



# ***NURSING PAPERS*** ***PERSPECTIVES EN NURSING***

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for the Study of a Chronic Disease

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Spring/Printemps 1985

Volume 17, No. 1



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*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.

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*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.

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Dépôt légal — 1er trimestre 1974.

Bibliothèque Nationale du Québec.

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CONTENTS — TABLES DES MATIÈRES

2 Editorial

4 Role of Social Resource Variables upon Life Satisfaction  
in Black Climacteric Hysterectomized Women

*Résumé:* Être satisfaite de son sort: rôle variable "ressources  
sociales" chez les femmes noires ménopausées soumises  
à une hystérectomie

Beryl B. Jackson

23 Computers in Use — Design of a System  
for the Study of a Chronic Disease

*Résumé:* Les ordinateurs au travail — conception d'un système  
pour l'étude d'une maladie chronique

Gloria L. Joachim

35 The Nursing Apprentice: An Historical Perspective

*Résumé:* Aptitudes à la communication des infirmiers en  
exercice: Infirmiers détenteurs d'un diplôme et des  
infirmiers détenteurs d'un baccalauréat

Barbara Keddy and Evelyn Lukan

48 La relation du rôle joué par le personnel infirmier sur la prise  
de rôle de la personne âgée en établissement de soins prolongés

*Abstract:* The Relationship Between the Role Played by Nursing  
Personnel and the Role Taken by Elderly Persons in  
Long-term Care Units

Marcelle Séguin Langlois

66 Critique: Diane Brisson

70 Teenagers' Rationales for their Food Behaviours:  
Directives for Teaching

*Résumé:* Justification du comportement alimentaire des  
adolescents par les intéressées: directives pédagogiques

M. Judith Lynam

80 Non-Degree Continuing Nursing Education Needs  
of Alberta's Registered Nurses

*Résumé:* Formation infirmière continue ne menant pas à un  
grade: besoins des infirmières de l'Alberta

Sharon Richardson and Jennifer Sherwood

101 Information for Authors/Renseignement à l'intention des auteurs



## ÉDITORIAL

De toutes les techniques et méthodes récentes pour faciliter le travail du professeur et du chercheur, la micro-informatique se place probablement en tête de liste. Elles l'est déjà dans l'industrie secondaire et tertiaire. Elle est devenue le véhicule d'information associé au critère d'efficacité dans les communications de toutes sortes. L'article de Joachim sur l'utilisation des ordinateurs pour étudier des groupes de clients qui souffrent de maladies chroniques démontre comment cette méthode ouvre aux chercheurs en sciences infirmières et aux cliniciens des horizons nouveaux.

De par sa nature, le soin infirmier s'adresse à l'individu dans sa globalité. Aussi, la quantité d'information à recueillir dans une situation de soin est toujours très grande. Même si un dossier contient un grand nombre de renseignements, l'utilisation que le personnel infirmier ou même le chercheur en fait est généralement limitée. La micro-informatique permet de corriger cette lacune. L'auteur fait référence à des outils pour colliger l'information selon une philosophie holistique ou une conception des soins infirmiers clairement identifiée. Aussi, le danger d'une quantification purement mécanique de l'individu que brandissent certains n'est pas créé par le système d'information automatisée mais plutôt par une conception inadéquate des soins au départ. Il est facile d'imaginer les possibilités qu'offre un système semblable pour arriver à des réponses plus précises et pour élucider certains ambiguïtés et limites dans les résultats de recherche. Les mêmes possibilités s'offrent également au clinicien qui pourra rapidement "connaître" et "comprendre" la situation des clientèles suivies à long terme.

Demain, il faudra penser à des systèmes de communication automatisée compatibles d'une université à l'autre; des chercheurs d'universités différentes ou de centres de recherche différents feront partie d'une même équipe qui étudiera des phénomènes semblables auprès de populations diverses. La technologie est de plus en plus présente; c'est aux chercheurs et aux cliniciens de l'utiliser pour améliorer leur efficacité dans la découverte des connaissances et le soin des clientèles. J'ai parfois l'impression que demain, c'est aujourd'hui.

Marie-France Thibaudeau

## EDITORIAL

Microcomputing is on the verge of taking over as the most important of all the technique and methods recently developed to facilitate the task of teachers and researchers. In secondary industry and in the service fields, it already occupies pride of place, and is synonymous with efficient communication. Joachim's article on the use of computers to study groups of patients suffering from chronic illness demonstrates how the system can open new horizons to nursing researchers and clinical workers alike.

The very nature of nursing care is such that it must be concerned with the whole individual, and from this angle the amount of information required for overall health care is huge. Even when a file contains a great deal of data, often nursing staff or researchers can make only limited use of it. This is where microcomputers can help. The author speaks of them as tools to collect information, based on a holistic philosophy — a clearly identified concept of nursing care. Some people warn that we may be heading toward a mechanical quantification of the individual, but the danger stems from an inadequate concept of care, not from the fact that information is computerized. It is readily apparent that a computerized system can help us to find the right answers; it can elucidate ambiguities and limitations in research results. The same possibilities are available to the clinical worker, who will find it easier to know and understand the condition of patients under long-term observation.

Soon, we shall be thinking about automated communications systems compatible between universities: different university research workers or separate research centres will constitute a team studying similar phenomena among different populations. The technology is here now: it is up to research and clinical workers to use it to improve patient care and push back the frontiers of knowledge. Sometimes I have the feeling that "soon" is right now.

Marie-France Thibaudeau

# ROLE OF SOCIAL RESOURCE VARIABLES UPON LIFE SATISFACTION IN BLACK CLIMACTERIC HYSTERECTOMIZED WOMEN

Beryl B. Jackson

Hysterectomy, the surgical removal of the uterus, is the most commonly performed major surgery in the United States. In 1975, the incidence of hysterectomies peaked at 808,000. Although in 1980 there was a slight decrease, 5.6 per 1,000, America still has the highest rate of hysterectomies in the world (Finck, 1979; Krueger, Hassell, Goggins, Ishimatsu, Pablico, & Tuttle, 1979; U.S. Superintendent of Documents, 1983). Over the years, perhaps no other surgical procedure has prompted more concern among the medical profession, government agencies, third-party payers, feminist groups, and the laity about its indications and possible overuse (Doyle, 1953; Larned, 1974; Miller, 1946; Parrott, 1972). In response to this widespread concern, a Policy Statement — "The Determination of the Necessity of Gynecological Surgery" was issued by the Executive Board of the American College of Obstetricians and Gynecologists (1977). Equally alarming over the years are reports that removal of non-pathological uteri constitutes 32-39% of the total number of hysterectomies performed each year (Doyle, 1953; Zussman, Zussman, Sunley, & Bjornson, 1981). "It is fairly clear that socio-economic status may be a selective factor in determining who is to be hysterectomized" (Patterson, Craig, Dinitz, Lefton, & Pasamanick, 1960). It was documented in the mid-fifties that the percentage of hysterectomies performed on medically uninsured women is double that of insured (Anderson & Feldman, 1956), leading Parlee (1978) to conclude that "there is some suggestion that the figure may be related to the race and social class of the woman, as to whether or not she had medical insurance..." (p. 36).

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\*The analysis of data for this study was supported by Alumni Funds from the University of Pittsburgh School of Nursing, Pittsburgh, Pa. The author wishes to thank Dr. Enid Goldberg, Dean and Dr. Elizabeth J. Martin, Associate Dean for Graduate Academic Affairs, University of Pittsburgh School of Nursing for the many ways in which they assisted during the study, and Dr. Jerome Taylor, Director, Institute for the Black Family University of Pittsburgh, for his assistance with the design of the study.

Although the majority of the reported hysterectomy studies on white women are retrospective in design, and the methodology used is subject to criticism, there are a number of these empirical studies reporting that post-hysterectomy adjustment is often associated with elevated level of depression (Barker, 1968; Drellich & Bieber, 1958; Richards, 1974, depressed levels of feminine self-concept (Deutsch, 1945; Drellich & Bieber, 1958; Williams, 1973), psychosocial stress (Melody, 1962; Raphael, 1976) and psychiatric morbidity generally (Richards, 1974). Therefore, scientific investigation of this possible health risk problem is one of considerable urgency for a large number of women.

Although voluminous studies as well as clinical articles have reported on white hysterectomized women, and on their post-operative course of adjustment, a review of the literature indicates little or no evidence of scientific information on black hysterectomized women as a sub-group within the major culture of American or Canadian society. The study of closest relevance is that of Williams (1973) who investigated two ethnic groups, Anglo- and Mexican-American, and documented the effect ethnicity and culture had upon their pre-hospitalized and post-hysterectomized adjustments to the surgical removal of the uterus. She found marked differences existed between responses of the two groups that reflected contrasting levels of feminine self-concept, self-esteem, and coping ability. She concluded that these differences were primarily the result of ethnicity and culture. The theoretical and practical clinical significance of the conditioning effects of social support on a wide range of stress events justifies evaluation of its validity on this sample of black climacteric hysterectomized women.

### Purpose

The purpose of this study was to investigate the role of the social resource variables upon life satisfaction of black climacteric hysterectomized women. These variables were defined in terms of five components: (1) husband or sexual partner; (2) children as source of support; (3) female relatives as confidants; (4) female friends as confidants, and (5) members of voluntary organizations.

Social support was defined as social and emotional support with the affirmation that one is loved and cared for. Confidants were defined as close female relatives and friends with whom personal and private concerns were shared. Life satisfaction was defined as the maintenance of one's self-esteem, one's coping abilities and one's sense of mastery over life's circumstances.

## Review of Literature

Empirical studies have linked social support with positive outcomes of stressful life events in a variety of population samples, and have evaluated its influence as an effective buffer against negative personal experiences. Cobb (1976), defining social support as information leading one to believe he or she is loved, cared for, valued, and esteemed, found that quality involvement with others reduced the effect of such stresses as job loss, bereavement, aging and retirement, and recovery from traumatogenic illness. Nuckolls, Cassel, and Kaplan (1972) investigated the socio-emotional support for wives in their 32nd week of pregnancy from husbands, relatives, friends, and community and found that high stress was unrelated to the percentage of complications among women with high quality social support. Among women with high stress and low quality support, however, the percentage of pregnancy complications was significantly elevated.

Likewise, friendship and kinship, as social support, have been described as effective buffers against a variety of stress events in the lives of women in midlife crisis. Robertson (1978) investigated the value of friendships and kinships and reported that friendships were often value above kinships. In addition, Myers, Linderthal, and Pepper (1975) reporting on the concept of social support, stated that "people who have ready and meaningful access to others, feel integrated into the system, and are satisfied with their roles, seem better able to cope with the impact of life events" (p. 426). Even the availability of someone to talk to on superficial issues has been documented as having salutary effects upon levels of psychological adjustments and on recovery from major illnesses and other life events (Williams, Ware, & Donald, 1981).

### **Husband or Sexual Partner**

Although having a hysterectomy has been perceived as an emotional blow by almost every woman who has had one, some were able to bring into play adequate coping mechanisms to establish and maintain healthy adjustments in response to having a hysterectomy (Turpin & Heath, 1979). However, several researchers and clinicians have reported statements of hysterectomized women that indicated a wide range of feelings toward the effects of hysterectomy on their feminine self-concept. "If you don't have a womb, you are not a woman" (Wolf, 1970, p. 167); "I feel useless and not a whole woman... I am only a shell of a woman" (Melody, 1962, pp. 412-413); and "you are not a proper woman, if you can't have any more children" (Raphael, 1976, p. 430).

Williams (1973) reported feelings, expressed by Mexican-American hysterectomized women, of overt concern and fear about infidelity



and about losing their husbands to other women following hysterectomy. "I was afraid my husband would leave me... I was afraid he would get another woman if I wasn't any good" (Williams, 1973, p. 382). One woman reported that she had suffered for years from postponing the hysterectomy, which had been medically recommended, for fear of losing her husband. Another woman who reluctantly had the operation did not tell her husband the truth, that the uterus was removed, for fear that he would no longer consider her a sexually attractive partner (Williams, 1973). Although the extent of such insecurity in the women's feminine self-concept in their marital relationship may have been culturally determined, these expressions, nevertheless, indicate the perceived importance of the uterus in maintaining their feminine self-concept in an intimate relationship, and of its function as the primary link between the marital bond and fidelity. In the mid-fifties, Drellich, Bieber, and Sutherland reported similar expression of women from other cultures. One woman told her husband after having a hysterectomy that only one ovary was removed for fear he would feel she was no longer useful for work or sex.

Nor are such personal feelings and fears unrealistic. Some husbands and sexual partners have asserted that, for them, their partner's feminine attractiveness had altered following hysterectomy. Some women have experienced unhelpful interactions with their husbands or sexual partners that they consider derogatory to their perceptions of themselves as women and sexual partners, and they have had to grapple with hurtful and rejected feelings. In extreme instances, desertion, taunting, and physical and emotional divorce within the intimate relationship have been documented as preceding depressive reactions in hysterectomized women (Barker, 1968; Drellich, Bieber, & Sutherland, 1956; Melody, 1962; Raphael, 1976).

Melody (1962), who stressed the importance of quality relationships and social interactions, which he believed invariably determined the post-operative course, said: "Intimate human relations and interactions are so essential to health that one's sanity and potential for self-fulfillment are jeopardized for the most part by the perceived thread of disapproval, rejection, devaluation, or loss of security" (p. 410).

It is interesting to note that Brown and Harris (1978), who investigated the relationship between depression and intimate relationships, found "that women with confiding intimate relationships had only one-fourth of the incidence of depression of those with high stress but little support" (p. 363). Investigators have found that successful post-hysterectomy adjustment was dependent upon the quality of emotional support, and on an intimate relationship with husband or sexual partner, in providing acceptance and approval of the hysterectomized woman (Melody, 1962; Raphael, 1976, Williams, 1973).

### *Children as Source of Support*

Investigators have found that some women have reported that it was not only the quality of intimate relationships, but also the quality relationships with their children that were sources of special support from which they were able to sustain themselves during periods of personal stress or crisis. However, the mother's self-image often comes up against the realities of her children's aloofness, rejection, indifference, and, sometimes, disappointments, all of which she must integrate into her personal experience (Benedek, 1950; Deutsch, 1945; McAdoo, 1980; Rodgers, 1980).

### *Female Relatives and Friends as Confidants*

Raphael (1976) believed that the extent to which most women withstand or cope with a hysterectomy also depends, to a considerable degree, on social network components which often include mothers, close female relatives, and friends. Equally important are the caring and empathic understanding qualities expressed by their doctors. She approached her investigations concerning the quality of life in post-hysterectomized women by conceptualizing hysterectomy as a psycho-social crisis. Some women find themselves, at the time of the hysterectomy, without a supportive environment, a husband or sexual partner, but fortunately these women often are able to rely on other women for information and reassurance. Close female relatives and friends often fill the role of confidant with whom the hysterectomized woman shares perceptions and fantasies about the operation, particularly if these women have had similar experiences (Drellich & Bieber, 1958; Melody, 1962; Raphael, 1976).

### *Members of Voluntary Social Organizations*

Several investigators have explored the relationship between life adjustment and social interaction through the medium of voluntary social organizations, and have found that the two are significantly correlated (Palmore & Luikart, 1972; Tobin & Neugarten, 1961). Church groups, self-help groups, and mutual aid groups, which provide support for social, emotional, and spiritual concerns, have been found to be effective because people affect each other through multiple linkage and chain reactions as they share their fears, their knowledge, and their ways of coping (Maguire, 1983). Other researchers have found statistical support for the relationship between social interactions and quality of adjustment and mid-life, and have systematically linked social support to the quality of one's life. Even where the involvement may have been superficial, the availability of such formal or informal social involvements has played a significant role in

physical and psychological adjustment and recovery.

### Conceptual Framework

Anthropologists and sociologists were the first to document empirically the effects of social support associated with the primary reference group. More recently psychologists, sociologists, and epidemiologists have considered empirically and theoretically the therapeutic effectiveness of social support systems.

Supportive social relationships have been shown to be effective buffers against the negative consequences of a wide variety of social stressors: puerperal depression (Paykel, Emms, Fletcher, & Rassaby, 1980); marital separation (Weiss, 1975); mastectomy (Bloom, 1979); and divorce (Hetherington, Cox, & Cox, 1978). In addition, social and emotional support have been documented as being effective in the remediation of physical symptoms and illness: in reducing migraine headache, asthma, and essential hypertension (Berle, Pinsky, Wolf, & Wolff, 1952), in coping with mastectomy (Bloom, 1979), in reducing anxiety in relatives of loved ones with life-threatening illness (Bunn & Clarke, 1979), in recovering from strokes (Robertson & Suinn, 1968), in rehabilitation outcome of orthopedically disabled patients (Litman, 1966), and in producing favorable outcomes of myocardial infarction (Finlayson, 1976). Social support from social networks, as Cobb (1976) has noted, "...has beneficial effects on a wide variety of health variables throughout the life course from conception to just before death" (p. 113).

A clue as to why social networks indicate such positive health outcomes is given in Cobb's (1976) identification of three components of social support: (1) emotional support is "information that one is cared for and loved," (2) esteem support is "information that one is valued and esteemed," and (3) network support is "information that one belongs to a network of mutual obligations" (p. 119). People usually look to others, particularly members of their families for recognition of their worth and value, especially where it involves serious illness or disfigurement (Moos & Tsu, 1977). This is crucial to one's self-image and the feelings of self-esteem that enable the individual to build a new identity and cope with readjustment.

For this study, the investigator used social networks involving husband or sexual partner, children, female friends, relatives who are confidants, and members of voluntary social organizations to explain *the relation between post-hysterectomy adjustment and the quality of support that black hysterectomized women received.*

Based upon the preceding review, the following hypotheses are offered:



1. Black hysterectomized women who have more extensive and better quality relationships with their husbands or sexual partners will report higher levels of life satisfaction than those with less extensive and poorer quality relationships.

2. Black hysterectomized women with more extensive and better quality relationships with their children will report higher levels of life satisfaction than those with less extensive and poorer quality relationships.

3. Black hysterectomized women with more extensive and better quality relationships with their female relatives will report higher levels of life satisfaction than those with less extensive and poorer quality relationships with relatives.

4. Black hysterectomized women with more extensive and better quality relationships with female friends will report higher levels of life satisfaction than those with less extensive and poorer quality relationships with friends.

5. Black hysterectomized women with more extensive and better quality involvement with members of voluntary social organizations will report higher levels of life satisfaction than those with less extensive and poorer quality involvement with social organizations.

## Methodology

### *Sample*

A final voluntary convenience sample consisted of 89 black hysterectomized women between the ages of 40 and 60, who were born and raised in the United States, who reported no psychiatric hospitalization, and who signed a consent form. This was obtained from a larger survey sample of 209 black climacteric women. The setting from which they were obtained included one ambulatory care clinic in a health center, one community health clinic, one black sorority organization, the private practice of two black gynecologists, several educational institutions and community organizations, and many black churches, all located in an urban area. The mean age of this sample was 50.8 years; 79.9% were Protestant; 42.8% were married, 21.3% divorced, 6.7% never married and the remaining 29.2% remarried, separated, or widowed. Of this sample of 89 women, 69.7% reported that they were in good to excellent health, and 18.0%, 76.4%, and 5.6% reported they were hysterectomized before, during, and after the cessation of menstruation, respectively. Over 53% of the sample reported that they had undergone surgical menopause before age 41. Educationally, 10% reported completion of the 9th grade, 36% reported that they had graduated from high school, and

53% reported formal training beyond high school.

### *Procedure*

Individual respondents to the questionnaires were asked to participate voluntarily. A letter of introduction to the investigator, with information about the need for the study and the importance of her participation, was sent to each participant. Two consent forms were enclosed — one for the respondent to keep, the other to be signed and returned — along with assurances that all information would be kept in strict confidence.

Coded sets of questionnaires were mailed out to each participant. Also enclosed were two self-addressed stamped envelopes — one for the return of the signed consent form and the other for the return of the completed questionnaires. Signatures were separated from protocols, thus providing a further degree of confidentiality.

### *Instruments*

1. Neugarten, Havinghurst, and Tobin's (1961) measure of life satisfaction, Life Satisfaction Index (LSIA), has been accepted as reliable and valid, although primarily for white samples. This measure is theoretically and empirically structured around five components:

a. Zest versus apathy: The respondent's enthusiasm of response and degree of ego involvement in any of the various activities that involves the respondent and other people.

b. Resolution and fortitude: The extent to which the respondent regards his life as meaningful and accepts resolutely that which his life has been.

c. Congruence between desired and achieved goals: The extent to which respondent feels he has achieved certain goals in life, whatever those goals might be.

d. Self-concept: The respondent's concept of self-physical as well as psychological and social attributes.

e. Mood tone: The extent to which the respondent expresses happy, optimistic attitudes, depression, feeling blue and lonely, or feelings of bitterness (Neugarten et al., 1961, pp. 137-139).

The full set of 20 items was used as recommended by Neugarten et al. For this sample of black women, the items were scored giving 2 points for an affirmative response, 1 point for each uncertain response, and 0 for each non-affirmative response. The dependent variable, life satisfaction, was measured by this 20 item LSIA scale.

