham, B. A., & Gleit, C. J. (1981). Clinical sites used in baccalaureate programs. *Nursing Outlook, 29,* 291-294.

Greaves, F. (1982). Innovation, change, decision-making and the key variables in curriculum implementation. *International Journal of Nursing Studies,* 19(1), 11-19.

Hall, E. M. (1980). Canada's national-provincial health program for the 1980's. Commitment for renewal. Ottawa: Health and Welfare Canada.

Hawkins, J. W. (1980). Selection of clinical agencies for baccalaureate nursing education. *Journal of Nursing Education,* 19(8), 7-17.

Heggerty, L., & Kidzma, E. C. (1980). Expectant parents' classes. An alternative environment for learning health maintenance. *Journal of Nursing Education*, 19(1), 13-19.

Huckabay, L. M. D. (1980). *Conditions of learning and instruction in nursing.* St. Louis: Mosby.

Kernen, H. J. (1979). Tailoring nursing education programs to meet the nature of community needs. *Nursing Papers, 11*(1), 6-18.

Ketefian, S. (1981). Critical thinking, educational preparation and development of moral judgment among selected groups of practicing nurses. *Nursing Research, 30,* 98-103.

Kramer, M. (1981). Philosophical foundations of baccalaureate nursing education. *Nursing Outlook, 29,* 224-228.

Kramer, M. (1974). *Reality shock: Why nurses leave nursing.* St. Louis: Mosby.

Lalonde, M. (1974). *A new perspective on the health of Canadians.* Ottawa: Information Canada.

Lawrence, R. M., & Lawrence, S. A. (1980). Student experience in voluntary health care agencies. *Nursing Outlook, 28,* 315-317.

Maddison, D. (1980). Professionalism and community responsibility. *Social Science and Medicine, 14*A, 91-96.

Mezey, M., & Chiamulera, D. N. (1980). Implementation of a campus nursing and health information center in the baccalaureate curriculum. Part I: Overview of the center. *Journal of Nursing Education,* 19(5), 7-15.

Pender, N. J. (1982). *Health promotion in nursing practice.* New York: Appleton-Century-Crofts.

Pridham, K. H., & Hurie, H. R. (1980). A day care health program: Linking health services and primary care nursing education. *International Journal of Nursing Studies, 17*(1), 55-62.

Robischon, P. (1978). Community health and expanded assessment skills. In *Utilization of the clinical laboratory in baccalaureate nursing programs.* New York: National League of Nursing Publication, 15-1726, pp. 1-23.

Roper, N. (1976). *Clinical experience in nurse education.* Edinburgh: Churchill Livingstone.

Ruffing, M. A. (1979). Community health nursing in an urban day care center. *Journal of Nursing Education, 18*(8), 21-26.

Schenk, K. (1976). Teaching distributive nursing. *Nursing Outlook, 24,* 574-577.

Shuval, J. T., & Adler, I. (1980). The role of models in professional socialization. *Social Science and Medicine, 14*A, 5-14.

Smith, L. (1982). Models of nursing as the basis for curriculum development: Some rationales and implications. *Journal of Advanced Nursing, 7,* 117-127.

Sorgen, L. M. (1979). Student learning following an educational experience at an alcohol rehabilitation centre in Saskatoon, Saskatchewan, Canada. *International Journal of Nursing Studies, 16,* 41-50.

Thomas, M. C. (1979). Study difficulties in undergraduate nursing students — a British perspective. *International Journal of Nursing Studies, 16,* 299-305.

Toffler, A. (1970). *Future shock.* New York: Random House.

White, C., Knollmueller, R., & Yaksich, S. (1980). Preparation for community health nursing: Issues and problems. *Nursing Outlook, 28,* 617-623.

Williams, C. A. (1977). Community health nursing — what is it? *Nursing Outlook, 25,* 250-254.

RÉSUMÉ

Enseignement universitaire des sciences infirmières en milieux cliniques inhabituels

Le nombre croissant des inscriptions en sciences infirmières assure la relève à une époque de restrictions budgétaires. L'évolution vers la reconnaissance d'un baccalauréat comme préparation minimale à la profession infirmière en sera le moteur. Toutefois, le nombre accru d'étudiants qui devront acquérir une expérience pratique dépassera les capacités des établissements traditionnels. C'est pourquoi, depuis 1977, nous avons progressivement dirigé nos étudiants de dernière année du baccalauréat davantage vers des milieux non traditionnels que vers les lieux de stage habituels.

La transition graduelle a commencé par le choix prudent d'organismes dont les objectifs et les services étaient étroitement liés à ceux des milieux traditionnels. Quand il fut établi que ces milieux se conformaient aux objectifs du programme du baccalauréat, nous avons poussé nos recherches pour étendre les stages cliniques à des milieux moins familiers. L'exercice de la liberté de choix, du transfert de l'apprentissage, de la résolution des problèmes, du modèle de rôle, en milieux souples d'enseignement, ainsi que des stratégies de changement sont autant de facteurs qui ont contribué aux résultats positifs de cet essai.