2. The second instrument, developed, piloted, and refined on a sample of 120 black climacteric women by the author, has acceptable reliability and distributional characteristics (Jackson, 1982). The items were structure around those areas identified in the literature review as important in understanding climacteric and post-hysterectomy adjustments of black women. Five subscales were used to estimate performance in these five areas and were entered as the independent variables:

- (a) Husband or sexual partner, an 8-item measure;
- (b) Children as support resources, a 12-item measure;
- (c) Female relatives as confidants, an 8-item measure;
- (d) Friends as confidants, a 16-item measure;
- (e) Members of voluntary social organizations, a 15-item measure.

Alphas of .93, .90, .85, .85, and .93, respectively, were reported in a previous study of 120 black climacteric women (Jackson, submitted). Data supporting the provisional validity of the social resource measure were also reported in the earlier study.

### *Analysis and Data*

The sample was divided at the median, on all data available, to create "High" and "Low" groups for each social resource measure. A univariate t-test was then used to evaluate differences between Highs and Lows on Life Satisfaction. In this way, each of the five hypotheses were evaluated for significance at  $p < .05$ . Essentially, these analytic procedures are consistent with an ex post facto design.

## Results

### *Preliminary Findings*

A mean of 25.90, median of 27.57, standard deviation of 7.86, and Cronbach alpha of .81 were found for the LSIA scale on this sample of 89 black hysterectomized women. Table 1 represents the descriptive statistics for the five measures of the Social Resource Inventory Measure, and results in relation to each of the five hypotheses are contained in Table 2.

Hypothesis 1 was supported. There was a significant difference between the means of subjects classified as Lows and Highs. The difference indicating the Highs with more extensive and better quality relationships with their husband or sexual partner have higher levels of Life Satisfaction than Lows who have experienced less extensive and poorer quality relationships with their husbands or sexual partners.

Table 1

Central Tendency and Variability of Each Component of the Social Resource Measure

(N = 89) Social Resource Measures	Mean	Median	Standard Deviation	Alpha
1. Husband or Sexual Partner	41.25	44.50	11.17	.90
2. Children as Source of Support	64.04	64.25	14.77	.91
3. Female Relatives as Confidants	35.06	34.16	11.44	.88
4. Female Friends as Confidants	78.98	79.50	15.56	.89
5. Voluntary Social Organizations	68.30	66.75	24.85	.95

Hypothesis 2 was supported. There was a significant difference between the means for subjects classified as Lows and Highs, the difference suggesting that Highs who shared more extensive and better quality relationships with their children have higher levels of Life Satisfaction than Lows who have experienced poorer quality relationships.

The difference between means for Hypothesis 3 as significant. Subjects classified as Highs, who participated in more extensive and better quality relationships with their female relatives, have higher levels of Life Satisfaction than Lows, who have less extensive and poorer quality relationships.

Hypothesis 4, pertaining to Friends as Confidants, was not supported. There was no significant difference between LSIA means of subjects classified as Lows and Highs.

Hypothesis 5, that black hysterectomized women with more extensive and higher quality involvement with voluntary social organizations would have higher levels of life satisfaction than those who did not, was supported.

Table 2

Evaluation of Five Hypotheses Linking Social Resources to Life Satisfaction in a Sample of 89 Black Hysterectomized Women

Hypothesis	n*	Mean	Standard Deviation	t-Value	df	p-Value
1. Husband or Sexual Partner						
Group 1. Lows	24	22.38	9.03			
Group 2. Highs	30	27.40	7.64	-2.21	52	.01
2. Children as Support Resource						
Group 1. Lows	28	23.75	8.61			
Group 2. Highs	19	27.42	9.22	-1.39	45	.04
3. Female Relatives as Confidants						
Group 1. Lows	33	23.61	8.44			
Group 2. Highs	27	28.59	6.66	-2.50	58	.007
4. Female Friends as Confidants						
Group 1. Lows	29	25.24	8.00			
Group 2. Highs	29	26.13	8.70	-0.41	56	.34
5. Voluntary Social Organizations						
Group 1. Lows	36	24.28	8.67			
Group 2. Highs	21	28.22	7.20	-1.70	55	.05

\*The component sums for Highs and Lows do not total 89 because of missing data.

## Discussion

The major findings of this study clearly indicate that a relationship exists between social resources and life satisfaction.

### *Husband or Sexual Partner*

In relation to the first hypothesis, the findings of this study are consistent with both the theoretical literature and empirical evidence. Melody (1962), Raphael (1976), and Webb and Wilson-Barnett (1983) found that supportive intimate relationships are capable of having salutary effects upon the recovery and post-hysterectomy adjustment in hysterectomized women. Melody (1962) found that male intimates who are accepting, approving, and supporting of their hysterectomized partners play an important role in the prevention of adverse reactions, as well as in fostering security and satisfaction.

Raphael (1976) found that, of the 100 Australian post-hysterectomized women studied in relation to social support provided by spouses, the majority of the women reported that they had received adequate support and reassurances that hysterectomy would not make any difference in their intimate relationships from their husbands or sexual partners.

As well, Webb and Wilson-Barnett (1983), reporting on a sample of 95 post-hysterectomized English women, found that women who were positively supported by their partners had greater decreases in mean "Helplessness Self-concept" scores than those who were not supported. This indicates, then, that positive social support from male intimates is of paramount importance in helping women recover their normal behaviour and feminine identity after a hysterectomy.

### *Children as Source of Support*

This hypothesis was supported both by empirical findings and in theoretical literature. Middle-aged women, during stressful times such as serious illnesses, life-cycle change, and loss of intimate relationships, have reported that their children's love and emotional support was able to sustain them until their psychological equilibrium was restored and until new forms of inter-personal relationships were established (Deutsch, 1945; Raphael, 1976).

It is possible that quality of relationships improve as the generation gap between mother and adult child is closed, permitting more emotionally secure and satisfying adult-to-adult attachments. Rodgers's (1980) study is supportive of this view. Interviewing several middle-aged women with respect to areas of the relationship with their children that they found to be satisfying and supporting, she reported



such responses as: "I am enjoying my children now as parent-friend. Since they are older, we can mutually share." "I love my children... I am sure if I were sick, they would be very concerned...", and, "my children have enriched my life enormously. I'd probably be a rigid old housewife without them" (p. 205).

#### *Female Relatives as Confidants*

Black hysterectomized women with more extensive and quality relationships with female relatives reported higher levels of life satisfaction, as predicted. The importance of female relatives is borne out in a study by Nuckolls, Cassel, and Kaplan (1972) who investigated wives in their 32nd week of pregnancy with respect to support from husbands, relatives, friends, and community. They found that relatives were as effective a buffer in reducing stress as were husbands and friends. Raphael (1976) believed that female relatives of hysterectomized women have been important because they served not only as confidants, but also as models for feminine identification. The results of this study, are consistent with those primarily using samples of white women. The cross-ethnic application of the present hypothesis is thus supported and generalizable.

#### *Female Friends as Confidants.*

This hypothesis was not supported. Such a finding was not consistent with the study's conceptual framework, which underscored the importance of friends as an essential component of social network theory. Studies of hysterectomized women, that operationalized the concept "female friends" in terms of social support, provided negative findings in relation to the present study (Raphael, 1976; Webb & Wilson-Barnett, 1983).

This failure could be related to the measure used to operationalize the relationship with female confidants. However another study, which found the expected linkage between relationships to female confidants and life satisfaction, used identical measures to those in this study (Jackson, 1982). The failure could also be related to the sample used. Black women having undergone major surgery might well rely more heavily upon relatives than on friends. Perhaps black women who have not undergone major surgery rely as heavily upon friends as upon relatives, a speculation which only future research can settle.

#### *Members of Voluntary Social Organizations*

This hypothesis was supported and is consistent with studies linking organizational involvement and quality of life at mid-life (Palmore & Luikart, 1972; Tobin & Neugarten, 1961). This linkage is reinforced

by studies that have found that membership and participation in social organizations increases during the middle years (Payne, Payne & Reddy, 1972), that women are more active in church organizations than men, and that their involvement is more socio-emotional than instrumental (Payne, 1975).

#### Nursing Implications for Research, Clinical Practice and Education

The findings of this study suggest implications for research, for clinical practice, and for educational application to nursing. First, the researcher could utilize these findings in future studies. Although the findings are consistent with those reported in the literature for white women, and also affirm a similar pattern between social support variables and life satisfaction for black women, future studies are needed. While it is tempting to speculate that social support may be causally related to life satisfaction, one could also argue that levels of life satisfaction may be causally related to social support. Perhaps this relationship is bi-directional. These possibilities can only be settled by future research.

Secondly, the findings of this study suggest implications for clinical nursing practice. Given the centrality of the uterus and its functions in relation to the feminine self-concept, social roles, and levels of life satisfaction, and since, according to the literature, hysterectomized women are much more vulnerable to emotional disorder, nursing interventions should be directed toward prevention of emotional problems (Melody, 1962). Nurses should establish helpful relationships with their pre- and post-hysterectomized black patients, so as to provide appropriate reassurance and support. They should explore with them latent concerns, unrealistic fears, and misconceptions about the operation, in relation to post-hysterectomy adjustment and sexual functioning, and provide them with concise and concrete factual information.

It has been documented that when planned pre-operative teaching models were implemented by nurses, surgical patients made more positive post-operative adjustments (Ley, 1977). The nurse, however, should carefully evaluate her intervention strategies for black hysterectomized women within the context of complex cultural or sub-cultural life styles, including ethnic, racial, socio-economic, personal, and psychological life history. Differences and similarities inherent in human response to stressful life experiences should also be evaluated.

Patient teaching that is intended to create change must be given at the right time, when the patient is ready, in the right amount, and in the right way (Ley, 1977). By using the patient educational approach



and planning with other appropriate health professionals, the nurse, who is academically prepared in group dynamics and group process, can intervene by introducing and leading pre- and post-hysterectomy individual counselling and group discussion sessions. Knowing that learning and behaviour changes are often facilitated by means of interpersonal processes within small groups, the nurse group leader can help her black hysterectomized patients begin to do early self-appraisal, which has wide applicability for many occasions and types of personal stress.

Another benefit the black hysterectomized patient might receive from participating in pre- and post-surgery discussion groups is exposure to new or alternate ways of thinking about herself, changing her views of herself, or her views of her social environment.

The nurse, as a clinical practitioner, serves in many different roles. One of these roles is that of interpreter for members of the health team, the spouse or sexual partner, and the patient's family. Among members of the health team, nurses are usually the ones who are best qualified for the role of interpreter because of their availability to patients 24 hours per day. They are able to clarify and interpret their patients' behaviours, uniqueness, and sensibilities to other members of the health team and to the patient's significant social network, and to maintain a consistent health care approach. Nursing intervention, then, interrupts and replaces potentially unhealthy behaviour with that which promotes health and a more satisfying way of life for her patients.

Thirdly, literature indicates that researchers have found that hysterectomized women were inadequately counselled by nurses, and strongly recommends that theory content specific to human sexuality should be included in professional nursing curricula (Krueger et al., 1979; Webb & Wilson-Barnett, 1983). Nursing students, undergraduate and graduate, should be knowledgeable about and sensitive to the socio-cultural differences of their female patients. The inclusion of female socio-cultural content in the psycho-educational component of the teaching role of the nurse facilitates competent nursing care delivery.

Finally, the professional nurse must be provided with the knowledge, as well as the skills, necessary to objectively, positively, and sensitively teach hysterectomized patients of various ethnic groups. The nurse must be instrumental in directing patients physical and emotional health, both before and after surgery.

## Recommendations

1. Future studies that would settle questions concerning the bi-directionality of social support and life satisfaction of hysterectomized and non-hysterectomized black women are recommended.

2. Replication studies need to be done, using both larger and more representative samples of black hysterectomized women, from urban and rural geographic areas that would increase the generality of the findings. This was a voluntary convenience small sample, obtained from one urban area in the United States.

## REFERENCES

- Anderson, O.W., & Feldman, J.H. (1956). *Family medical costs and voluntary health insurance: A nationwide survey*. New York: McGraw-Hill.
- Barker, M.G. (1968). Psychiatric illness after hysterectomy. *British Medical Journal*, 2, 91-95.
- Benedek, T. (1950). Climacterium: A developmental phase. *Psychoanalytic Quarterly*, 19, 1-27.
- Berle, B.B., Pinsky, R.H., Wolf, S., & Wolff, H.G. (1952). A clinical guide to prognosis in stress diseases. *Journal of American Medical Association*, 149, 1624-1628.

- Bloom, J.R. (1979). Social support, coping and adjustment to mastectomy. *American Association for Cancer Research*, 20, 360-364.
- Brown, G.W., & Harris, T. (1978). *Social origin of depression: A study of psychiatric disorders in women*. London: Tavistock.
- Bunn, T.A., & Clarke, A.M. (1979). Crisis intervention: An experimental study of the effects of a brief period of counseling on the anxiety of relatives of seriously injured or ill hospital patients. *British Journal of Medical Psychology*, 52, 191-195.
- Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine*, 38, 300-314.
- Deutsch, H. (1945). *The psychology of women. Volume II*. New York: Grune and Stratton.
- Doyle, J.C. (1953). Unnecessary hysterectomies. *Journal of the American Medical Association*, 151, 364.
- Drellich, M.G., & Bieber, I. (1958). The psychological importance of the uterus. *Journal of Nervous and Mental Disorders*, 126, 322-336.
- Drellich, M.G., Birbrt, I., & Sutherland, A.M. (1956). The psychological impact of cancer surgery VI. Adaptation to hysterectomy. *Cancer*, 9, 1120-1126.
- Finck, K.S. (1979). The potential health care crisis of hysterectomy. In D. Kjevik & I.M. Martinson (Eds.), *Women in stress: A nursing perspective*. New York: Appleton-Century-Crofts.
- Finlayson, A. (1976). Social networks as coping resources: Lay help and consultation patterns used by women in husband's post-infarction career. *Social Science and Medicine*, 10, 97-103.
- Hetherington, E.M., Cox, M., & Cox, R. (1978). The aftermath of divorce, stress and coping in divorce: A focus on women. In N. Gullahorn (Ed.), *Psychology and transition*. New York: B.H. Winston.
- Jackson, B.B. (1982). *Life satisfaction in black climacteric women*. Doctoral dissertation, University of Pittsburgh.
- Krueger, J.C., Hassell, J., Goggins, D.B., Ishimatsu, T., Pablico, M.R., & Tuttle, E.J., (1979). Relationship between nurse counseling and sexual adjustment after hysterectomy. *Nursing Research*, 28, 145-150.
- Larned, D. (1974). The gleening of the womb. *New Times*, 2, 35-39.
- Ley, P. (1977). Psychological studies of doctor patient communication. In S. Rachman (Ed.), *Contributions to medical psychology Volume 1*. Oxford: Pergamon Press.
- Litman, T.J., (1966). The family and rehabilitation. *Journal of Chronic Disease*, 19, 211-217.
- Maguire, L. (1983). *Understanding social networks*. Beverly Hills: Sage Publications.
- McAdoo, H.P. (1980). Black mothers and the extended family support network. In L. Rodgers-Rose (Ed.), *The black woman* (pp. 124-144). Beverly Hills: Sage Publications.
- Melody, G.F. (1962). Depressive reactions following hysterectomy. *American Journal of Obstetrics and Gynecology*, 83, 410-413.
- Miller, N.F. (1946). Hysterectomy: Therapeutic necessity or surgical racket? *Obstetrics and American Journal of Gynecology*, 51, 804-810.
- Moos, R.H., & Tsu, V.D. (1977). *Coping with physical illness*. New York: Plenum.
- Myers, I., Linderthal, J., & Pepper, M. (1975). Life events, social integration, and psychiatric symptomatology. *Journal of Health and Social Behavior*, 16, 121-127.
- Neugarten, B.L., Havinghurst, R.J., & Tobin, S. (1961). The measurement of life satisfaction. *Journal of Gerontology*, 16, 134-143.

- Nuckolls, K.B., Cassel, J., & Kaplan, B.H. (1972). Psychosocial assets, life crisis and prognosis of pregnancy. *Journal of Epidemiology*, 95, 431-441.
- Palmore, E., & Luikart, C. (1972). Health and social factors related to life satisfaction. *Journal of Health and Social Behavior*, 13, 68-80.
- Parlee, M.B. (1978). Social factors in the psychology of menstruation, birth, and menopause. *Primary Care*, 3, 447-490.
- Parrott, M.H. (1972). Elective hysterectomy. *American Journal of Obstetrics and Gynecology*, 113, 113-536.
- Patterson, R.M., Craig, J.B., Dinitz, S., Lefton, M., & Pasamanick, B. (1960). Social and medical psychiatric patients. *Obstetrics and Gynecology*, 15, 209-216.
- Paykel, E.S., Emms, E.M., Fletcher, J., & Rasaby, E.S. (1980). Life events and social support in puerperal depression. *British Journal of Psychiatry*, 136, 339-346.
- Payne, B.P. (1975). The elderly woman volunteer: Sex differences in role continuity. Paper presented at the annual meeting of the Society for the Study of Social Problems. San Francisco, CA.
- Payne, R., Payne, B.P., & Reddy, R. (1972). Social background and role determinants of individual participation in organized voluntary action. In D.H. Smith, D. Reddy, & B.R. Baldwin (Eds.), *Voluntary action research*. Lexington, MA: D.C. Heath.
- Raphael, B. (1976). Psychiatric aspects of hysterectomy. In J. Howells (Ed.), *Modern perspectives in the psychiatric aspect of surgery*. New York: Brunner/Mazel.
- Richards, D.H. (1974). A post-hysterectomy syndrome. *The Lancet*, 2, 430-433.
- Robertson, E.K., & Suinn, R.M. (1968). The determination of rate of progress of stroke patients through empathy measures of patients and family. *Journal of Psychosomatic Research*, 12, 189-191.
- Robertson, J.F. (1978). Women in mid-life crisis, reverberations and support networks. *Family Coordinator*, 27, 376-381.
- Rodgers, D. (1980). *The adult years*. Englewood Cliffs, NJ: Prentice-Hall.
- The determination of the necessity of gynecological surgery. The Statement Policy (1977). As issued by the Executive Board of the American College of Obstetricians and Gynecologists, Chicago, May 7.
- Tobin, S.S., & Neugarten, B.L. (1961). Life satisfaction and social interaction in the aging. *Journal of Gerontology*, 16, 344-346.
- Turpin, T.J., & Heath, D.S. (1979). The link between hysterectomy and depression. *Canadian Journal of Psychiatry*, 24, 247-252.
- United States Superintendent of Documents. (1983). *Statistical abstract of the United States*, 115.
- Webb, C., & Wilson-Barnett, J. (1983). Self-concept, social support and hysterectomy. *British Journal of Nursing Studies*, 2, 97-107.
- Weiss, R.S. (1975). *Marital separation*. New York: Basic Books.
- Williams, A.W., Ware, J.E., & Donald, C.A. (1981). A model of mental health life events and social supports applicable to general populations. *Journal of Health and Social Behaviour*, 22, 324-337.
- Williams, M.A. (1973). Cultural patterning of the feminine role: A factor in the response to hysterectomy. *Nursing Forum*, 12, 379-387.
- Wolf, S.R. (1970). Emotional reactions to hysterectomy. *Postgraduate Medicine*, 47, 165-169.
- Zussman, L., Zussman, S., Sunley, R., Bjornson, E. (1981). Sexual response after hysterectomy-oophorectomy: Recent studies and reconsiderations of psychogenesis. *American Journal of Obstetrics and Gynecology*, 140, 725-729.

## RÉSUMÉ

### **Être satisfaite de son sort: rôle variable "ressources sociales" chez les femmes noires ménopausées soumises à une hystérectomie**

Les variables "ressources sociales" ont été identifiées comme pouvant éventuellement assurer la médiation du rapport entre la réaction de la femme noire à l'hystérectomie et son niveau de satisfaction face à la vie. Les variables de ressources sociales ont été évaluées en termes d'appui social et affectif apporté par: 1) le mari ou le partenaire sexuel, 2) les enfants dans leur rôle de soutien, 3) les parentes dans leur rôle de confidentes, 4) les amies dans leur rôle de confidentes, et 5) les membres d'organismes sociaux de bénévoles. Les femmes noires ayant subi une hystérectomie ont été définies de la façon suivante: femmes afro-américaines âgées de 40 à 60 ans, nées et élevées aux États-Unis sans hospitalisation psychiatrique connue et ayant subi une hystérectomie simple ou une hystérectomie-ovariectomie. Un dernier échantillon maniable de 89 sujets volontaires a été recruté parmi des femmes afro-américaines répondant aux critères et prêtes à signer le formulaire de consentement; elles ont été retenues parmi un échantillon plus important de 209 femmes noires ménopausées. L'inventaire des ressources sociales de Jackson (1982) dont les 59 éléments ont fourni une gamme de 0,85 à 0,93 de cohérence interne a servi à mesurer les aspects qualitatifs et quantitatifs des relations du réseau, et l'indice de satisfaction de la vie (Life Satisfaction Index A (LSIA)) de Neugarten (1961) en 20 éléments, outil sûr et valable, a servi à mesurer le degré de satisfaction face à la vie. Les données ont été analysées à l'aide d'un test t à variable unique pour déterminer si le groupe ayant obtenu un score élevé et le groupe ayant obtenu un bas score à chacune des cinq composantes présentaient des niveaux de satisfaction différents face à la vie. Les statistiques ont corroboré quatre des cinq hypothèses. Les implications théoriques et cliniques au niveau des sciences infirmières sont proposées d'après ce schème de résultats.

# COMPUTERS IN USE — DESIGN OF A SYSTEM FOR THE STUDY OF A CHRONIC DISEASE

Gloria L. Joachim

This paper will show how a conventional commercial method of data processing, using a mini computer, can be applied to establish a computerized system for the study of a chronic disease. Inflammatory bowel disease (IBD) is a long term disorder whose cause and cure are unknown (Thayer, 1980). IBD is usually diagnosed sometime between the patient's late teens and early thirties, and lasts for the duration of the person's life (Grace & Priest, 192). Dealing with a chronic disease like IBD highlights the necessity for using modern technology to increase the available body of knowledge about it.

Using the proposed method in nursing practice will place the nurse in the role of data collector, user of technology, and key person for future scientific study. The method describes the logical and technical development of a system, excluding details about programming and actual file creation on the computer. The proposed system consists of four parts: a permanent file, an update file, an index file, and an output or access to the file.

The availability of data from large numbers of patients makes it possible to examine nursing problems that previously could have been studied only in small sample populations. The proposed system creates files for any number of patients, and makes the information available to the nurse for study.

## Literature Review

A review of the literature pertaining to information systems in both nursing and medical practices, and the significance of the problem of IBD led to the conclusion that while computers have been used in some areas of nursing and medicine, they have not been used to establish a comprehensive, longlasting file of records for patients with severe chronic diseases, such as IBD. Much has been said about the need for computers to be used in nursing practice with little having been done (Edmunds, 1982; Johnson & Stegen, 1982; Muirhead, 1982; Powell, 1982; Pritchard, 1982; Sorkin & Bloomfield, 1982). The nurse's expanding role now necessitates the availability of computers

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that will facilitate the retrieval of data accurately, efficiently, and quickly (Reeves & Underly, 1982). The nurse becomes the central figure and must learn to put information into the computer and to obtain useful information from it.

In nursing and medical practice, computerization has first advanced where it is most needed and cost-effective: in areas of medical records, statistics, monitoring laboratory values, and in the administration of patient care services (Cook, 1982; Doyle, 1980; Groves, 1980; Groves & Davidson, 1980; Meldrum, 1981; Reeves & Underly, 1982; Reilly, 1982; Turner, Jones, & Streeter, 1980). The use of mini computers for equipment inventory (Howlett, Kenyon, & Kinder, 1981), for calculating the nurse's workload (Henney & Bosworth, 1980), for ordering supplies (Reeves & Underly, 1982), and for sorting nursing education records (Marks, 1981) has been documented. It has been suggested that computers be used to determine hospital staffing needs and to compile work-related data on the nursing staff (Reeves & Underly, 1982).

A computer was used to index a diabetic clinic population, in terms of age, sex, treatment, and complications (Watkins, Sutcliffe, Pyke, & Watkins, 1980). The records were updated at regular intervals and were compared with records of a like patient population that had been obtained in another country.

A computerized disease registry that records all patients seen in a clinic according to disease, age, and sex was compiled (Meldrum, 1981). The registry enables patients to be contacted for one problem even if their reason for seeking help was another problem. Computers can be used to examine a patient's history, to see what makes him ill, and to determine which patients improved most using certain treatments (Turner et al., 1980). Computers can specify the number of patients seen for a given disease over a period of time, and can quickly retrieve the data, along with related statistical analyses (Turner et al., 1980).

Advantages of using computers for keeping medical records include more accurate documentation, neat notations that cannot be misinterpreted, efficiency, and time and money saved (Reeves & Underly, 1982). No literature was found that cited the use of computers to establish a scientific, patient-oriented long term data base.

IBD is a chronic inflammatory gastro-intestinal disorder. The term IBD is commonly applied to diagnoses of ulcerative colitis and Crohn's disease (Anderson, 1982). The manifestations of the inflammatory process can be severe, and may affect multiple aspects of a person's life. While the prevalence of IBD has been established as be-

tween 90-300 per 100,000 population (Mendeloff, 1980), the disease is on the increase (Farmer, 1980). Although the given prevalence does not indicate that IBD is a problem of great magnitude, the extent to which IBD patients use hospital services does indicate its severity. In British Columbia, from April 1981 to March 1982, 7,054 hospital discharges, involving 48,045 hospital days were IBD cases (British Columbia Ministry of Health, 1983).

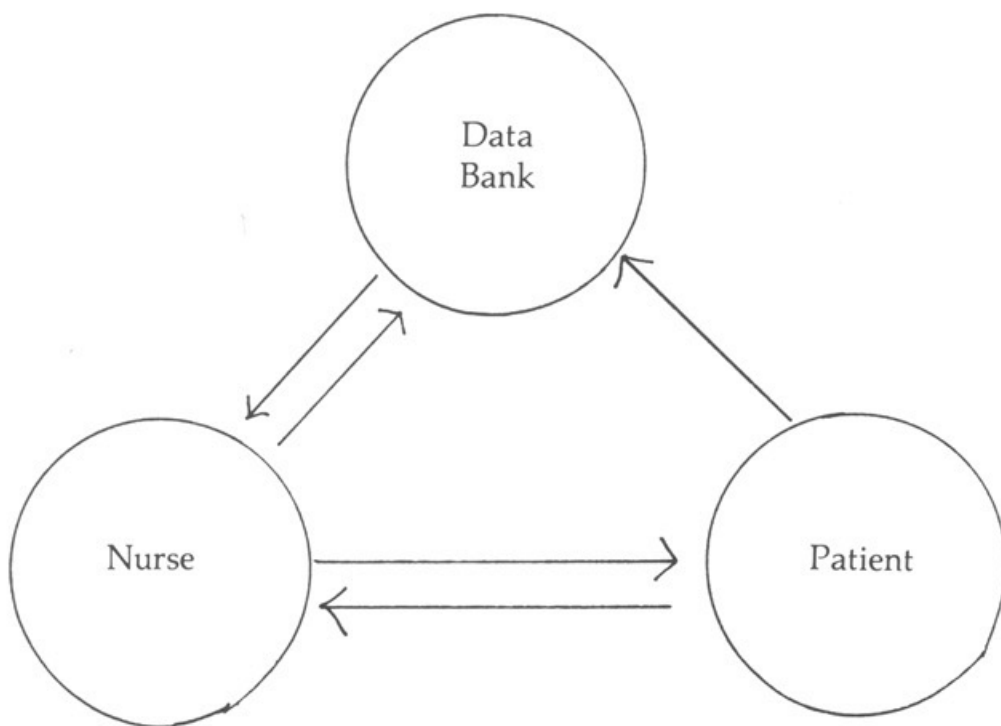
The cause and cure of this chronic life-long condition remain unknown (Anderson, 1982). There has been speculation about the etiology that involves genetic factors (Cullen, 1982), injurious substances (Beck, 1982), hypersensitivity of the individual (Goodacre, 1982), viruses or bacteria (Baker, 1982), and infectious agents (Tyrrell, 1982); but none of these possibilities has been confirmed. More research is needed to find the cause and cure of IBD, so that the needs of sufferers can be met (Anderson, 1982).

### Development of the System

Several steps led to the development of the system. A problem has always existed in the area of history taking. Gathering standardized information that could become a data base for scientific study for nursing purposes has rarely been done. Patients seeking treatment for IBD have been assessed with general history forms. On subsequent visits, they are assessed with the same form again. General forms with headings such as history of present illness, medication, and effect of disease on lifestyle collect non-specific information that may overlook significant factors about the patient. In addition, these forms lack information regarding details of past problems and interventions. The problem of lack of continuity of information becomes more acute. Most of the information collected in these depends upon the education, experience, and point of view of the nurse present. A high rate of staff turnover may also make it impossible to collect consistent, objective information.

Another factor that has been considered in the development of this system is the mobility of information. Regardless of the initial geographical location of the patient, by having all information available in the master file, the proposed system is able to "carry" the patient's information to his or her next location. Economic conditions continue to force many people to move and relocate. The flexibility of an information system that is intended to answer today's demands creates new independence and aids in the continuity of care.





*Figure 1. Data flows independently of patient location.*

A data collection tool that addresses the specific requirements of the IBD patient was developed. Great consideration was given to making the system "dynamic" — that is, having the flexibility to adapt itself to changes that occur over time, or to changes from the demands of the nursing profession. New categories to be monitored can easily be added to the system, and those that become insignificant can be deleted.

The distribution of IBD cases is proportional to the distribution of the Canadian population (IMS, 1983). This factor gave rise to the idea of having one central data base where all of the information is housed, and, that communicates with many satellite clinics on terminals which have 2-way input/output into the system. For the first time, a nurse in a remote centre would have access to the information of a large centre. In phase I, the data base will be established and, in phase II satellite centres will become participants in the information exchange.

Available hardware was examined. The search led to the conclusion that the proposed system will use an IBM personal computer XT unit that will have an initial capability up to 128 K memory, disk drive 1-320 K, one 10 megabyte hard drive, one Monochrome display screen, one printer, and will use 2.0 DOS, a COBOL compiler, and one asynchronous communications 2.0. If needed, this system can be

increased to 640 K memory, 20 megabyte hard drive, and disk drive that can be increased to 640K (IBM, 1983).

This configuration will have a memory large enough to contain all necessary programs. It will also have a large storage capacity on disk, it will produce printout reports, will contain a ready made software compiler (COBOL) with versatility for processing data and scientific work. The system is also capable of connecting with satellite IBD clinics in remote areas, and communicating with hospitals and other medical facilities about the personal record and permanent file.

The decision to use commercially available software with a COBOL compiler was made because it enables the system to have built in routines and commands for scanning each record thoroughly, and because it has other features that facilitate the programming process of this system.

The low cost of developing and maintaining the system was a major consideration in the choice of both the hardware and the software. It may surprise nurses and administrators to learn that leasing the above hardware and built-in software costs approximately \$300 per month for the data centre, and \$150 per month for each satellite centre (IBM Configuration Guide). Programming, an expense incurred only once, is estimated at approximately \$10,000. Maintenance of the systems would be done by one operator/programmer. In comparison with this cost, usage of central processing unit time for one hour is \$800 for commercial use, and additional charges are incurred for storage of information and usage of the system (UBC, 1983).

### *The Permanent File*

The permanent file contains and stores the permanent records of the IBD patient. To date, no permanent file exists with data about IBD patients. Valuable information about individuals once treated for IBD is lost. The permanent record enables the information to be gathered and housed for later analysis. The permanent file consists of all records of individuals seen for IBD.

The format of each record is that of the data collection tool. The record contains a patient identification code and a secondary protection code. The codes protect the patient's identity while allowing records to be recognized and made accessible to researchers. Each question on the tool is defined as a category and the number of categories appears following the secondary protection code. Each category maintains the same number in all records for easy identification. Each category will consist of an identification number, the total number, the total number of updates, and will be followed by the updates.

<u>code number</u>	<u>second safety code</u>	<u>number of categories entered in the record</u>
<u>category number</u>	<u>no. of entries in category</u>	<u>Information #1</u>
		<u>Information #2</u>

EXAMPLE: Weight in Kg.

<u>0 1 0</u>	<u>0 0 3</u>	<u>8 1 0 2 2 2 0 5 5 2 5</u>	= FEB. 22/81	55.25 Kg
		Y Y M M D D W W W W W		
		<u>8 1 8 0 1 2 0 5 1 5 0</u>	= OCT. 12/81	51.50 Kg
		<u>8 2 0 3 1 5 0 4 8 7 5</u>	= MAR. 15/82	48.75 Kg

Y = year  
M = month  
D = date  
W = weight

Figure 2. Structure of a record.

Figure 2 illustrates the structure of a record and category. The example presented illustrates the weight category, its number, the number of updates, date of update, and the information collected in kilograms. Similar information in all specified categories will be recorded for each patient. Figure 2 shows how the patient responds to nursing care by keeping track of the present state and keeping in mind the past history.

Additional categories can be incorporated by assigning a new category number and adding it to the tool. Deleting information from the master file, when it is no longer needed, could be automatically done by the program.

The quantity of information that will be collected from a patient during his lifetime is difficult to estimate because of the variability of the disease process. Therefore, collecting the data on disk drive, maximizes the system's ability to house information. Large volumes of information can now be stored.

Benefits of a permanent file include accurate history taking about the patient's status, decreased time spent filling out and filing papers, and a continuous, updated account of the patient's health status. The information is stored and easily accessible for research purposes.

#### *Development of the Tool\**

A data collection tool, designed to collect specific information from the IBD patient, was developed. The information is collected in a standardized format and becomes the basis for scientifically gathering information about the IBD patient. Much nursing literature now concerns itself with holism, a philosophy that deals with the total person and with the individual's relationship to all aspects of his environment (Iveson & Iveson, 1981). This tool employs that philosophy and collects data about the patient's family, environment, habits and attitudes.

The tool consists of two parts. Part One contains data about the patient and his family prior to diagnosis, and Part Two deals with data related to individual characteristics following diagnosis. Part One collects unchanging information about the family history, environment, dietary habits, diseases, and areas that could be implicated in contracting IBD. Part Two collects a social and changing data base, a nutritional data base, and a physiological data base. While Part One data is collected only once and stored, Part Two data is collected on each visit.

\*For a copy of this tool please write to the author.

A two-part tool was developed for several reasons. First, baseline patient information is collected and stored about the patient and his family prior to diagnosis. This information does not change, and when examined may give clues about common factors implicated among persons contracting IBD. It also enables changes from the pre-illness state in each IBD patient to be followed. Part Two data allow a current, useful working data base for each patient to be readily available.

The categories of the tool are organized under the headings; social, nutritional, and physiological data bases. These headings were selected from a review of the literature of IBD, from consultation with health care professionals, and from the writer's work. They identify the major coping challenges to the IBD patient. The categories of questions allow objective data to be elicited in areas of importance. The questions have employed the work of major theorists and clinicians in the area of IBD.

The social data base includes aspects about work, travel and environment, family, and coping with a chronic illness (Friedman, 1981). A detailed nutritional data base assesses the kind and quantity of food consumed and the effects of the food on the patient. The patient is asked about his use of natural laxatives such as pecans, tapioca, fruit, and wheat bran. He is asked about his intake of peanuts, almonds, yogurt, sesame seeds, and certain spices because they are known to alter intestinal flora and might have effects on the disease (Le Sassier, 1978). Vitamin intake is also assessed. The intake of tea and coffee, which aggravate the disease in some people (Given & Simmons, 1979), is determined.

The physiological data base addresses symptoms of the disease such as weight loss, diarrhea, diarrhea alternating with constipation, anemia, pain, sleep difficulties, arthritis, iritis, abscesses, fissures, fistulas, and skin problems (Farmer, 1980). In addition, current allergies, exercise, and intake of medications are covered.

The data collection tool ensures that the same questions are asked consistently each time the patient is seen, and that the answers are recorded in a standard manner. The information is banked in the permanent file. Availability of data in a large population, over a period of time, will contribute a broad knowledge base from which to draw conclusions.

### *The Update File*

The first time a patient is seen, both parts I and II of the data collection tool are used. Both historical and patient update information are collected. On subsequent visits, only part II, the patient update infor-

mation from is used. The information collected in the update file is then transferred, by program, to the permanent file. The format of the update file is the same as that of the permanent file.

### *The Index File*

A major dilemma of computerized health records involves the desire that information be available for study and the need for anonymity of the patient. The index file cross-references the patient's real name and personal information with his code. His code is a number unique to the individual. Access to the index file is limited to those giving direct care to the patient, and to those needing clerical information. Information may be retrieved in the form of a printout or on the screen of the video display terminal. It may be a complete patient history or one or more categories from the patient tool.

### Advantages of the System

The patient contributes information to the system and receives benefits from the system. Advantages for the patient over conventional record-keeping include comprehensive individualized monitoring, prompt treatment of problems, and rapid transfer of records. The system enables patient problems to be monitored closely and changes to be spotted quickly, and treated promptly. Significant weight changes, for example, could be identified over a period of time. In the conventional manner of following patients these might be missed.

Patients who did not return for an appointment could be located and contacted in order to find out why they did not return. Once a month, the system could be programmed to identify all patients who missed appointments. The person with access to the index file could then identify the individuals, and, if necessary, schedule an appointment. Perhaps the symptoms have improved or he objected to some aspect of his care. These areas could be pursued with him, his record updated, and his plan of care changed to best meet his needs. As more information is known about IBD, patients can be better cared for.

### New Directions in Nursing

Nurses who use this system will find data that is objective, collected consistently, and has validity as the basis of scientific study. The system makes data available that has a common denominator for the study of trends among IBD patients, that can be used to generate clinical research. Avenues of study opened through this system include the ability to isolate one variable and to compare it with other variables within the same patient, and to compare one patient's condition with another patient's condition.



It is also possible to study several variables as a group and to examine their inter-relationship. It might be noted, for example, that those patients who use stress management techniques or who exercise regularly report less intake of medication or a lower incidence of diarrhea than patients who do not. If this were the case, learning stress management techniques and exercise could be built into the care plan of the IBD patient.

Previously, physiological, psycho-social, and nutritional aspects of the IBD patient were not studied together in a large population. This would be an interesting avenue to study.

### Conclusion

A system in which the nurse uses an IBM mini-computer to manage collection and retrieval of data about the IBD patient has been described. In her 1982 editorial comment, MacPhail states, "The greatest need in nursing as a discipline is to develop the scientific base of nursing practice for the purpose of improving nursing care" (MacPhail, 1982). Implementing the proposed system will comply with this vision of the future nurse.

### REFERENCES

- Anderson, F.H. (1982). An Overview. In A.B.R. Thomson (Ed.). *Idiopathic Inflammatory Bowel Disease: Crohn's Disease and Chronic Ulcerative Colitis*. Ottawa: Canadian Public Health Association.
- Baker, S.J. (1982). Intestinal Microflora. In A.B.R. Thomson (Ed.). *Idiopathic Inflammatory Bowel Disease: Crohn's Disease and Chronic Ulcerative Colitis*. Ottawa: Canadian Public Health Association.
- Beck, I.T. (1982). The Inflammatory process: Cellular response and tissue repair. In A.B.R. Thomson (Ed.). *Idiopathic Inflammatory Bowel Disease: Crohn's Disease and Chronic Ulcerative Colitis*. Ottawa: Canadian Public Health Association.
- British Columbia Ministry of Health, Hospital Programs, Research Division, March 11, 1983, personal communication, M. Gardner.

- Cook, M. (1982). Selecting the right computer system. *Nursing Management*, 13(8), 26-28.
- Cullen, J.B. (1982). Genetic and familial aspects. In A.B.R. Thomson (Ed.). *Idiopathic Inflammatory Bowel Disease: Crohn's Disease and Chronic Ulcerative Colitis*. Ottawa: Canadian Public Health Association.
- Doyle, O. (1980). Data base: New management power. *Modern Health Care*, 10 (5), 88, 90.
- Edmunds, L. (1982). Computer assisted nursing care. *American Journal of Nursing*, 82(7), 1076-1079.
- Farmer, R.G. (1980). Clinical features and natural history of Inflammatory Bowel Disease. *Medical Clinics of North America*, 64(6), 1103-1115.
- Friedman, M.M. (1981). *Family nursing theory and assessment*. New York: Appleton-Century-Crofts.
- Goodacre, R.L. (1982). Altered Immunology: Humoral and cellular aspects. In A.B.R. Thomson (Ed.). *Idiopathic Inflammatory Bowel Disease: Crohn's Disease and Chronic Ulcerative Colitis*. Ottawa: Canadian Public Health Association.
- Given, B.A., and Simmons, S.J. (1979). *Gastroenterology in clinical nursing* (3rd ed.). Toronto: C.V. Mosby.
- Grace, M., and Priest, G. (1982). The epidemiology of Inflammatory Bowel Disease. In A.B.R. Thomson (Ed.). *Idiopathic Inflammatory Bowel Disease: Crohn's Disease and Ulcerative Colitis*. Ottawa: Canadian Public Health Association.
- Groves, W.E. (1980). Storage and retrieval of coded patient diagnoses and data on a clinical laboratory computer system. *Computer Programs in Biomedicine*, 12, 225-229.
- Groves, W.E., and Davidson, W.R. (1980). A computerized chart management system for medical records. *Computer Programs in Biomedicine*, 11, 158-164.
- Henney, C.H., and Bosworth, R. (1980). A computer-based system for the automatic production of nursing workload data. *Nursing Times*, 76, 1212-1217.
- Howlett, P.J., Kenyon, N.G., and Kinder, N.J. (1981). Information handling in the hospital: A flexible mini computer approach. *Journal of Medical Engineering and Technology*, 5(2), 36-39.
- IBM, Configuration Guide, IBM Personal Computer, March 7, 1983.
- IBM, IBM Personal Computer XT, 1983.
- Intercontinental Medical Statistics of Canada, Limited. (1983). *The Canadian Disease and Therapeutic Index*.
- Iveson-Iveson, H. (1981). Holism: A philosophy of life. *Nursing Mirror*, 152(20), XXIV-XXV.
- Johnson, I., and Stegen, A. (1982). Will the computer be the new nurse's aid? *RNABC News*, 14(1), 8-9.
- Le Sassier, W. (1978). Meet your colon. In Berkeley Holistic Health Center (Compiler), *The holistic health handbook a tool for attaining wholeness of body, mind, and spirit*. Berkeley, California: And/or Press.
- MacPhail, J. (1982). Editorial. *Nursing Papers/Perspectives en Nursing*, 14(3), 2-3.
- Marks, R.J. (1981). Is the computer the answer? *The Journal of Continuing Education in Nursing*, 12(2), 25-27.
- Meldrum, D. (1981). Practice research simple computerised disease register. *British Medical Journal*, 282, 191-198.