Les étudiants ont pris connaissance de nouvelles dimensions des sciences infirmières et des services de santé au cours de leur stage au sein d'organismes axés sur la communauté; ils ont appris à adapter les principes théoriques et les démarches analytiques à des soins globaux axés sur le client, quel que soit son environnement. Il est évident qu'une telle souplesse est essentielle si l'on veut que la profession infirmière soit en mesure de faire face aux exigences d'une société en pleine évolution.

Ces nouveaux laboratoires d'apprentissage devront compléter et non remplacer les milieux conventionnels de stages. Il faudra procéder à des recherches plus poussées pour évaluer les effets à long terme de ces stages en milieux non traditionnels et pour les comparer aux stages en milieux conventionnels; la constance des diplômés au sein de la profession et le type de postes occupés dans leur carrière en seront les critères d'évaluation.

INFORMATION FOR AUTHORS

Nursing Papers/Perspectives en nursing welcomes research and scholarly manuscripts of relevance to nursing and health care. Please send manuscripts to *The Editor, Nursing Papers/Perspectives en nursing*, School of Nursing, McGill University, 3506 University Street, Montreal, PQ H3A 2A7.

Procedure

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

Style and Format

Acceptable length of a manuscript is between 10 and 15 pages. The article may be written in English or French, and must be accompanied by a 100-200 word abstract (if possible, in the other language). Please submit original diagrams, drawn in India ink and camera-ready. Prospective authors are asked to place references to their own work on a separate sheet and to follow the style and content requirements detailed in the Publication Manual of the American Psychological Association (3rd. ed.), Washington, D.C.: APA, 1983.

Manuscript Review

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

Assessing content

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

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

Assessing presentation

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

Publication Information

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

RENSEIGNEMENTS À L'INTENTION DES AUTEURS

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

Modalités

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

Style et présentation

La longueur acceptable d'un article doit osciller entre 10 et 15 pages. Les articles peuvent être rédigés soit en anglais, soit en français et ils doivent être accompagnés d'un résumé de 100 à 200 mots (si possible, dans l'autre langue). Veuillez remettre l'original des schémas, dessinés à l'encre de Chine et prêts à être photographiés. Les auteurs sont tenus de fournir les références à leurs propres oeuvres sur une feuille séparée et de suivre les consignes énoncées dans le Publication Manual of the American Psychological Association (3rd. ed.), Washington, D.C.: APA, 1983, en ce qui concerne le style et le contenu de leurs articles.

Examen des manuscrits

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

Evaluation du fond

Validité interne: Le problème dont traite l'article est-il clairement défini? La forme des recherches ou la structure de l'essai sont-elles appropriées à la question soulevée? Les méthodes statistiques, logiques et les modalités de recherche sont-elles appropriées? Les conclusions peuvent-elles être justifiées à l'aide des données présentées? Les implications de l'article sont-elles fondées sur les conclusions?

Validité externe: Le problème soulevé présente-t-il un intérêt véritable? Ce problème est-il d'actualité? Existe-t-il des problèmes de divulgation ou de déontologie? Les conclusions de la recherche ou de l'article sont-elles importantes? Ces conclusions ou résultats peuvent-ils s'appliquer à d'autres situations? Est-ce que l'article contribue à l'avancement du savoir dans le domaine des sciences infirmières? De quelle façon?

Evaluation de la présentation

L'auteur développe-t-il ses idées de manière logique? Les exprime-t-il clairement? La longueur de son article est-elle appropriée au sujet abordé? Est-ce que le nombre de notes ou de tableaux dépasse le strict nécessaire?

Renseignements relatifs à la publication

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

McGILL UNIVERSITY
SCHOOL OF NURSING

GRADUATE PROGRAM IN NURSING
MASTER OF SCIENCE (APPLIED)

This program has been designed to prepare clinicians and researchers for the expanding function of nursing in our rapidly developing health care services.

Options available:

Option A: Clinical Nursing Practice

Option B: Research in Nursing and Health Care

Graduates will be prepared to incorporate either option within careers in the teaching of nursing or the development and management of nursing service.

Admission requirements

Either a Baccalaureate degree in Nursing comparable to B.Sc.(N) or B.N. from McGill; or a Baccalaureate degree comparable to B.A. or B.Sc. offered at McGill.

Length of program

Two years for those with nursing degrees
Three years for those with non-nursing degrees

Language of study: English

Further information from:

Director, School of Nursing
Master's Program
3506 University Street
Montreal, P.Q. H3A 2A7