- Mendeloff, A.I. (1980). The epidemiology of Inflammatory Bowel Disease. *Clinics in Gastroenterology*, 9(2), 259-271.
- Muirhead, R. (1982). Happening now: The decline and fall of paperwork. *RN*, 45, 34-40.
- Powell, N.M. (1982). Designing and developing a computerized hospital information System. *Nursing Management*, 13(8), 40-45.
- Pritchard, K. (1982). Computers possible applications in nursing, part 3. *Nursing Times* 78(11), 465-466.
- Reeves, D.M., and Underly, N.K. (1982). Computerization of nursing. *Nursing Management*, 13(8), 50-53.
- Reilly, D. (1982). A computerized patient information system. *Nursing Management*, 13(8), 32-34, 36.
- Sorkin, J., and Bloomfield, D. (1982). Computers for critical care. *Heart Lung*, 11(4), 287-293.
- Thayer, W.R. (1980). Inflammatory Bowel Disease: Where are the Frontiers? *Medical Clinics of North America*, 64(6), 1220-1231.
- Turner, R.D., Jones, R.V.H., and Streeter, J.E.M. (1980) Computers in primary care: where next? *British Medical Journal*, 11, 1020-1021.
- Tyrell, D.L.J. (1982). Transmissible agents. In A.B.R. Thomson (Ed.). *Idiopathic Inflammatory Bowel Disease: Crohn's Disease and Chronic Ulcerative Colitis*. Ottawa: Canadian Public Health Association.
- U.B.C. Computer Price List Quotation, July 6, 1983.
- Watkins, G.B., Sutcliffe, T., Pyke, D.A., and Watkins, P.G. (1980). Computerization of diabetic clinic records. *British Medical Journal*, 281, 1402-1403.

## RÉSUMÉ

### Les ordinateurs au travail — conception d'un système pour l'étude d'une maladie chronique

Le présent article décrit comment une méthode de traitement des données peut être appliquée, à l'aide d'un mini-ordinateur, à un domaine de la pratique infirmière en vue de favoriser la recherche et d'accroître les connaissances infirmières. On envisage un système composé d'un fichier permanent, un fichier de mise à jour et un fichier d'index, et d'un dispositif de sortie ou d'accès au fichier qui est utilisé par l'infirmière pour consigner des données au sujet d'un malade atteint d'une affection intestinale inflammatoire.

Les affections intestinales inflammatoires sont courantes et l'on n'en connaît ni la cause ni le traitement. Le système, tout en protégeant l'identité du malade, permet à l'infirmière d'obtenir des données recueillies auprès d'un grand nombre de sujets, pendant une longue période de temps et d'utiliser ces données à des fins de recherches sur la maladie et les soins infirmiers qu'elle requiert.

# THE NURSING APPRENTICE: AN HISTORICAL PERSPECTIVE

Barbara Keddy and Evelyn Lukan

History records the process of change and can become a guide for the future if it is used to analyze past events. Social history, though often difficult to define, is most commonly associated with the history of social activities, as, for example, the membership in and development of a profession such as nursing.

In nursing research, the historical approach has generally been neglected, with the result that the whole area of the social history of the nursing profession has also been neglected. In Canada, the scarcity of literature reflects the absence of researchers who have expertise and interest in this area. There are, however, elusive questions to raise: data must be pulled together to retrieve older nurse's work lives from invisibility; studies, which will enrich our knowledge of nursing's past through first hand accounts of these activities, can be undertaken by the oral history approach. In order to broaden our understanding of the world of nursing, we need to broaden the area of research by interviewing older Canadian nurses who have important stories to tell. Far too often valuable information from one generation to another is lost because it has not been recorded.

Nursing has a long and important history, and a knowledge of this history can help give nurses a sense of belonging and identification. A knowledge of nursing history provides a historical perspective which enables nurses to build a background for understanding present day and future developments. As nurses, we need to clarify some important aspects of why and where we now are. It is often said that to know our history is to begin to see how to embark on the future.

## Purpose of the study

The purpose of the study was to examine the career histories of thirty-five older nurses, collected by means of taped interviews of nurses who had practised in Nova Scotia in the 1920s and 1930s.

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The data collected in these oral history interviews were analyzed using a grounded theory approach, to develop some perspective on the social history of nursing. In particular, the experiences and perceptions of these nurses, as they went through their training, were examined and analyzed in the hope of gaining some insights into the development of nursing as a profession.

### *Research Questions*

The specific research questions explored were:

1. What was the nature of the nursing profession in Nova Scotia in the 1920s and 1930s?
2. What types of educational background and training were necessary to practice nursing?

### *Methodology*

#### *Data Collection*

The data were collected in two stages. The first stage was a pilot study in which fifteen older nurses were interviewed, in their own homes, by the primary researcher. These data were subsequently analyzed, using a grounded theory approach, by a team of twenty research assistants who were trained by the researcher in a Research Methods class. All of the assistants were experience registered nurses. Initially all of the transcribed interviews were read by each member of the research team. Each researcher then brought to the group several concepts that had emerged from their coding of the data. Six main concepts were subsequently developed from this process, after consensus of the coders was achieved. The team was then divided into small groups, each to pursue the development of the six specific conceptual frameworks. The apprenticeship-type work ethic discussed in this paper was one of the main concepts which was developed.

After the analysis of the fifteen interviews by the grounded theory method, the second state of the study was undertaken, the research assistants each then interviewed an older nurse, using a modified interview guide based upon changes made after the first phase of the study. The data were then analyzed using, once again, the grounded theory technique. As the same patterns emerged from the second stage, they provided a check on the researchers' interpretation of the categories. All of the data from the thirty-five interviews was combined in the analyses since the findings from both stages were congruent.

## *The Grounded Theory Approach*

Nursing researchers have more usually used a deductive research approach, drawing from other related fields, extrapolating existing theories, and applying them to nursing knowledge. Few researchers have used an inductive or grounded theory whereby one enters a research situation without a preconceived idea of what one is looking for. Instead, as data are collected, examined, and analyzed, a concept emerges and requires further exploration, refinement, and testing. Glaser and Strauss (1967) describe grounded theory as a theory that is generated by, and is grounded in, raw data that has been systematically obtained and analyzed. They emphasize that one of the very important aspects of grounded theory is that the processes of collecting, coding, categorizing, and analyzing the data are all done, as much as possible, at the same time. They go on to say that the processes should blur and intertwine continually from the beginning of the project until the end, to do otherwise would hinder the generation of the theory. This differs from the deductive approach whereby the researcher focuses on each particular aspect of the project step by step, in a linear fashion.

Stern (1980), in discussing grounded theory, refers to Ludeman's article of 1979 in which it is pointed out that an inductive research technique is often thought of as "somehow second class and a little less than scientific." Stern goes on to say that grounded theory provides a method for investigating previously unsearched areas, and helps provide a new point of view in familiar situations. Using this method, the researcher attempts to identify various processes that take place within a social situation and compares these data to every other piece of datum obtained.

During the content analysis, an attempt was made to categorize the raw data into particular groupings where main ideas emerged. This categorization then allowed the researcher to select one specific category to be more closely examined in search of a particular concept. In this instance, the apprentice ethic evolved as one category to be developed.

The data were analyzed using the following steps as described by Stern (1982).

1. **Concept Formation:** At this stage, the data were examined to generate a tentative conceptual framework. The investigators determined the importance of the data according to the emphasis given by the subject, and focused on these data to gain direction for further study. Coding and categorization of data were also included in concept formation.

2. Coding: Data were grouped according to their similarities and contained the processes selected from the data by the investigators.

3. Categorization: The grouping of processes occurred according to related codes, which the investigators then placed in categories name for the processes they described.

4. Concept Development: This next stage had three components that served to broaden and consolidate the developing theory, giving it a sense of completeness. These stages, reduction, selective sampling of the literature and selective sampling of the data, helped isolate the central variables.

5. Reduction: Reduction was the process of reducing or linking small discrete categories into larger, more encompassing ones.

6. Selective Sampling of the Literature: This step involved searching the literature for information on the new categories that arose from the data analysis that was related to the work of other authors. The literature was screened for material to help expand, clarify and strengthen the theory. Relevant literature contributed to the refinement of the theory and related in to other theories.

7. Selective Sampling of Data: To assist with formation of the conceptual framework, data were collected during the second stage of the study. This helped in revision, addition, or deletion of aspects in the framework. This process continued until no new data were found.

8. Discovery of the Central Variables: Eventually, as a result of the above processes, the core or central variables began to emerge, with the ability to explain the situation under study. At this point, the data were scrutinized to assess the "fit" of the core variables. The ability of the data to be the central pivot, around which events and actions were understood and could explain the phenomenon, provided verification that the results of the investigation were grounded in the data.

9. Concept Modification and Integration: In the theoretical stage the data were translated from descriptive terms into abstract theoretical terms. These abstractions were enhanced by analytical schemes such as causes, consequences, conditions, etc. which assisted this conceptualization.

Through memo-writing we noted ideas and thoughts that illuminated the analyses and preserved them for later use in the report. The research notes provided greater awareness of the implications and meaning of behaviours, and formed the basis of the research report.



From the analysis of the data, several core variables became evident. This report, however, will deal only with one, that is, the apprenticeship-work ethic.

### *Oral History Taking*

The data were collected by means of oral histories. Although the questions were relatively structured, the approach was extremely flexible. In this way, the person being interviewed was allowed freedom to reminisce as much as was deemed necessary. The respondents were invited to share their memories of their careers, with specific reference to the effects of social events that influenced their lives or their decisions to become nurses. There was also an overlap into the area of personal history, which allowed the respondent the pleasure of re-living her past, and which allowed the researcher primary source data of an historical nature. Telling one's life story is a method that is particularly well suited to finding out the meaning that people give to their lives. These oral histories become, not only a research tool, but also, a method whereby the results could be transmitted and interpreted. The process becomes a means of analyzing historical information about individuals, groups, or professions, and interweaving it with the literature. In addition, recalling past life experiences can promote pride in past accomplishments for the respondents (Kotre, 1984).

### *Interview Technique*

Interviews were conducted after the purposes of the study were described to respondents, and they had agreed to be interviewed. Informed, signed consent allowed the researcher to make public both the data and the tapes. Each individual was interviewed in her own home at her convenience. An interview guide had been previously developed, using structured questions, to help determine demographic variables and to provide some stimuli for the respondents. However, the interview was structured only in this sense. After several interviews, many questions were dropped from the list for subsequent interviews. After the first phase the interview guide was modified. This approach is consistent with the grounded theory method.

Although there were multiple interviewers in the second stage of data collection, there was no attempt made to establish inter-rater reliability, which in the usual sense of the procedure is familiar to the deductive approach. Instead, each respondent was allowed to interpret the questions in whatever way she felt comfortable. The interviewers followed through on areas of interest that could provide rich data, and were free to pursue the questioning in a manner that permitted a great deal of flexibility. This decision is consistent with



that of Angrosino (1982). He writes:

This approach cost us with respect to the comparability of the narratives since each interview is, in a sense, a unique encounter between informant and researcher. But the preservation of the variable human tone was more important to us than the satisfaction of a vigorous research design. (p.101)

While the collection of data employed a subjective free-form approach, as has already been discussed, the codes and categories were developed after consensus among the coders was achieved. In this sense inter-rater reliability was attained.

### *Population*

Nurses were selected by means of a snowball technique; that is, as one interview was completed the respondent would suggest the name of another respondent. Or, in some cases, various other interested persons would provide names of potential respondents. A non-random selection technique was used, whereby an attempt was made to provide for a sample that was representative of a cross-section of nurses from most of the counties in Nova Scotia. Their ages ranged from 70 to 85 years. All of the nurses were interviewed in their own homes.

## Data Analysis and Literature Review

### *Apprenticeship-Training Ethic*

The apprenticeship-training ethic is one of the six major concepts which emerged from an analysis of the raw data obtained in the interviews. Those interviewed were asked to describe different aspects of their training, by recalling the period from their first day, onward. The description of each respondent brought forth the concept of an apprenticeship-training ethic, which was very much in evidence in the 1920s and 1930s. Webster's defines training as "the development of a particular skill or group of skills; to instruct or drill in habits of thought and action", while apprenticeship is defined as "one who is learning by practical experience under skilled workers a trade, art, or calling for a prescribed period of time."

### *Learning on the Job*

That nursing be recognized and accepted as a profession is an issue nursing leaders have struggled with for more than a century. Yet, it is an issue that has frequently been questioned throughout the history of nursing, particularly in light of apprenticeship-type training. Kelly (1981) argues that in the early 1900s, nursing education was not

professional, and was not even a respectably run apprenticeship, because novices learned from their peers and not from skilled masters. She goes on to say that nursing was not considered a profession partly because it was not situated in an academic setting. Consider the answer of one respondent who described her first day in training, in 1922, in the Regina General Hospital in this way... "I was taken up and shown the gauze room and taught how to make dressings. The next day, I had a new one with me, so I was the senior one in the gauze room." And another respondent, who trained in the late 1920s in Glace Bay, N.S., described her first day as follows..." It was a Sunday and I was assigned to a third year student who was in charge of a women's surgical unit." Although Dock and Stewart (1920) describe this pattern as prevalent primarily in the early hospitals of the Christian era, their quote aptly sums up the situation in the 1920s and 1930s. They write, "The educational system was largely that of apprenticeship, a training through actual experience, the experience being graded and varied" (p. 301).

Historically, the status of the nursing profession not only closely paralleled the that place women were given in society, but it was also closely related to the prevailing philosophies of the time. Pelly (1964) points out that the pattern of organization and the practice of nursing evolved in relation to the evolving pattern of European Society. As a result, she says, nursing was strongly influenced by the monastic religious orders who did most of the caring for the sick throughout the Middle Ages, the Renaissance, and the Reformation. Allan and Jolley (1982) describe the beginnings of nursing schools during the 1840s as small societies of nurses formed to work among the poor. There was little actual training. The nurses went daily, for a few months, to learn from the ward sisters, who themselves were not educated and so were limited in their ability to impart knowledge; no theoretical instruction was given. Was this so different in the 1920s? One older nurse said, "We learned from other students then we taught others." In the 1870s, the Augustine Sisters introduced an apprenticeship method of instruction and training into their preparation of those appointed to care for the sick. In Canada, a form of organized nursing was first introduced by French nuns in their effort to care for the new settlers. Their system too, closely conformed to the French monastic system. Shryock (1959) argues that for more than three centuries after the Reformation, nursing involved no career whatsoever. There was no training required for nurses other than that which could be picked up by experience. In the late 19th century, because of the work of Florence Nightingale, great effort was made to raise nursing from a craft to a profession. Much of the instruction, however, continued to be taught at the bedside in an apprenticeship form. Melosh

(1982) says that the nurses' work ethic was strongly rooted in the apprenticeship tradition of the hospital school, and valued craft methods and practical experience. In fact they were considered to be "jack-of-all-trades", a term used by one of the respondents. One older nurse said; "A nurse should be able to do everything; go to every department of the hospital and fill in, whether in the kitchen, furnace room, lab, laundry, whatever." Upon being asked to describe her probationary period, one respondent explained how she learned her skills on the ward, especially those regarding "douches, catherizations, and hypodermics." She said that "the head nurses taught us to give enemas, but those things we had to have her oversee before we were allowed to do it ourselves." They learned their crafts by the bedside.

### *The Nurse as Housekeeper*

As hospitals everywhere began to establish schools of nursing, labor was provided by student nurses at little or no cost. Bullough and Bullough (1965) state that the hospitals were staffed by bringing in students who were paid little or nothing, but had to work long hard hours in return for their room and board, often doing primarily housekeeping jobs under supervision of a senior student nurse. Consider this quote from the respondent who trained in Glace Bay in 1929 who said "...we never questioned anything — we went in at seven in the morning and we worked until seven at night." Another respondent from Yarmouth who trained in 1930, said:

...When we were on night duty, at a certain time in the night, we would have to knead the bread down so it would be ready for the cook to put in the pans the next morning. We used to have to feed the furnace for quite a while, but after a while we persuaded them to give us a man.

In the morning, we would have to shake down the coal stove in the kitchen, open it up, and stir the cereal, put it on the front of the stove so it would be hot when the nurses came in for their breakfast at 7 a.m.

The same respondent describe how heavy the work was.

...We would work twelve hour days and usually we got two hours off. First thing in the morning, we had to scrub the soiled sheets and linen because it was in the days before linen went to the laundry.

Because of the nature of the work little education was thought necessary. The older nurse who trained in Regina responded to the issue with this statement:

We had no nurses aides. We were the aides. We cleaned the bed pans and the utility rooms, the service rooms, whatever, ourselves, as probies. And our superintendent said one day ...any nurses that can't keep a bed pan clean, can't keep a dinner plate clean.

One nurse from the Victoria General Hospital in Nova Scotia was a probationer in 1929. She said that probies were responsible for "cleaning the bedside tables and straightening up." In response to a question asking how much student nurses were paid at that time, the answer varied from four dollars a month in first year, to fourteen dollars a month in the third year.

According to Gibbon (1947), the nurses related long hours, low pay, poor living conditions and ample housekeeping tasks in their job descriptions. In addition, they were taught "on the job". Coburn (1974) states that nursing duties were regarded as familial labors of love, and that education was not necessary to carry on a job that was an extension of the skills they already had as women. Not only was it the responsibility of the senior student nurses and head nurses to teach junior students, but many teaching experiences occurred at the bedside with the physicians. Rushmore (1940) wrote "it is the doctor's duty to educate nurses and say what level is acceptable." One older nurse said, "They seemed to realize that you were just training, you know and they helped a lot."

Kelly (1981) refers to job descriptions in the late 19th and early 20th centuries as giving major priority to scrubbing floors, dusting, keeping the stove stoked and kerosene lamps trimmed and filled, controlling insects, washing clothes, rolling bandages and other unskilled housekeeping tasks. Certainly, in reviewing the nursing career histories of the respondents in this study, their training is described very much in keeping with Kelly's perspective.

### *Low Priority of Education*

Kelly (1981) writes that, as late as 1890, only 20 percent of nurses' training was theory. Roberts (1964) says, however, that for years after the earliest nursing schools opened their doors, the term "professional" was applied without regard to the very wide range of education that was given. Roberts (1964) further points out that no other profession has been developed on the assumption that an education can be obtained in exchange for service. Bullough and Bullough (1965) maintain that frequently hospitals allowed teaching to suffer because ward duty came first. Lecture hours were those most convenient to the hospital schedule, with little consideration for the student nurse. Again, this is verified by the respondent from Glace Bay General who



said, "We were supposed to get two hours off a day, but if we had classes, we were sitting down anyway, and if the ward was busy, they figured we didn't need extra time off, and if your work wasn't finished by seven, you stayed until you finished it."

It becomes apparent that nursing, while trying to be recognized as a profession, was being hindered by nurses themselves, who did not give a sound theoretical education the importance it required. As described in the career histories, aspects of apprenticeship training were maintained well into the first half of the present century. A respondent from the Regina General answered the question regarding the role of the senior student in this way: "If you were in a higher group, you were expected to look after those who came in after you and to teach them things — they worked under you." Many respondents also said that, even if classes were arranged, it was acceptable to miss some if you were busy on the wards.

The conflict between educational needs and hospital needs has existed since the establishment of hospital nursing schools, and, as has been shown in an analysis of the nursing career histories and in the literature review, the needs of the hospital came first. One can readily understand that all hospitals, operating under the philosophy of service first, saw little need to set higher educational entrance requirements. Almost all of the respondents required only grade ten for entrance in the 1920s. In reviewing nursing history, there can be no doubt that the struggle to become recognized as a profession has to be, in part, a result of the long time it has taken for nursing to become academically respectable.

### The Synthesis

What do these seventy hours of rich data mean in terms of nursing history? These data encompass many issues. They are not only related to the social history of nursing, but to feminist, labour, and other socio-economic issues. It is obvious that these older nurses were part of a sex-segregated labour force and that they occupied low-paying positions. Bellaby and Oribabor (1982) maintain that nursing involved a well-disciplined corps of subordinated individuals who acted as hospital housekeepers, that was rooted in the class and gender relations of the Nightingale era. Their jobs exemplified the role of women in society in general and their position within the hospital structure. It was no accident that professional standards, tasks and training were subject to the approval of physicians and hospital administrators. These two interest groups could allow the apprentice-work ethic to continue because it served the purpose of severely limiting the professionalization of nursing. The data clearly illustrate the dual roles of

the nurses as physician-handmaidens and as hospital workers.

### Nursing Implications

History has recorded the progress that has been made over the past centuries in the field of nursing. It has demonstrated the evolution of a nursing from a totally vocational, apprenticeship-type structure to a professional structure. The process of reaching professionalism, however, has not been an easy one. History has shown us that factors, such as the vested interests of hospitals and the limitations placed on women because of social traditions of the times, have greatly affected this process.

Kelly (1981) suggest that one of the major differences between an occupation and a profession lies in the practitioners' long-term commitment to the profession. This commitment includes working towards the development of the profession. Great strides have been made, during the past half-century, in making nursing education and nursing service independent. This is not to say that nursing has disregarded the importance of the clinical aspect of the nurses' education, but rather that nursing leaders have realized that a sound theoretical base is essential. To assert control over education and practice is the mark of an established profession. The challenge of continuing the development of the nursing profession is the responsibility of the profession itself, and each generation of professionals has its own contribution to make to that continuing process.

### Research Theoretical Implications

There are other implications to be found in this research. As well as more fully developing the concept of an apprentice-type ethic from the interweaving of data and literature, there are methodological issues which should encourage the researcher who is a neophyte, both in historical research and in the inductive approach, to undertake this challenging method. Many of our older nurses have invaluable data to record and preserve. Only by in-depth interviews, which allow them to review their lives through recall of past events can information about our professional past be gleaned. This approach is a rich data field which as yet has been relatively untapped. The results are as satisfying for the researcher as they are for the respondents as patterns emerge and themes evolve from the data.

The combination of oral histories and grounded theory have not frequently been used as a research approach. It is necessary, therefore, at this point to refer back to the initial intent of the study. Did this inductive approach serve to answer the research questions? Did a concept evolve from the data, substantiated by the literature, that could



serve as a guide to future research? We believe we accomplished that aim. Other researchers could, no doubt, verify our findings through oral history, or even through a survey approach, by asking specific questions regarding the apprentice ethic of the past. Answers to questions which have perplexed theorists in the past could be more readily available if the concepts were initially grounded in the research data.

## REFERENCES

- Allan, P., & Jolley, M. (1982). *Nursing midwifery and health visiting since 1900*. London: Faber and Faber.
- Angrosino, M. (1982). Personal narratives and cultural complexity: An oral anthropology of Aruba, Netherland Antilles. In *Oral History Review* California: KN1 Inc. pp. 93-118.
- Bellaby, P. & Oribabor, P. (1977). The growth of trade union consciousness among general hospital nurses. *Sociological Review*, 25, 801-22.
- Bullough, B., & Bullough, V.L. (1965). *The emergence of modern nursing*. New York: MacMillan.
- Coburn, J. (1974). I see and am silent. In J. Acton & P. Goldsmith & B. Sheppard (Eds.). *Women at Work 1850-1930* (pp. 127-159). Toronto: Canadian Women's Educated Press.
- Dock, L. & Stewart, I. (1920). *A history of nursing*. New York: Putnam's Sons.
- Gibbon, J.M. (1947). *Three Centuries of Canadian nursing*. Toronto: MacMillan.
- Glaser, B.G. & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Kelly, L. (1981). *Dimensions of professional nursing*. New York: Macmillan.
- Kotre, J. (1984). *Outlining the self: Generativity and the interpretation of lives*. Maryland: Johns Hopkins University Press.
- Melosh, B. (1982). *The physicians hand work culture and conflict in American nursing*. Philadelphia: Temple University Press.
- Pelly, T. (1964). *Nursing: Its history, trends, philosophy, ethics and ethos*. Philadelphia: W.B. Saunders.
- Roberts, M.M. (1964). *American nursing*. New York: Macmillan.
- Rushmore, S. (1940, June). Nursing nurses and doctors. *New England Journal of Medicine*, 222 (24), 997-999.
- Shyrock, R.H. (1959). *The history of nursing*. Philadelphia: W.B. Saunders.
- Stern, P.N. (Winter, 1982). Affiliating in Stepfather Families Teachable Strategies Leading to Stepfather — Child Friendships. *Western Journal of Nursing Research*, 4 (1), 75-89.
- Stern, P.N. (1980). Grounded theory methodology: Its uses and processes, *Image*, 12 (1), 20-23.
- Webster's New Collegiate Dictionary*. (1981). Thomas Allen & Son.

## RÉSUMÉ

### **Aptitudes à la communication des infirmiers en exercice: comparaison des infirmiers détenteurs d'un diplôme et des infirmiers détenteurs d'un baccalauréat**

Les tentatives visant à distinguer l'exercice de la profession infirmière chez les infirmiers détenteurs d'un diplôme et détenteurs d'un baccalauréat ont rarement fait appel à des critères comportementaux spécifiques. La présente étude pilote propose de comparer les aptitudes à la communication des infirmiers détenteurs d'un diplôme et des infirmiers détenteurs d'un baccalauréat par le biais du test comportemental de relations inter-personnelles (Behavioral Test of Interpersonal Skills). L'analyse des données a révélé des différences significatives au niveau de l'empathie exprimée par les deux groupes d'infirmiers et de la fréquence des tentatives faites pour supprimer l'expression des sentiments chez leurs clients. Ces observations reflètent l'emphase de la formation offerte dans chacun des programmes. Il faudra obtenir un échantillon plus important si l'on veut généraliser ces observations.

# LA RELATION DU RÔLE JOUÉ PAR LE PERSONNEL INFIRMIER SUR LA PRISE DE RÔLE DE LA PERSONNE ÂGÉE EN ÉTABLISSEMENT DE SOINS PROLONGÉS

Marcelle Séguin Langlois

De façon générale, on attribue l'apprentissage de divers rôles sociaux aux attentes qu'un individu ou qu'un groupe d'individus entretient par rapport au fonctionnement d'une personne dans une situation sociale particulière. Cet apprentissage a trait à un changement ou à une amélioration des croyances, des attitudes, des comportements et des valeurs de cette personne (Brim, 1976). Gordon (1978) précise, néanmoins, que l'apprentissage de rôles s'opère par la différenciation et l'intégration de valeurs-thèmes bien spécifiques qui caractérisent et varient à chaque stade de développement. Ces valeurs humaines et sociales idéalisées émergent de l'interaction des transformations physiques, de l'acquisition du savoir et du changement des fonctions sociales. À l'âge avancé, ces valeurs-thèmes sont l'autonomie personnelle et l'intégration significative. La première valeur s'intéresse à l'auto-suffisance, c'est-à-dire à l'établissement et à l'atteinte de ses propres objectifs quel qu'en soit le contenu et le niveau. L'intégration significative distingue la relation réciproque de la personne âgée à l'égard d'une personne ou d'un très petit nombre de personnes par opposition à un mode d'existence isolée. L'intégration significative contribue à maintenir l'auto-suffisance. Dans ce contexte, le rôle est conceptualisé comme étant le répertoire de comportements et de sentiments qui distinguent le fonctionnement de la personne. Ainsi défini, le rôle peut ou ne peut pas être relié à une position organisationnelle.

Le processus interactionnel demeure le pivot de l'apprentissage de rôle et dépend partiellement du renforcement d'autrui. La personne âgée, admise en établissement de soins prolongés, est particulièrement vulnérable au rétrécissement de son réseau social. Le plus souvent, la maladie débilitante ou la détérioration physique et/ou mentale qui précipite son admission en établissement requiert une réorganisation de comportement (Moses, 1972). Quoiqu'il en soit, le développement d'un comportement particulier chez la personne âgée reste inséparable de son environnement physique et social (Yarrow et al., 1963; Schooler, 1969).

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L'apparition graduelle de comportements similaires chez bon nombre de personnes âgées institutionnalisées semble nier leur individualité. Des comportements tels l'indifférence, la docilité dans les échanges interpersonnels, la dépendance progressive et la désorientation laissent entrevoir un processus de socialisation homogène selon lequel les attentes et les valeurs des agents socialisants sont incorporés au comportement des personnes âgées (Brody, 1973; Harrison, 1968). L'infirmière est la seule professionnelle de la santé à entretenir un contact statistiquement significatif avec le vieillard institutionnalisé (Barney, 1974). Outre les autres malades, les membres du personnel infirmier sont aussi les principales sources de référence sociale de la personne âgée. Il est donc raisonnable de croire que le personnel infirmier puisse exercer une influence prépondérante sur le comportement de la personne âgée.

#### But de l'étude

Cette étude avait pour but d'explorer, dans des situations bien précises, les comportements de la personne âgée vivant en établissement de soins prolongés et ceux du personnel infirmier afin de vérifier si le rôle du personnel infirmier influençait le développement d'un rôle particulier chez la personne âgée.

#### Instruments de mesure

Deux instruments de mesure ont été utilisés pour explorer l'influence du rôle joué par les intervenants, soit l'infirmière, l'auxiliaire ou le(la) préposé(e), sur le développement d'un rôle particulier chez la personne âgée:

1. l'Analyse du Processus d'Interaction de Bales (1951) et
2. un questionnaire-entrevue développé à l'intention des personnes âgées pour recueillir des données au sujet de variables aptes à influencer la prise de rôle chez ces dernières.

#### *Analyse du Processus d'Interaction de Bales (API).*

L'API, tel que représenté au tableau 1, comprend douze catégories de comportement réparties en dyades selon la démarche interactionnelle qu'elles soulèvent. Les catégories se regroupent aussi par trois selon que les comportements qui en relèvent sont des tentatives de réponses ou des questions (composante de la tâche) ou sont des réactions positives ou négatives (composantes socio-affectives). Chaque catégorie d'interaction est essentiellement de même durée et représente un seul item de comportement verbal ou non-verbal irréductible. Le comportement verbal est toutes paroles ou sons émis par la personne. Le comportement non-verbal comprend toutes réactions corporelles observables telles le contact des yeux, le toucher, la distance, la posture, le geste, l'expression faciale et les silences.

TABLEAU I

LE SYSTEME DES CATEGORIES D'OBSERVATION ET LEURS RELATIONS<sup>1</sup>

Composante Socio-affective: A Positive	A	1. <u>MONTRE DE LA SOLIDARITE,</u> REHAUSSE LE STATUT DE L'AUTRE, AIDE, RECOMPENSE:							
		2. <u>MONTRE UNE DIMINUTION DE TENSION,</u> FAIT DE L'HUMOUR, RIT, MONTRE DE LA SATISFACTION:							
		3. <u>EXPRIME SON ACCORD,</u> ACCORTE PASSIVEMENT, COMPREND, COLLABORE, SE CONFORME:							
Composante de la tâche: Neutre	B	4. <u>DONNE DES SUGGESTIONS,</u> DES DIRECTIVES TOUT EN RESPECTANT L'AUTONOMIE DE L'AUTRE:							
		5. <u>DONNE SON OPINION,</u> EVALUE, ANALYSE, EXPRIME UN SENTIMENT, UN DESIR:							
	C	6. <u>ORIENTE,</u> INFORME, REPETE, CLARIFIE, CONFIRME:	a	b	c	d	e	f	
		7. <u>DEMANDE QU'ON L'ORIENTE,</u> L'INFORME, QU'ON REPETE, QU'ON CONFIRME:							
Composante Socio-affective: D Négative	C	8. <u>DEMANDE UNE OPINION,</u> UNE EVALUATION, UNE ANALYSE, UNE EXPRESSION DE SENTIMENT:							
		9. <u>DEMANDE DES SUGGESTIONS,</u> DES DIRECTIVES POUR DES MODELES D'ACTION POSSIBLE:							
	D	10. <u>EXPRIME SON DESACCORD,</u> REJETTE PASSIVEMENT, REFUSE D'AIDER, DE PRODIGUER LES RESSOURCES NECESSAIRES:							
		11. <u>MONTRE DE LA TENSION,</u> DEMANDE DE L'AIDE, SE RETIRE DU PROCESSUS D'INTERACTION:							
		12. <u>ANTAGONISE,</u> RABAISS LE STATUT DE L'AUTRE, SE DEFEND OU S'AFFIRME:							

## LEGENDE:

- a. Problèmes de communication
- b. Problèmes d'évaluation
- c. Problèmes de contrôle
- d. Problèmes de décision
- e. Problèmes de diminution de tension
- f. Problèmes de réintégration

- A. Réactions positives
- B. Tentatives de réponses
- C. Questions
- D. Réactions négatives

<sup>1</sup> Bales. R. F. 1950. Interaction Process Analysis. Cambridge, Mass.: Addison-Wesley Press. p. 9.

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L'ensemble des catégories représente un cadre théorique général selon lequel une série d'indices standards permet d'analyser la structure et la dynamique d'interaction d'un petit groupe pouvant se composer de deux à vingt personnes. L'API permet de dégager le profil d'interaction de chaque membre ainsi que certains aspects critiques de son rôle. Des chercheurs de différentes disciplines, dont au moins deux infirmières (Conant, 1964; Semradek, 1962), se sont déjà servis de l'API dans cette perspective.

L'analyse du processus d'interaction consiste à interpréter, à catégoriser chaque comportement et à lui attribuer un acteur et une cible. Quoique la catégorisation des interactions soit indépendante de l'attribution de l'acteur et de la cible, des divergences marquées par rapport à l'"itemisation" des comportements affectent les trois opérations précédentes (Bales, 1951, p. 114). Essentiellement, ce processus et la fidélité subséquente de la classification inter-observateurs reposent sur l'entraînement rigoureux de ces derniers. Bales recommande l'utilisation d'un test d'efficacité de l'ajustement pour vérifier la concordance de la classification des comportements laquelle doit tenir compte des différentes inclinations mentales des observateurs. L'utilisation du chi-carré ( $\chi^2$ ) avec un seuil de signification de  $p = 0,50$  est suggéré pour mesurer l'efficacité de l'ajustement.

Dans cette étude les catégories d'interaction entre la personne âgée et l'intervenant ont été élaborées (Séguin Langlois, 1982) à partir des définitions des catégories générales d'observation de Bales. Suite à un pré-test de l'instrument, les données relatives de l'API ont été recueillies par observation non participante. Quinze processus d'interaction, soit 3 622 unités d'interactions, ont été enregistrés sur bande sonore auprès de cinq groupes composés d'une personne âgée et d'un ou de deux intervenant(s), au cours de trois activités spécifiques. Le déjeuner, la toilette du matin, le dîner ou l'installation de l'après-midi. Les comportements non-verbaux observables ont été notés et identifiés aux séquences parallèles de comportements verbaux à l'aide de mots-clé provenant de ces derniers. Une fois intégrés en un texte, les comportements verbaux et non-verbaux ont été catégorisés par unité de comportement et un acteur et une cible ont été attribués à chacune d'elle. Les scores ainsi obtenus ont ensuite été transcrits sur une feuille conçue pour faciliter l'analyse de ces données. Afin de vérifier la concordance de la classification des comportements d'interaction, cinq processus d'interaction ont été choisis de façon aléatoire et classifiés par une observatrice interdépendante à l'aide des textes et des enregistrements correspondants.

Une analyse de contenu a été pratiquée sur deux des activités observées dans chaque groupe. À l'aide d'une grille, les interactions



ont été reprises de façon séquentielle de manière à répondre aux questions, "Qu'est-ce que l'acteur voit, entend, touche, etc.? La relation émergeant des actions réciproques des membres de chaque groupe a été examinée selon les critères d'évaluation de la communication par Clark (1977) pour en faire ressortir les traits dominants. Cette auteure stipule que la communication d'un message n'est pas complète avant que ce dernier n'ait été transmis et reçu et qu'une réaction de la part de l'interlocuteur n'ait eu lieu. Les facteurs qui entravent la communication, c'est-à-dire l'anxiété, le conflit et les attitudes stéréotypées, restreignent le processus observation-perception-communication et le sens de satisfaction qui devrait normalement résulter de l'interaction.

L'analyse de contenu des processus d'interaction de deux des cinq groupes a été validée par une infirmière clinicienne spécialisée en soins infirmiers psychiatriques.

### *Le questionnaire-entrevue*

Le deuxième instrument, le questionnaire-entrevue, comprenait dix-neuf questions développées à partir de dix variables qui, selon plusieurs auteurs, ont un effet sur la perception de bien-être et la participation sociale de la personne âgée. Ces variables incluent:

1. le fait de posséder une connaissance relative de son diagnostic médical, de son régime thérapeutique et des politiques institutionnelles qui régissent les faits et gestes de la vie quotidienne;
2. le choix de l'institution;
3. la satisfaction par rapport au choix de l'institution;
4. la perception de son état de santé;
5. la satisfaction relative à l'espace vital qui se rattache au besoin de solitude et d'intimité tout comme au besoin de sociabilité;
6. la perception de contrôle par rapport aux actions et décisions qui influencent la vie quotidienne;
7. l'orientation temporelle;
8. l'espace social et le réseau de personnes significatives;
9. la capacité d'exercer un jugement ou de solutionner des problèmes quant à sa réalité quotidienne; et
10. le sentiment de contribuer de manière satisfaisante au milieu social.

Ces variables semblent se relier à une mesure d'autonomie personnelle et/ou à un certain appui des personnes significatives dans l'entourage de la personne âgée. De ce fait, elles semblent pouvoir influencer la prise de rôle chez cette dernière.

Les items du questionnaire comprenaient des questions ouvertes

sauf l'item 4 qui était une question à choix multiples. Au cours du pré-test, un item s'est avéré ambigu et a été éliminé du questionnaire.

Le questionnaire-entrevue, d'une durée moyenne de seize minutes, a été enregistré dans la chambre de chaque personne âgée et, analysé de façon descriptive.

### Description du milieu

L'étude s'est déroulée dans un centre hospitalier de soins prolongés de 165 lits. Des 127 bénéficiaires hospitalisés, 63 % avaient 65 ans et plus, et la moyenne d'âge s'établissait à 64.5 ans. L'étude s'est effectuée sur deux des quatre unités. Les soins aux bénéficiaires y étaient dispensés selon le concept de soins intégraux.

### Description des sujets

L'échantillon était composé de cinq (5) personnes âgées et sept (7) intervenants.

Pour satisfaire aux critères de sélection, la personne âgée devait:

1. posséder un état de santé stabilisé;
2. avoir la capacité de communiquer en français;
3. avoir une faculté mentale intacte telle que démontrée par l'orientation par rapport à la personne et au lieu;
4. avoir la capacité de donner un consentement informé, oral et écrit, pour participer à l'étude;
5. avoir la capacité de participer à la prise de décision telle que manifestée par le critère précédent; et
6. avoir été admise à l'institution depuis au moins trois mois pour lui permettre de s'être familiarisée avec les intervenants de l'unité et avec les routines et politiques du centre.

Le seul critère d'exclusion était l'exacerbation des maladies chroniques.

D'un nombre possible de 80 bénéficiaires, dix personnes âgées étaient éligibles pour faire partie de l'étude et cinq d'entre elles, dont quatre femmes et un homme, ont formé l'échantillon final. Ces dernières étaient d'origine canadienne-française et de religion catholique. Quatre d'entre elles étaient veuf ou veuves et la moyenne de leur âge se situait à 74 ans. La durée moyenne de leur hospitalisation était de trois ans et variait entre un an et cinq ans. Aucune information n'était disponible au dossier des personnes âgées concernant leur occupation antérieure, leurs intérêts récréatifs actuels ou passés ou leur réseau familial. Trois des sujets étaient classifiés selon la catégorie A<sub>3</sub> de bénéficiaires et les deux autres, selon la catégorie A<sub>4</sub> telles que définies par le ministère des Affaires sociales du Québec. Les pathologies

diagnostiquées à l'admission des personnes âgées reflétaient la prédominance des troubles neurologiques observés par divers chercheurs en gériatrie (Kart et al., 1978; Pablo, 1974); Jaeger et Simmons, 1970). Les sujets étaient continents, ne nourrissaient seuls mais chacun devait recevoir de l'aide pour se mobiliser.

Sept intervenants, dont six femmes et un homme, ont aussi fait partie de l'étude. Pour satisfaire aux critères de sélection, l'intervenant devait:

1. avoir terminé la période de probation exigée par l'établissement;
2. pouvoir communiquer en français;
3. participer aux soins d'une des personnes âgées faisant partie de l'étude; et
4. avoir consenti à participer à l'étude.

L'échantillon-intervenant s'est composé de deux auxiliaires et de cinq préposés(ées). La seule infirmière qui a fait partie de l'interaction d'un groupe observé a refusé, à postiori, que le matériel la concernant soit utilisé. L'âge des intervenants se situait entre 21 et 50 ans et leur expérience de travail auprès des personnes âgées variant entre 2 mois et 11 ans. Deux sujets, une auxiliaire et une préposée, ont attesté avoir suivi des cours sur le vieillissement, l'une durant sa formation d'auxiliaire, l'autre en cours d'emploi.

Chaque intervenant dispensait des soins à cinq bénéficiaires. Ses responsabilités incluaient aussi servir les repas à quatre bénéficiaires et à en faire manger deux autres. En plus, les auxiliaires devaient préparer et distribuer les médicaments pour un certain nombre de bénéficiaires. Chaque intervenant travaillait seul, sauf lorsqu'il sollicitait l'aide d'un collègue pour effectuer le transfert d'un bénéficiaire du lit au fauteuil. Afin de distinguer chacun, l'expression intervenant primaire et intervenant secondaire a été utilisée lors de l'analyse des processus d'interaction.

#### Considérations relatives à l'éthique

Un consentement écrit a été obtenu de la personne âgée après s'être assuré que cette dernière comprenait bien la nature, le but et les méthodes de collecte de données envisagées dans l'étude. Le fait que la personne âgée pouvait retirer sa participation sans que cela n'affecte ses soins avait été stipulé sur le formulaire de consentement. Ce formulaire, dont une copie a été remise à la personne âgée, a été daté et signé par la chercheuse. De plus, la chercheuse avait prévu de rencontrer le procureur des personnes âgées qui en feraient la demande. Cependant, aucune requête n'a été adressée à ce sujet.

Les intervenants ont fait l'objet des mêmes considérations. Cependant, le but général de l'étude leur a été présenté ainsi, "L'étude vise à explorer en quoi consiste le rôle de la personne âgée en milieu de soins prolongés." Selltiz, Wrightsman et Cook (1977) expliquent que la dissimulation dans la recherche qui utilise les méthodes d'observation vise à diminuer la propension des observés à réagir. Selon ces auteurs le changement possible du comportement des sujets qui se savent observés et qui connaissent les buts précis de l'étude limite les possibilités de généralisation de données recueillies en milieu naturel. Par contre, les intervenants ont été invités à se joindre à la communication des résultats de l'étude.

Tous les sujets ont été assurés de l'anonymat et du caractère confidentiel des résultats obtenus individuellement. À cette fin, un numéro d'identification a été assigné à chacun. Le matériel susceptible d'associer les sujets à une ville, ou le nom de proches, a été remplacé par des tirets au cours de la dactylographie des processus d'interaction. Les patois ou autres expressions identifiables dans ces textes ont aussi été remplacés. De plus, l'oblitération des magnéto-cassettes a été effectuée dès que l'étude a été terminée.

Le rôle de la chercheuse comme observatrice non-participante a aussi été l'objet de considérations déontologiques. À l'aide d'exemples concrets, cette dernière a indiqué clairement qu'elle ne participerait pas aux activités ou à la conversation des sujets. Si elle devait être témoin d'une situation requérant une interaction auprès de la personne âgée, elle se limiterait à en informer le personnel de l'unité de soins.

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## Résultats

### *L'Analyse du Processus d'Interaction de Bales (API)*

Le chi-carré ( $X^2$ ) a été utilisé comme test d'efficacité de l'ajustement de la classification des comportements interactionnels entre les deux observatrices. Aucun des processus d'interaction sur lesquels le test a été pratiqué n'a atteint le seuil de signification anticipé de  $p = 0,50$  pour l'"itemisation" des comportements. Par conséquent, le test n'a pas été pratiqué pour vérifier l'efficacité de l'ajustement de la catégorisation et de l'attribution de l'acteur et de la cible des comportements puisque des divergences par rapport à "l'itemisation" affectent les trois autres opérations (Bales, 1951, p. 114). Ces résultats permettent de conclure que la période et/ou la méthode d'entraînement conjoint des observatrices a été insuffisante pour assurer qu'un

système uniforme d'analyse des interactions soit employé par ces dernières. Sans doute, l'observation directe du processus d'interaction, sinon à l'aide de cassettes vidéo, aurait été avantageuse pour l'observatrice indépendante. De même, après avoir constaté les écarts de classification entre les observatrices, il aurait été approprié de reclassifier les comportements interactionnels une fois que certains aspects de l'enregistrement et du texte eussent été clarifiés conjointement (Bales, 1951, p. 102). Cependant, le cadre de cette étude n'a pas permis ces rajustements.

Bien que la fidélité des résultats obtenus par l'API soit mise en doute, ces résultats sont tout de même communiqués puisque l'analyse de contenu des processus d'interaction tend à les confirmer.

Le profil d'interaction des membres de groupes a été tracé à partir des taux d'interaction dans chacune des douze catégories d'observation au cours des trois activités de soins. Chez trois de intervenants primaires, le taux d'interactions le plus élevé s'est situé dans la composante socio-affective négative, soit à la catégorie "Antagonise". La catégorie "Montre de la solidarité" a dominé le profil des deux autres intervenants primaires. Il s'avère que ces deux intervenants étaient ceux qui disaient avoir suivi des cours sur le vieillissement. Sans exception, les intervenants primaires se sont montrés plus aptes à donner de l'information, des opinions et des suggestions qu'à en solliciter. Dans tous les groupes, la participation de l'intervenant secondaire a été négligeable, représentant moins de 2 pour cent des interactions.

Les personnes âgées ont fourni des profils d'interaction bien disparates. Chez deux d'entre elles, le taux d'interactions le plus élevé a été noté à la catégorie "Montre de la tension". Chez deux autres, la catégorie "Exprime son accord" a légèrement dominé celle "Montre de la tension". Le profil de la cinquième a démontré que la catégorie "Montre de la solidarité" dépassait de beaucoup les taux dans les autres catégories. Toutes les personnes âgées ont montré des taux de tension plus élevés que ceux de diminution de tension. Néanmoins, quatre d'entre elles ont plus souvent affiché leur solidarité que leur antagonisme à l'égard de l'intervenant. Ces constations suggèrent que les personnes âgées avaient intérêt à maintenir une entente relativement amiable avec l'intervenant de qui elles dépendaient pour satisfaire leurs besoins fondamentaux. Contrairement aux intervenants, les personnes âgées ont été peu actives dans les catégories de la tâche mais, comme eux, elles préféraient donner de l'information plutôt que d'en solliciter.

Des indices du rôle fonctionnel pour chacun des membres de groupes ont été calculés à partir de l'analyse du processus d'interaction



de la toilette du matin. Ces indices tentaient de représenter:

1. l'accès direct aux ressources;
2. l'accès indirect aux ressources;
3. le degré de contrôle; et
4. le statut général, calculé à partir des trois indices précédents.

Les formules qui ont été utilisées sont celles proposées par Bales (1951, p. 165) et donnent un nombre entre 0 et 100. Les résultats du calcul de ces indices sont présentés au tableau 2.

L'indice d'accès direct aux ressources a excédé 70 chez toutes les personnes âgées et reflètent la propension qu'avaient les intervenants à donner de l'information, des opinions et des suggestions gratuitement. L'indice d'accès indirect aux ressources a aussi été plus élevé chez quatre des personnes âgées. En terme de leurs demandes d'information, de suggestions et d'opinions, ces personnes âgées ont effectivement reçu beaucoup plus d'information qu'elles n'en ont sollicité de l'intervenant. Pour sa part, la personne âgée du Groupe II a fourni deux fois plus de réponses que lui en demandait l'intervenant et chacun a obtenu un indice de 0,4 et 42 respectivement.

Les valeurs de l'indice du degré de contrôle permettent d'expliquer la contribution minimale des personnes âgées à la Section B des catégories d'observation. Les valeurs de l'indice du degré de contrôle chez toutes les personnes âgées ont été inférieures à celles des intervenants dans tous les groupes. Cette constatation indique que les réponses des personnes âgées, aussi peu nombreuses qu'elles eussent été, ont été accueillies négativement plutôt que positivement par les intervenants. Ce fait est particulièrement notable chez la personne âgée du Groupe II qui s'était distinguée en contribuant plus d'information au processus d'interaction que les autres personnes âgées. En effet, elle a obtenu l'indice le plus bas de tous, soit 0,003. En comparaison, l'intervenant du même groupe a recueilli une valeur d'indice de 32.

Les valeurs des deux indices précédents ont démontré que les membres du Groupe II se partageaient la distribution des ressources. Selon Bales (1951, p. 153), l'accès aux ressources tend à différencier le rôle fonctionnel d'un membre de groupe. À mesure que les rôles se différencient, des contraintes, particulièrement décelables dans le Groupe II, se créent vers l'exercice d'un contrôle plus centralisé. Ces contraintes ont été exercées par l'intervenant du Groupe II. En outre, il est inévitable que toutes les personnes âgées perçoivent le peu de contrôle situationnel qu'elles détiennent. Cette perception a pour effet d'inhiber la participation active de la personne âgée et de limiter l'exercice de son autonomie. (Chang, 1978; Langer & Robin, 1974).



TABLEAU 2

INDICES DE RÔLE FONCTIONNEL DE LA PERSONNE AGÉE ET  
DE L'INTERVENANT PRIMAIRE PAR GROUPE, 5 GROUPE

INDICES	Groupe I		Groupe II		Groupe III		Groupe IV		Groupe V	
	Personne âgée	Inter- venant	Personne âgée	Inter- venant	Personne âgée	Inter- venant	Personne âgée	Inter- venant	Personne âgée	Inter- venant
Accès direct aux ressources	75	25	78,7	14,9	70,8	16,6	100	0	83,3	16,6
Accès indirect aux ressources	53,6	18	0,4	42	60	10	70	0	40	14,3
Degré de contrôle	6,7	15,9	0,003	32	14	35	2	18	45	55,3
Statut général	45,1	19,6	26,4	29,7	48,3	20,5	57,3	6	56,1	28,7

À longue échéance, la répétition de ces réactions négatives tend à engager la soumission de la personne âgée à l'intervenant (Brim, 1976).

L'indice de statut général a été dérivé des trois indices précédents. Seule la personne âgée du Groupe II a obtenu un indice inférieur à celui de l'intervenant bien que l'écart ne soit que de 3,3 points. Par contre, cet écart varie sensiblement entre les membres des autres groupes, particulièrement dans le Groupe IV où il se chiffre à 51,3. À la lumière de l'analyse qui précède, on peut conclure que plus la personne âgée se soumet aux requêtes de l'intervenant plus son indice de statut général augmente.

Enfin, un indice de solidarité interindividuelle a été calculé. Cet indice tentait de mesurer l'aspect structural du rôle des membres. Les résultats sont présentés au tableau 3.

La valeur de l'indice s'est avérée plus élevée chez trois des personnes âgées, dont celle du Groupe II, et chez deux des intervenants. Bales remarque que plus la solidarité entre les membres d'un groupe est marquée, plus leur statut est atténué et plus la performance de leur rôle fonctionnel tend à être moins formelle et moins spécialisée (1951, p. 153). Cette affirmation tend à valider les valeurs de l'indice de statut général des membres du Groupe II.

#### *L'analyse de contenu*

L'analyse de contenu, pratiquée à partir du déjeuner et du dîner ou de l'installation de l'après-midi, a su mettre en évidence les différents comportements des membres d'un groupe l'un envers l'autre tel que le recommandait Conant (1964). Cette analyse a démontré que les intervenants se préoccupaient primordialement d'accomplir leur tâche, établissant la ligne de conduite à suivre, demandant parfois l'opinion de la personne âgée sans en tenir compte par la suite et, généralement, restant insensibles aux comportements de tension non-verbaux manifestés par cette dernière. La brusquerie, particulièrement celle de l'intervenant du Groupe IV, et les comportements de maternage, davantage notés chez l'intervenant des Groupes I et V, interdisaient les gestes autonomes et spontanés de la personne âgée. Ces comportements condescendants et souvent défensifs bloquaient aussi l'expression de ses sentiments. L'analyse démontre que certains comportements attendus de la part des intervenants, tels l'explication d'un retard ou l'exécution d'une activité de soin, ne se manifestaient pas. Par contre, un malaise face à ces comportements semblaient être évident dans le fait que tous les intervenants exigeaient une approbation verbale de la personne âgée avant de quitter ses côtés pour accomplir d'autres tâches.

TABEAU 3

INDICE DU RÔLE STRUCTURAL DE LA PERSONNE ÂGÉE ET  
DE L'INTERVENANT PRIMAIRE PAR GROUPE, 5 GROUPES

	Groupe I		Groupe II		Groupe III		Groupe IV		Groupe V	
	Personne âgée	Intervenant	Personne âgée	Intervenant	Personne âgée	Intervenant	Personne âgée	Intervenant	Personne âgée	Intervenant
Indice de solidarité interindividuelle	39,5	28	78,3	60,9	54,4	64,8	20	52,9	76,9	32,6

À l'exception de celle du Groupe II, les personnes âgées n'avaient pas tendance à maintenir une opposition aux comportements de l'intervenant. Au contraire, chacune anticipait les gestes de ce dernier et, en général, subissait la confrontation et la condescendance en se prêtant de façon minimale à l'interaction verbale. Malgré la tension corporelle qu'elles manifestaient, elles accordaient habituellement les marques d'approbation sollicitées par l'intervenant. Seule la personne âgée du Groupe IV, était visiblement réticente à accorder cet appui. Pour sa part, la personne âgée du Groupe II affirmait son autonomie. Sa résistance aux contraintes imposées par l'intervenant résultait souvent en une lutte de pouvoir entre elle et ce dernier.

### *Le questionnaire-entrevue*

Les données recueillies par rapport aux variables accès à l'information et perception de contrôle se sont avérées identiques chez les cinq personnes âgées. L'analyse a démontré qu'elles ne connaissaient pas ou peu les politiques de l'établissement et qu'elles n'étaient pas renseignées uniformément quant à ces dernières. Aucune d'entre elles ne percevait exercer un contrôle quelconque par rapport à la disponibilité du personnel et à l'emploi du temps relié aux activités de la vie quotidienne. Quant à réaliser un désir qui leur tenait à coeur, les personnes âgées de cette étude ne percevaient pas qu'elles pouvaient communiquer ce désir aux autorités compétentes et encore moins les influencer favorablement.

Exception faite des relations familiales, aucune des personnes âgées ne désirait entretenir des liens avec le milieu extérieur et seules celles des Groupe II et V participaient aux activités sociales de l'établissement. Le fait de posséder une orientation temporelle reliée au futur a semblé influencer, au moins en partie, les résultats de l'analyse du processus d'interaction chez la personne âgée du Groupe II. Une orientation temporelle vers le passé et l'absence complète d'un réseau familial a aussi semblé influencer la personne âgée du Groupe IV qui a obtenu un indice de solidarité interindividuelle de 20.

À la lumière de l'analyse qui précède, il est permis de conclure que le rôle joué par l'intervenant influence la prise de rôle chez la personne âgée. Cependant, il faut également reconnaître l'influence du milieu institutionnel sur cette prise de rôle de même que les prescriptions personnelles des personnes âgées par rapport à leur cheminement individuel (Brim, 1976).

### Recommandations

Les résultats de cette étude permettent de faire des recommandations pour la recherche, l'éducation et la pratique infirmière.

### *Recommandations pour la recherche*

Cette étude devrait être reprise sur une plus grande échelle. À ce titre, elle devrait inclure des établissements de soins prolongés de régions différentes. Compte tenu de la population des centres d'accueil qui comporte progressivement plus de personnes âgées des catégories A<sub>3</sub> et A<sub>4</sub>, ces milieux pourraient être inclus dans une reprise de l'étude.

Une étude similaire pourrait être poursuivie à des intervalles réguliers après l'admission des personnes âgées en établissement. L'évolution d'un rôle particulier chez les personnes âgées en établissement. L'évolution d'un rôle particulier chez les personnes âgées pourrait être analysée en tenant compte de variables spécifiques, telles l'autonomie fonctionnelle et le maintien d'un réseau social.

L'entraînement des observateurs à l'Analyse du Processus d'Interaction devrait faire l'objet d'une démarche de groupe. Un budget adéquat et une période de temps suffisante doivent être prévus à cet effet.

Autant que possible, la présence de l'observateur indépendant devrait être privilégiée au cours des processus d'interaction entre la personne âgée et les intervenants. Il est également recommandé d'utiliser des cassettes vidéo lors de l'observation et de l'analyse du processus d'interaction. En plus de fournir le contexte global de l'échange, ces cassettes permettraient d'en arriver à une analyse plus détaillée des comportements non-verbaux. De même, certaines ambiguïtés relatives à la classification des interactions pourraient être plus facilement résolues.

### *Recommandations pour l'éducation*

Il est recommandé que la mise sur pied de programmes de formation en cours d'emploi devienne prioritaire dans les milieux de soins prolongés. Formulés à l'intention du personnel infirmier, ces programmes devraient inclure les notions fondamentales des aspects bio-psycho-sociaux du vieillissement et faire ressortir l'importance des besoins psycho-sociaux des personnes âgées. Une révision des attitudes des intervenants et la communication interpersonnelle devraient faire partie de ces programmes.

### *Recommandations pour la pratique infirmière*

Les recommandations pour la pratique infirmière découlent du paragraphe précédent. La chercheuse recommande que des structures organisationnelles plus flexibles soient mises en place par les établissements de soins prolongés. Ces structures permettraient au personnel infirmier de dispenser des soins individualisés aux personnes

âgées et favoriseraient la participation de ces dernières à leurs soins. De même, l'utilisation d'un modèle conceptuel de soins infirmiers et des instruments de pratique qui en découlent est recommandée. Cette démarche permettrait d'uniformiser l'approche aux bénéficiaires et assurerait la cohérence de la collecte des données, de la planification des soins, des modes d'interventions ainsi que de l'évaluation.

### Conclusion

Cette étude se proposait d'explorer si le rôle de l'intervenant influençait la prise de rôle de la personne âgée résidant en établissement de soins prolongés. Cinq groupes, composés d'une personne âgée et d'un ou de deux intervenant(s), ont participé à cette étude.

L'analyse du processus d'interaction selon Bales, une analyse de contenu et un questionnaire-entrevue ont servi à recueillir les données.

Le chi-carré a été utilisé comme mesure d'efficacité de l'ajustement de la classification des interactions entre observatrices. Ce test n'a pas atteint le seuil de signification anticipé. Les résultats obtenus à partir de l'API ont quand même été rapportés parce qu'ils s'accordaient aux constatations de l'analyse de contenu.

Sous la réserve des limites identifiées, il est permis de conclure que le rôle joué par l'intervenant influence la prise de rôle de la personne âgée en établissement de soins prolongés. Cette prise de rôle est aussi influencée par le milieu institutionnel de même que par les prescriptions personnelles de la personne âgée face à son propre cheminement.

### RÉFÉRENCES

- Bales, R.F. (1951). *Interaction process analysis*. Cambridge, Mass.: Addison-Wesley Press.
- Barney, J. (1974). Community presence as a key to quality of life in nursing homes. *American Journal of Public Health*, 64 (3), 265-268.
- Brim, O.G., Jr. (1976). Adult socialization. In R. Atchley & M. Seltzer (Eds.), *The sociology of aging: Selected readings*. Belmont, Calif.: Wadsworth Publishing Co. for the Scripps Foundation Gerontology Center, Miami University.
- Brody, E.M. (1973). A million procrustean beds. *Gerontologist*, 13 (Winter), 430-435.
- Chang, B.L. (1978). Perceived situational control of daily activities: A new tool. *Research in Nursing and Health*, 1 (4), 181-188.
- Clark, C. C. (1977). *Nursing concepts and processes*. Albany, N.Y.: Delmar.
- Conant, L.H. (1964). *Nurse — patient role relationships in home visits*. Unpublished doctoral dissertation, Yale University.
- Gordon, C. (1972). Role and value development across the life cycle. In J.A. Jackson (Ed.) *Role*. London: Cambridge University Press.
- Harrison, C. (1968). The institutionally deprived elderly: A challenge for nurses to change their role. *Nursing Clinics of North America*, 3 (4), 697-707.



- Jaeger, D. & S., L.W. (1970). *The aged ill: Coping with problems in geriatric care*. New York: Appleton-Century-Croft.
- Kart, C.S., Metress, E.S. & Metress, J.F. (1978). *Aging and health*. Toledo: Addison-Wesley.
- Langer, E.J. & Rodin, J. (1974). The effects of choice and enhanced personal responsibilities for the aged: A field experiment in an institutional setting. *Journal of Personality and Social Psychology*, 32 (2), 191-198.
- Moses, D.B. (1972). Assessing behavior of the elderly. *Nursing Clinics of North America*, 7 (2), 225-235.
- Pablo, R.Y. (1974). The chronically ill: The demographic and clinical correlates of their outcome of hospitalization. *Canadian Journal of Public Health*, 65 (6), 427-436.
- Schooler, K.A. (1969). The relationship between social interaction and morale of the elderly as a function of environmental characteristics. *Gerontologist*, 9 (Spring), 25-29.
- Séguin L., M. (1982). *Étude exploratoire de la relation qui existe entre le rôle que joue la personne âgée en établissement de soins prolongés et celui du personnel infirmier*. Mémoire de maîtrise non publié, Université de Montréal, pp. 142-173.
- Selltiz, C., Wrightsman, L.S. & Cook, Stuart W., (1977). *Les méthodes de recherche en sciences sociales*. Traduit par D. Bélanger. Anjou, Québec: HRW, pp. 261-262.
- Semradek, J. (1962). *Methods of analyzing interaction in public health nursing home visits*. Unpublished master's report, Yale University.
- Yarrow, M.R., Blank, P., Guinn, O.W., Youmas, E. G. & Stein, J. (1963). Social psychological characteristics of old age. In James E. Birren, et al. (Eds), *Human Aging: A Behavioral Study*. Washington, D.C.: U.S. Dept. Health, Education & Welfare, Public Health Service for the National Institute of Mental Health.

## RÉSUMÉ

### **The relationship between the role played by nursing personnel and the role taken by elderly persons in long-term care institutions**

This article is based on a study undertaken to explore whether the role played by nursing care personnel influenced the development of a particular role in institutionalized elderly persons. Five groups, each comprising an elderly person residing in a long-term care facility and one or two nursing staff members, participated in the study. Bales' Interaction Process Analysis and an interaction content analysis were used in specific nursing care situations to collect data on role relationships. An interview questionnaire directed at the elderly was developed to analyze ten variables conceived as having potential to influence role-taking. The elderly residents' medical records were also used to collect data. Chi-square was used as an index of goodness of fit of the interaction classification between observers. This test did not reach the anticipated probability level. However, analysis of the data collected was continued with the purpose of acquiring more knowledge about nurse-resident interaction in the geriatric setting. A descriptive analysis was made of the interview questionnaire and of the medical record. The interaction profiles of groups and individual group members were obtained from interaction process analysis. Functional and structural role indices were calculated for each subject. Results indicate that the Index of Degree of Control is higher for nursing care personnel than it is for elderly residents. With the exception of one, elderly residents obtain an Index of Generalized Status, as defined by Bales, that is higher than that for nursing care personnel. The elderly's generalized status, as defined above, is found to be inversely proportional to their degree of autonomy. Interaction content analysis supports these findings. Analysis of the interview questionnaire lends further support to the interpretation of the results.

# CRITIQUE

Diane Brisson

Depuis quelques décennies, le vieillissement de la personne est devenu un phénomène social important. Cette raison, à elle seule, donne à la recherche en nursing orientée sur la gériatologie et la gériatrie un caractère essentiel. Toute aussi essentielle est la compréhension par l'infirmière du concept de rôle. De là à s'intéresser au rôle que prend la personne âgée en institution, il n'y avait qu'un pas à faire. C'est donc dans cette optique que Marcelle Séguin Langlois nous propose un compte rendu de son étude traitant de l'influence du personnel infirmier sur la prise de rôle de la personne âgée en établissement de soins prolongés. Comme il est presque impossible dans ce contexte-ci, d'analyser ce travail dans tous ces aspects, ma discussion se limitera aux points suivants, à savoir, le but de l'étude, la méthodologie et les résultats.

## But de l'étude

Séguin Langlois pique notre curiosité efficacement lorsqu'elle souligne que les personnes âgées en institution développent graduellement des comportements similaires d'indifférence, de docilité et de dépendance. Qu'elle en ait fait le sujet de son étude nous concerne directement, non seulement nous, infirmiers et infirmières, mais aussi nous, les vieillards d'aujourd'hui ou de demain. Si une certaine irritation se développe, elle prend sa source dans le fait que l'auteure nous laisse définitivement sur notre appétit lorsqu'il devient évident qu'aucune infirmière ne participera à son étude. Pourtant, une référence directe à une étude de Barney (1974) qui identifie l'infirmière comme la seule à avoir un "contact statistiquement significatif avec le vieillard institutionnalisé" nous permettait d'espérer une recherche sur l'infirmière. Il existe donc une certaine ambiguïté quant à la description du but de l'étude, et le terme "personnel infirmier" reste vague. Néanmoins, l'auteure a réussi à maintenir notre intérêt en raison du sérieux de son thème de recherche et nous avons accepté de la suivre dans son cheminement.

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## Méthodologie

L'étude de Séguin Langlois porte sur un très petit groupe. Il est donc difficile d'en tirer des conclusions pouvant qualifier l'ensemble de la population des personnes âgées et celle des intervenants. Le groupe des cinq personnes âgées est bien délimité, mais le fait que l'âge moyen de celui-ci se situe à 74 ans (alors que celui des résidents de l'institution étudiée est de 64.5 ans), peut aussi être un facteur important dans la prise d'un rôle particulier. Le groupe des intervenants est pour sa part, plutôt disparate, rendant l'interprétation des relations avec la population très laborieuse. Cependant, l'auteure s'intéresse davantage au caractère relationnel entre l'acteur et la cible et, de ce fait, sa recherche lui permet d'aborder cette dimension. Un point d'éthique m'a toujours rendue un peu mal à l'aise; il consiste à demander à un groupe de personnes jugées dociles et dépendantes de participer volontairement à une recherche quelconque. Quoi qu'il en soit, le motif humain et professionnel de la chercheuse aura réussi à diluer mes doutes dans ce cas-ci.

La réputation de l'Analyse du Processus d'Interaction de Bales (1951) n'est plus à faire. Son utilisation, cependant, me semble pour le moins hasardeuse. En effet, depuis 1951, le champ de la psychologie sociale a beaucoup évolué. Distinguer le caractère positif du caractère négatif d'une composante socio-affective n'est pas chose simple et peut donner libre cours à une série d'interprétations d'ordre individuel et social. De plus, un critère jugé positif il y a trente ans l'est-il nécessairement encore aujourd'hui? Les observateurs sont-ils donc si habiles à différencier par exemple, les comportements qui montrent de la tension de ceux qui expriment un désaccord? Quel sens donner au fait que les deux observatrices n'aient pu classifier leurs observations de façon statistiquement concordante? Et même si Bales recommande un test d'efficacité d'ajustement, cela n'exclut pas le fait que deux ou plusieurs observateurs peuvent être "contaminés" par les mêmes biais personnels et professionnels, rendant le fruit de leur inventaire uniformément polarisé. Évidemment, je ne peux nier la valeur de l'outil de Bales, mais je suis quand même perplexe. Il s'agit donc de savoir si c'est la validité de l'outil comme telle ou l'utilisation qui en a été faite ici qui est discutable!

## Les résultats

Séguin Langlois rapporte que les intervenants se sont montrés plus aptes à donner de l'information, des opinions et des suggestions qu'à en solliciter, et qu'ils avaient tendance à interdire la manifestation des comportements autonomes. Pour leur part, les personnes âgées cherchaient surtout à témoigner de la solidarité envers les intervenants, en

dépit même du fait que leur taux de tension dépassait celui de leur diminution de tension. Qu'il y ait une certaine relation entre ces deux phénomènes est tout à fait plausible. Je pense cependant que la situation est plus complexe qu'elle n'apparaît dans cette présente étude. Je crois que les tâches analysées ici sont, jusqu'à un certain point, des indices de dépendance. En effet, se faire nourrir, se faire laver et installer nous renvoient à une étape de développement qui précède même celle du trotteur, à laquelle Erikson rattache justement le développement de l'autonomie. À vrai dire, ces tâches sont du niveau de la petite enfance, où l'acquisition de la confiance est prioritaire. Pendant cette période, il est dit que l'enfant recherchera surtout l'affection, désirera répondre aux attentes de son entourage. Le parallèle que l'on peut faire entre ceci et les comportements de solidarité manifestés par les résidents est troublant et pourrait, en soit, être l'objet d'une étude fort intéressante.

Et si l'on accepte que la nature même des tâches peut influencer, dans une certaine mesure, la personne âgée qui reçoit ces soins, on peut aussi admettre que ces tâches influenceront l'intervenant qui les effectue. Laver, faire manger, installer etc. sont des actes que les adultes accomplissent en général envers des enfants. Je crois que ce genre de tâche favorise, en soi, le développement d'une relation émotionnellement chargée pour les deux types de participants et que cette situation les prédispose l'un et l'autre à des réactions types. Selon la théorie des systèmes, la communication entre deux participants est circulaire, de sorte que chacun influence et est influencé par l'autre; j'en vois dans cette situation-ci une application concrète. Séguin Langlois est bien inspirée lorsqu'elle recommande que les attitudes des intervenants soient abordées dans les programmes de formation, en plus de notions sur les aspects biopsychosociaux du vieillissement et de la communication. C'est le professionnel éclairé et perspicace qui peut formuler son message de façon à ce que la personne âgée puisse répondre par la prise d'un rôle révélateur d'autonomie.

## RÉFÉRENCES

Erikson, E. H. (1963). *Childhood and society* (2nd ed.) New-York: W. W. Norton.

## RESUME OF CRITIQUE

A nursing study dealing with both geriatrics and the nurse's concept of "role" is timely and of utmost importance. The purpose of the study as well as the term "nursing personnel or staff" are somewhat vague and ambiguous. Seguin Langlois refers to Barney's research (1974) where it is noted that only the nurse maintains a statistically significant contact with the institutionalized elderly; she does not, however, involve nurses in her own study. The sample size of five residents and five staff members precludes generalization of the results; however, since the author is mainly interested the inter-personal relationship of the provider and the client, the limited sample size seems acceptable.

Utilization of the Bales Interaction Analysis Process Record is hazardous due to the inherent difficulty in differentiating among what could be considered to be confounding behavioural variables. Seguin Langlois's results seem plausible but, in my opinion, the tasks selected for analyzing the interactions between the residents and the staff members are, in themselves, expressions of dependency. Indeed, to be fed, washed, and positioned are requirements of the infant and precede the development of autonomy. Infants, in seeking affection, respond to the expectations of the environment: the resulting parallel between infancy and the residents' expressions of solidarity is both troubling and intriguing. Similarly, staff members may associate these tasks with those performed for the infant which, in turn, may introduce a variable affecting their behaviour. For these reasons, I strongly support Seguin Langlois's recommendation that attitudes of care providers toward the elderly be considered an integral component of the providers educational programme.



# TEENAGERS' RATIONALES FOR THEIR FOOD BEHAVIOURS: DIRECTIVES FOR TEACHING

M. Judith Lynam

As a result of the health policy established by Lalonde (1974), Canadian health care workers in general, and nurses in particular, have involved themselves in intervention programmes and research aimed at the modification of lifestyles. One category of health behaviour clearly linked to both long and short term health status is diet (Caliendo, 1981; Valadian, Berkey, & Reed, 1981). The study described here was designed to explore this category of health behaviours, specifically the nutritional behaviour of teenagers.

## Rationale for and Purposes of the Study

It is important to describe and identify dietary patterns, and to assess the incidence and type of nutritional problems. Several researchers have done this with the adolescent population. These studies include descriptions of meal patterns (Hinton, Eppright, Chadderdon, & Wolins, 1963; Huenemann, Shapiro, Hampton, & Mitchell, 1966), biochemical deficiencies (Faigle, 1973; Nutrition Canada, 1973 & 1975), and changing nutritional needs as a result of growth (Marino & King, 1980; Stare & McWilliams, 1973). In order to understand why some teenagers choose healthy diets and others do not, some researchers have examined the relationship between attitudes toward foods and food practices, as well as knowledge of nutrition and food practices (Kaufman, Poznanski, & Guggenheim, 1975; Thompson & Schwartz, 1977).

What is most striking about the literature is the lack of studies seeking the perspectives of teenagers on food. There is a lack of understanding of how teenagers interpret or make sense of facts, how teenagers develop their attitudes and in turn, how they make decisions about their food behaviours. Despite observations that diet and dietary behaviours are seen to be learned through socialization and everyday experience (Cussler & De Give, 1952), no studies were located which sought to describe adolescent nutritional behaviours by viewing adolescents as a cultural group, or by examining their everyday experiences. Questions related to why teenagers act as they do have not been responded to.

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There is a developing body of knowledge that identifies the importance of understanding individuals' rationales for their behaviours. The individual's perceptions are seen to influence decision making processes (Becker et al., 1979; Taylor, 1979). Powers and Ford (1976), upon reviewing literature on compliance, conclude that, "truly effective interventions must be based not only upon knowledge *per se* but also knowledge of the way the patient defines his situation" (p. 59).

Based on the described lack of information, this study was designed for the following purposes:

- to describe adolescents' perceptions of their food-related behaviours;
- to develop an understanding of the position food and food-related behaviours have within the values of the adolescent group;
- to describe variations or changes in food-related activities as adolescents are observed in selected situations at selected times.

### Theoretical Perspective of the Study

In order to address the purposes of the study, and to provide a clear representation of the teenagers' perspective, the phenomenological approach was used. Understanding the client's perspective is particularly important when research is intended to provide guidance to clinical practice. Davis (1978) argues that the effectiveness of interventions is increased when the practitioner is able to understand and to take direction from the client. In order to take direction from clients' perspectives, however, one must seek to understand the meaning and value that clients attach to events, and to describe how this in turn influences the clients' behaviours.

Kleinman's (1978) model of the individual's relationship with the health care system was used to develop initial interview questions, and to guide data analysis. The model proposes that different groups conceptualize or construct their own impressions of "clinical reality". As a result, health care professionals and clients explain or account for events differently. The model identifies questions that are helpful in ascertaining individuals' perceptions of their own situations.

### Methods

In a study of this nature individual participants are selected for their ability to address issues of concern:

On the assumption that all members of a culture are carriers of that culture, any person who belongs to the group under study is a possible informant (Brink & Wood, 1978, p. 123).

In this study, adolescents are considered to be a cultural group. Adolescence is a period of accelerated physical growth as well as a time of learning and developing new social roles. Teenagers' every day experiences, such as those with families and in high schools, contribute to the development of lifestyles and interests which differ from other social groups. For the purposes of this study, adolescent or teenager has been defined as: a youth, male or female, aged 12-18 years inclusive. As well as including teenagers of both sexes in the identified age range, additional selection criteria included not being under medical treatment or following a therapeutic diet, and being able to converse in English.

All teenagers in the study were volunteers. A sample of eleven adolescents (six boys and five girls) from different suburban areas of Vancouver was organized. The study conformed with the ethical review requirements of the University of British Columbia. Written consent was obtained from both the teenagers and their parents. Nine of the participants were interviewed on two occasions, the others were only available for one interview. The combined interview/observation times ranged from one to three hours, for a total of fifty-eight contact hours.

During initial interviews teenagers described their eating patterns and were asked their reasons for eating as they did. Throughout the interviews I sought to clarify statements and observations made by the teenagers.

After initial interviews, data were examined for basic patterns and recurrent themes, and additional topics for exploration were identified. In this way the processes of data collection and analysis were intertwined.

As a result of the on-going data analysis, some interviews lasted longer than others. Second interviews with the teenagers were used to clarify conceptual categories generated from the data. The use of subsequent interviews in this way ensured that conceptualizations were grounded in the teenagers' experiences, and that categories were developed systematically from the data.

#### Presentation of Findings

The purpose of interviewing the teenagers was to understand their food behaviours from their own perspectives. They identified many factors as influencing their food decisions. As data were analysed it became clear the subjects were actively involved in generating rationales for their actions. This was conceptualized as a process. Components of the process as identified by the researcher are presented below:

- receiving or seeking information;
- comparing information with their own experiences and beliefs;
- assessing the compatibility of the expected outcome of recommendations, with observations of themselves and others;
- identifying the relevance of information to personal goals and concerns.

In the following account a teenager comments upon information received which recommend one eating pattern over another. The rationale presented to the adolescent was that the eating pattern was more “healthy”, and that to follow the eating pattern would result in “feeling better”.

Subject: It doesn't seem to make any difference, so why bother with it anyway (referring to eating in the recommended manner). That's just how most people feel.

Researcher: What kind of differences would you look for?

Subject: Well, I mean the way people describe junk food compared to normal food.

Researcher: Yes.

Subject: Well, somebody who eats a lot of junk food would be walking around, you know, eyes all jerky, and kinda sagging along, and somebody who eats regular food will be running along. You know, that's the kind of difference you'd expect if you listened to a lot of people.

It is evident from the account that the recommended diet was not consistent with the adolescent's beliefs and experiences. The teenager, therefore, questioned the credibility of the conveyed knowledge. My interpretation is that the adolescent believes the negative and positive outcomes of eating certain foods to be exaggerated. The adolescent also argues that the consequences of “good” and “bad” diets are not as certain as some people believe. The intangible nature of the criteria measuring healthiness might be considered as one source of the problem.

Examples of the process of comparing information about food with their own beliefs about food were cited by all subjects teenagers in the study. In some instances they agreed and in others they did not. In all cases they willingly shared their reasons. In the following account the subject is discussing beliefs about “junk” food. Although the adolescent believes “junk” foods do not have the food value of recommended foods, the decision to eat junk foods is made.

It's not good for you, it hasn't got the protein and all that. That's why it tastes good... No, junk food really doesn't hurt me 'cause

I eat what I'm supposed to also. It gives me the calories. If I didn't eat junk food with all those calories, I'd just be a toothpick, worse than I am right now.

The account illustrates the teenager's belief that eating "what I'm supposed to" minimizes the negative effects of including junk foods in the diet. The example also illustrates the point that teenagers select information that they perceive to be consistent with their beliefs and experiences. It is important to note as well, that although all of the teenagers had concepts of "good" or "bad" foods, each definition differed. In each interview, clarification of the subjects classifications was sought.

When the subjects sought dietary information, their purposes appeared to be to gain knowledge as to how they might modify food behaviours. Some reasons presented for doing this were to increase rates of growth, to decrease weight, or to achieve a higher level of fitness. Despite the teenagers' openness to suggestion, they said that they still "tested it out". As a result of such testing, some adopted new food behaviours, and others selected only some suggested changes that they viewed to be most helpful or easiest to maintain.

The following account is an example of a subject who selected elements of advice or information that were viewed to be most appropriate:

I try really hard, I was on a, well not really a doctor's diet, but this diet out of a book. And I didn't follow it exactly or anything, but it was more or less. I tried to have meats and vegetables, and a lot of salad and water. And a lot of fruits in between, if I was hungry for my between meal snacks. My energy level was really good and I was feeling really good about it.

The testing of recommendations was something that all of the teenagers did. It appeared that, on occasion, information reinforced the maintenance of their food behaviours or provided them with a new awareness of reasons behind family eating patterns.

As well as considering information in relation to their beliefs or experiences, the subjects made observation on the effects of these recommendations in themselves and in others. Observations cited included their own bodies response to foods, and the eating patterns of others.

The following account is one example of how the same person carefully watched for cues signalling the body's response to different foods. The subject described how food information from this and similar situations was used in subsequent meal planning.

When I did dance, according to the foods I ate I could really feel the difference. If I went out and ate, a lot of pizza or pies and stuff like



that, I could really tell by the way my body reacted after I had exercised... Well, I'd really feel, uhm, blah, or more pep or more energy. (If I ate a pizza first) by the time we were to go home it was, I need a coke, or something. Other times I'd just have a nice quiet dinner at home with regular meat, vegetables, potatoes, and by the time we were finished (exercising), an apple would satisfy my thirst.

The respondents were seen to be testing actions and consequences, and weighing alternatives. Sometimes, as in the following instance, the feedback was immediate. "If you have to have energy, like in basketball, I get cramps if I don't eat... so I can't skip it (lunch) 'cause I feel really bad." In each situation it was evident the teenagers had their own ideas of what were preferred food behaviours.

The subjects further explained that they might adopt certain food behaviours because of observations of other persons possessing various esteemed qualities. Some were perceived as "knowledgeable" (i.e., mothers), "experts" (i.e., physical education teachers or nurses), or to have desirable physical characteristics (i.e., friends or athletes). In the latter instance, the subjects attributed some of the abilities or looks to foods eaten. They also used observations of others to justify eating practices:

Well, they (food habits) aren't that good, they're just average. But I don't think they're any worse than most other people's. Well, even my own parents. Like, I don't eat that much different. I have the same lunches practically, I have the same dinners, the same breakfasts.

In the preceding account the teenager points out that, because her food behaviours are like those of role models who were identified as having some credibility, there is no need to change them.

The teenagers in the study reported that observations of their own responses, to foods and those of others, helped them in their decisions to use or disregard information they acquired, and contributed to the development of their ideas about such concepts as varying metabolic rates, or predisposition to fatness or thinness.

Another element of the process of developing a rationale for food behaviours was the examination of information in relation to issues of personal concern. They also limited the types of knowledge they perceived to be useful, based on assessments of their own behaviours or that of others.

All of the teenagers cited at least one of three personal issues which they considered to influence their food decisions. Most cited more



than one. The issues may be broadly categorized as: body image, friends, and sports. While one may not assume that these were their only concerns, they did contribute in important ways to the particular food behaviours reported. These were seen as instrumental in resolving these concerns. The following account is an example of how a teenager conceptualized the relationship between food behaviours and friendships.

Everybody wants to be popular. So I guess one way to be popular, or to be liked is to look good. And so I guess that's one of the reasons I changed (the way I ate), so I could look better.

When the respondents sought information from outside sources, they all set limits on the nature of the information they would consider. One factor influencing these limits was their perception of need as reflected in their personal concerns. The three personal issues described above contribute to the development of rationales for acting by guiding the teenagers' decisions about the relevance of information. In a sense, the personal issues were seen, by the writer, to provide the teenagers with a context for interpreting knowledge and observations of their own and others' behaviours.

### Discussion

Although documentation of the actual nutritional status of teenagers exists, it was argued, when presenting the rationale for the study, that other studies were not found to explain the wide variability in food practices. The conceptualization of the process of developing rationales for eating arrived at in this study, could help to provide alternative interpretations of statistical findings.

The theoretical framework for the study directed the researcher in eliciting the teenagers' explanations for their behaviours. Having an understanding of an individual's perspective aids clinicians in choosing interventions that would be perceived as appropriate by clients, and may help them to convey information in terms meaningful to the clients.

The conceptualization developed in this study provides insight into how teenagers examine or evaluate information that they have received. It also suggests that personal interests or priorities will act to increase receptivity to differing types of information. Traditional approaches to health education have emphasized teaching, yet, research reports that knowledge does not necessarily predict compliance with prescribed regimens (Taylor, 1979). Similar findings have been reported in relation to adolescent food behaviours (Huenemann et al., 1966; Thompson & Schwartz, 1977). The conceptualization

proposed in this study identifies how teenagers respond to information; how they assess its relevancy to their own situation and its compatibility with their beliefs, and the impact that they described food behaviors as having on other aspects of their lives.

Studies examining factors influencing compliance with prescribed regimens indicate that working with the individual's situation (Sellers, Cappell, & Marsham, 1979) and appealing to perceived needs (Becker, et al., 1979) increases the successfulness of interventions. Several studies have reported that teenagers' food behaviours are influenced by their beliefs about foods (Kaufman, et al, 1975) and perceptions of themselves (Huenemann et al., 1966, 1968). These findings would be supported in this study, but the proposed conceptualization directs one to explore the beliefs of adolescents in relation to the information conveyed.

This study suggests that in order to increase the effectiveness of teaching interventions with teenagers, the teaching situation should provide opportunities for exploration of their pre-conceived notions about food. This approach would facilitate the assessment of information that the adolescent perceives as needed. The process-oriented approach would also encourage the nurse to seek the individual's perceptions of what had been taught, this providing opportunity to clarify misconceptions, to add information, or to identify conceptual barriers that inhibit the client's ability to incorporate new information. Opportunities for teaching and learning may be present in any interaction.

In addition, this study supports the need for clarity when describing the positive or negative effects of food behaviours. It has shown that, in the process of evaluating information, the adolescents were more likely to adopt recommended behaviour patterns if the desired outcomes were amenable to observation or if the responses were seen to be immediate. If this is an expectation of teenagers, it seems it would be important to convey information about just what is likely to happen in terms of bodily responses; how much time it might take to lose or gain weight, to have improved athletic performance, or to improve skin condition, and what other factors might be involved. Finally, the role of others as conveyors of information and as behavioural models was demonstrated. Credible sources were described as understanding the importance of issues to the teenager, explaining things in a manner which related to the teenagers' experiences, and as having behaviours consistent with their recommendations. All of the teenagers in the study were observing others in order to generate their own particular rationales for their food behaviours. Attempting to make sense of information, their experiences, and others' behaviours as well as to resolve issues of concern, was a part of their everyday experience.

## Summary

This study addressed the problem of a lack of understanding of the wide variation in teenagers' food behaviours by having the teenagers describe their views on the topic of food. By analysing data collected during indepth interviews, the author conceptualized the ways that teenagers use their experiences and observations to generate a rationale for their actions. The conceptualization contributes to the developing body of knowledge of the factors influencing health behaviours. It suggests that a process-oriented approach to teaching would increase its effectiveness. Contrasting the experiences of the teenagers in this study with those of teenagers from differing cultural backgrounds, or with those of teenagers with health problems (such as diabetes) would be useful in identifying similarities and differences in experiences; further exploration with additional groups would also facilitate generalizing the findings to other groups.

## REFERENCES

- Becker, M. H., Maiman, L. A., Kirscht, J. P., Haefner, D. P., Drachman, R. H., & Taylor, D. W. (1979). Patient perceptions and compliance: Recent studies of the health belief model. In B. Haynes, D. W. Taylor, & D. L. Sackett (Eds.), *Compliance in Health Care*. Baltimore: The Johns Hopkins University Press.
- Brink, P. J., & Wood, M. J. (1978). *Basic steps in planning nursing research*. North Scituate: Duxbury Press.
- Caliendo, M. A. (1981). *Nutrition and preventive health care*. New York: Macmillan Publishing Co., Inc.
- Cussler, M. & De Give, M. L. (1952). *'Twixt the cup and the lip*. New York: Twayne Publishers.
- Davis, A. J. (1978). The phenomenological approach in nursing research. In Norma L. Chaska, (Ed.), *The nursing profession: Views through the mist*. New York: McGraw-Hill Book Co.
- Faigle, H. C. (1973). Hematocrits in suburban adolescents, a search for anemia. *Clinical Pediatrics*, 12, 494-496.
- Hinton, M. A., Eppright, E. S., Chadderdon, H., & Wolins, L. (1963). Eating behavior and dietary intake of girls 12 to 14 years old; psychologic, sociologic and physiologic factors. *Journal of the American Dietetic Association*, 43, 223-7.
- Huenemann, R. L., Shapiro, L. R., Hampton, M. ., & Mitchell, B. W. (1966). A longitudinal study of gross body composition and body conformation and their association with food and activity in a teen-age population. *American Journal of Clinical Nutrition*, 18, 325-38.
- Huenemann, R. L., Shapiro, L. R., Hampton, M. C., & Mitchell, B. W. (1968). Food and eating practices of teen-agers. *Journal of the American Dietetic Association*, 53, 17-24.
- Kaufman, N. A., Poznanski, R., & Guggenheim, K. (1975). Eating habits and opinions of teenagers on nutrition and obesity. *Journal of the American Dietetic Association*, 66, 264-68.

- Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine*, 12, 85-93.
- Lalonde, M. (1974). *A new perspective on the health of Canadians*. Ottawa: The Queen's Printer.
- Marino, D., & King, J. C. (1980). Nutritional concerns during adolescence. *Pediatric Clinics of North America*, 27, 125-39.
- Nutrition Canada: The British Columbia Survey Report*. (1975). A Report from Nutrition Canada by the Bureau of Nutritional Sciences, Department of National Health and Welfare.
- Nutrition: A National Priority*. (1973). A report by Nutrition Canada to the Department of National Health and Welfare.
- Powers, M. & Ford, L. C. (1976). The best kept secret: Consumer power and nursing's potential. In F. Gilbert McMahon (Ed.). *Principles and techniques of human research and therapeutics: A series of monographs*, Vol. X. New York: Futura Publishing Co.
- Sellers, E. M., Cappell, H. D. & Marshman, J. A. (1979). Compliance in the control of alcohol abuse. In B. Haynes, D. W. Taylor, & D. L. Sackett, (Eds.). *Compliance in health care*. Baltimore: The Johns Hopkins University Press.
- Stare, F. & McWilliams, M. (1973). *Living Nutrition*. New York: John Wiley and Sons Inc.
- Taylor, D. W. (1979). A test of the health belief model in hypertension. In B. Haynes, D. W. Taylor, & D. L. Sackett (Eds.). *Compliance in Health Care*. Baltimore: The Johns Hopkins University Press.
- Thompson, J. K. & Schwartz, N. E. (1977). Nutrition knowledge, attitudes and practices of eighth grade students. *Journal Canadian Dietetic Association*, 38, 222-8.
- Valadian, I., Berkey, C. & Reed, R. B. (1981). Adolescent nutrition as it relates to cardiovascular disease and reproductive capacity later in life. *Nutrition Reviews*, 39, 107-11.

## RÉSUMÉ

### **Justification du comportement alimentaire des adolescents par les intéressés: directives pédagogiques**

Le présent article fait état d'une enquête sur les perceptions alimentaires des adolescents et sur leur comportement. Il s'agit d'une étude de conception qualitative. Les données ont été recueillies auprès de onze adolescents dans leur foyer au cours d'entrevues et d'observations approfondies qui ont duré au total 58 heures. L'analyse des données a révélé que les adolescents s'efforcent activement de justifier leurs actions. Cette démarche est conceptualisée sous forme de processus et l'on décrit quatre composantes de ce processus. L'orientation qu'offre la conceptualisation à des fins cliniques et pédagogiques notamment fait l'objet d'une discussion.

# NON-DEGREE CONTINUING NURSING EDUCATION NEEDS OF ALBERTA'S REGISTERED NURSES

Sharon Richardson and Jennifer Sherwood

Universities in western Canadian provinces have, for the past decade, been major providers of continuing nursing education. For much of the programing provided by these institutions, content and format selection has been based on individual director's or co-ordinator's perceptions of "what was needed", plus "what was available" by way of instructional and venue resources. In Alberta, a recently completed province-wide survey of non-degree continuing nursing education needs of registered nurses will assist programers in providing offerings tailored to meet their clientele's needs.

The most recent province-wide educational needs assesment in Alberta focused on the province's registered nurses' perceptions of their needs for university nursing education and clinical courses (Andrews, 1978). The last formal educational needs assessment designed to identify preferences for content and different methods of delivering continuing nursing education, was conducted in 1971 by the Advisory Committee of the Continuing Nursing Education Program of the University of Alberta. The findings were never published. Since these surveys were conducted six and twelve years ago, respectively, their findings may be of limited relevance today, given the rapid expansion of knowledge and the extensive changes in nursing practice.

## Purpose of the Study

The purpose of this study was to expand the data base available for planning non-degree continuing nursing education programs for Alberta's registered nurses. The specific questions addressed were:

1. What content areas do Alberta's registered nurses prefer for non-degree continuing nursing education?
2. What delivery formats do Alberta's registered nurses prefer for non-degree continuing nursing education?

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3. Are there differences among Alberta's registered nurses, categorized by selected personal and professional characteristics, in their preferences for content areas of non-degree continuing nursing education.?

4. Are there differences among Alberta's registered nurses, categorized by selected personal and professional characteristics, in their preferences for delivery format of non-degree continuing nursing education?

The term "non-degree continuing nursing education" was defined as educational programs for which no academic credit or certification is granted. These programs are designed to assist registered nurses to update and expand their knowledge and skills.

The study was only concerned with preferences or expressed needs of the respondents concerning continuing nursing education program content and format. No attempt was made to collect employers' perceptions of non-degree continuing nursing education preferences or needs of registered nurses. Similarly, needs based on competencies required of Alberta's registered nurses has not been a component of this study.

### Assumptions

The basic assumption underlying the study were:

1. Participation in non-degree continuing nursing education assists Alberta's registered nurses to update and expand their nursing knowledge and skills.

2. Alberta's registered nurses voluntarily engage in non-degree continuing nursing education.

3. Alberta's registered nurses are more likely to engage in non-degree continuing nursing education which satisfies their preferences for content area and delivery format.

### Methodology

A survey method employing a mailed questionnaire was selected as the most efficient method of collecting information about the preferences of Alberta's registered nurses for content and delivery format of non-degree continuing nursing education.

A questionnaire was developed by the investigators. The instrument was validated by a group of nurses employed in post-secondary educational planning for continuing nursing education. It was then pretested in a mailout to 30 Alberta registered nurses whose characteristics were similar to the study sample but who were not members of the sample. Content and format changes recommended

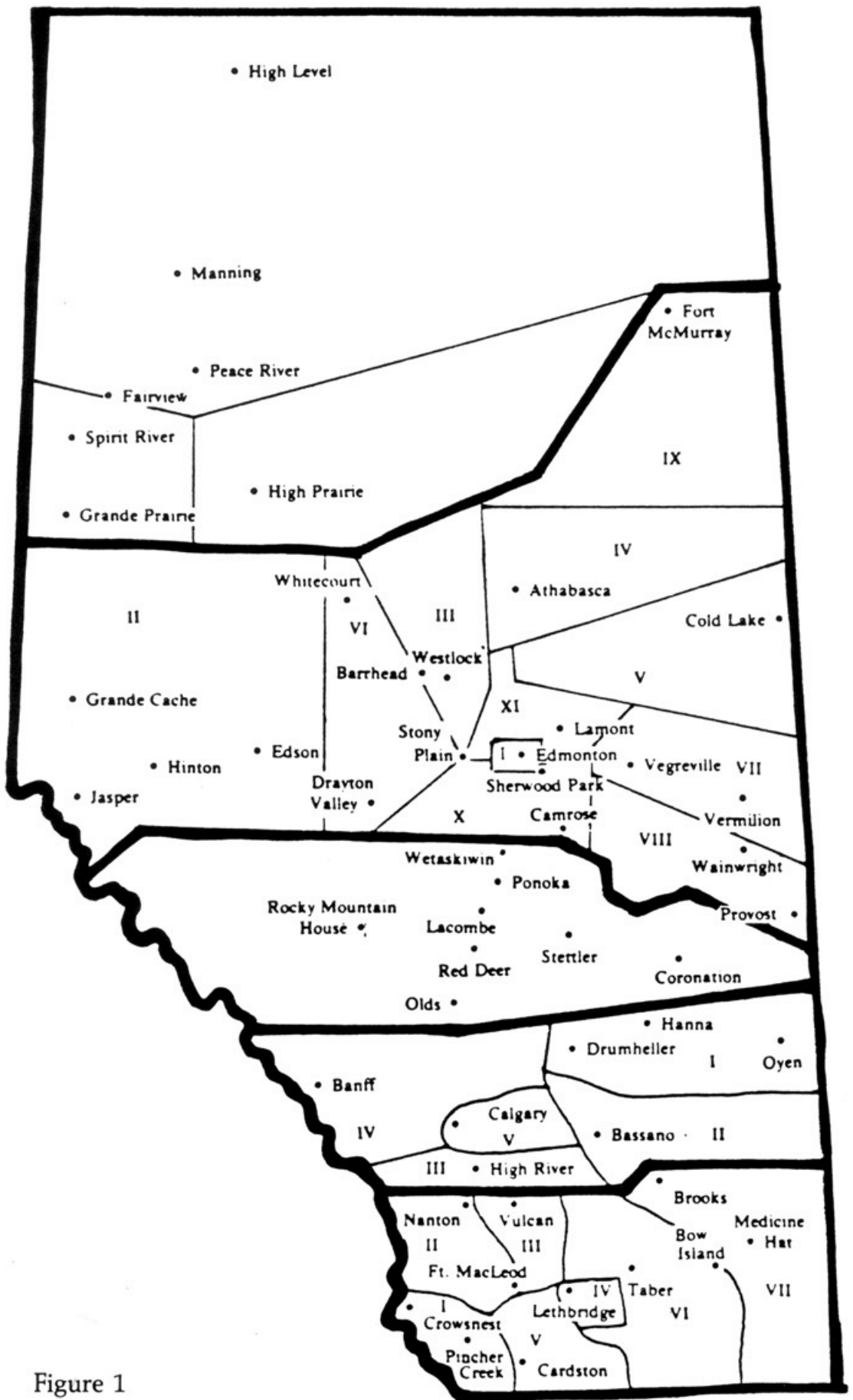


Figure 1

by these two groups were incorporated into the final draft of the questionnaire which was mailed to a 10% random sample of all actively registered nurses in Alberta, proportioned by A.A.R.N. District and stratified by employment setting (hospital or non-hospital). Figure 1 shows the boundaries of the A.A.R.N. Districts. The response rate by district and employment setting is shown in Table 1.

Table 1  
Survey Response Rate by  
District and Employment Setting

District	Number Delivered	Number Returned	Percentage Returned
<i>North:</i>			
Hospital	39	23	59%
Non-Hospital	13	8	62%
<i>North Central:</i>			
Hospital	552	281	51%
Non-Hospital	185	123	66%
<i>Central:</i>			
Hospital	100	45	45%
Non-Hospital	33	17	52%
<i>South Central:</i>			
Hospital	372	196	52%
Non-Hospital	124	71	57%
<i>South:</i>			
Hospital	106	61	58%
Non-Hospital	35	22	63%
Total	1,559	847	54%

The questionnaire consisted of four parts. Part I requested the following personal and professional characteristics of the respondent: AARN district; population of employment locale; employment status (full-time or part-time); employment setting (hospital, public health agency, physician's office, educational institution); size of employing hospital (if applicable); age; highest level of completed education; and years of nursing work experience. Part II allowed respondents to indicate their preferences for content of 64 provided non-degree continuing nursing education offerings, and to identify any additional content preferences. Part III requested respondents' preferences regarding format for non-degree continuing nursing education offerings. Part IV allowed respondents to make additional comments regarding non-degree continuing nursing education programming.

The characteristics of the respondents elicited in Part I of the questionnaire were summarized by frequency. Respondents' preferences for content and delivery format, obtained from Parts II and III of the questionnaire, were summarized using frequency counts. Because the level of measurement was ordinal, contingency and chi-square statistics were used to determine the existence of any statistically significant differences in content and format preferences among respondents categorized by selected personal and professional characteristics. Respondent comments obtained in Part IV of the questionnaire were categorized and summarized by frequency of occurrence.

### Generalizability of Findings

Although an overall questionnaire response rate of 54% is considered good for this type of study, some caution must be exercised in generalizing the study findings to the total population of actively registered nurses in Alberta. For providers of non-degree continuing nursing education, however, the study results are of considerable value since it is reasonable to expect that the study respondents are the nurses most likely to engage voluntarily in non-degree continuing nursing education programming. Their content and format preferences are important to program planners attempting to meet expressed participant needs.

Almost two-thirds of the respondents reported that they worked in an urban centre with a population of 100,000 or more; that is, they worked in either Calgary or Edmonton. Fifteen and one-half percent of respondents were employed in a town or city with a population of 10,000 to 99,999; 13.8% worked in a town of 9,999 or fewer, and 4.7% reported employment in a rural area.

Two-thirds of respondents were employed full time and had achieved a nursing diploma as their highest level of completed education. Three-quarters of the respondents worked in a hospital, and, of these, almost half reported the size of the hospital as more than 500 beds. Seventy percent were 40 years of age or younger, and slightly more than half of the respondents had 10 or fewer years experience in nursing.

### Content Preferences

On a four-point Likert scale, respondents rated their interest in participating in non-degree continuing nursing education which focused on 64 specific content areas. Possible responses ranged from 1, meaning "would never participate", through 2 and 3, meaning "possibly" and "probably" respectively, to 4, meaning "would definitely participate". Respondents were also provided an opportunity to indicate content for non-degree continuing nursing education which was not included in the 64 topics but in which they were interested.

Table 2 depicts the respondents' interest in participation in the 64 content areas ordered by the number of responses in the "would definitely participate" category.

One hundred and twenty-five respondents offered a total of 392 suggestions for additional content areas for non-degree continuing nursing education. An overwhelming majority — 84% — of all additional suggested topics were clinically oriented. Of these topics, more than half had already been provided in the questionnaire.

### Format Preferences

Respondents were asked to rate their preference for nine delivery formats and to indicate the times of the day, days of the week, and months of the year during which they would be most likely to participate in non-degree continuing nursing education. Respondents were also requested to indicate how much advance notice of events they required and how soon before the event's scheduled date they required specific program details.

On a four-point Likert scale, respondents rated their interest in participating in non-degree continuing nursing education programming offered as a one-day workshop; two-day workshops; three-day workshops; once-daily sessions from 1 to 6 weeks; once-weekly sessions from 7 to 12 weeks; home-study packages; one-way T.V. programs (viewer receives instruction); interactive T.V. programs (viewer may "talk back" to instructor); and workshop followed by home study followed by workshop sequence. Possible responses rang-

Table 2  
 Respondents' Content Preferences for Non-Degree  
 Continuing Nursing Education Ordered by  
 Absolute Frequencies in "Definitely" Category

Content Area	Absolute Frequency				
	Never	Possibly	Probably	Definitely	No Response
1. Managing Stress	58	202	233	344	10
2. Emergency Nursing of Multiple Trauma Patients	110	195	183	339	20
3. Preventing Burnout	85	200	230	321	11
4. Pharmacology Update	52	172	286	320	17
5. Legal & Ethical Issues	53	238	254	289	13
6. Drug Interactions	67	188	293	288	11
7. Diabetic Update	67	224	266	276	14
8. Assertiveness Training	112	234	244	244	13
9. Care of the Terminally Ill	123	227	235	242	20
10. Implications of Alcohol & Drug Abuse	88	224	289	229	17
11. Management of Pain	71	269	267	210	30
12. Health Assessment of Children	157	235	230	209	16
13. Introduction to Cardiac Arrhythmias	154	253	212	205	23
14. Interviewing Skills	115	287	229	199	17
15. Use of Teaching Methods	147	264	220	196	20
16. Care of Intravenous Infusions	195	226	215	196	15
17. Nursing of the Gerontologic Patient	171	276	191	194	15
18. Cardiac Arrhythmias - Advanced Concepts	148	275	191	192	41
19. Family Interviewing Skills	130	256	248	190	23
20. Health Assessment of Adults	115	258	260	190	24
21. Psychosocial Aspects of Aging	129	292	227	186	13
22. Staff Development for Nurse Managers	231	247	166	184	19
23. Principles of Patient Teaching	108	249	288	182	20
24. Meaningful Staff Performance Appraisals	227	247	177	177	19
25. Physiologic Aspects of Aging	131	292	236	176	12
26. The Nurse & Individual Counselling	149	262	241	176	19
27. Aspects of Total Parenteral Nutrition	165	258	235	173	16
28. Aspects of Intravenous Therapy	163	270	226	172	16
29. Family Crisis Intervention	131	267	261	167	21
30. Neurologic Nursing	198	279	183	166	21
31. Management of Burns	198	246	222	165	16
32. Community Skills	164	283	218	164	18
33. Oncology Update	135	319	217	153	23
34. Care of the Ill Neonate	295	232	151	151	18
35. Staff Motivation for Nurse Managers	274	249	152	150	22
36. Nursing Care During High-Risk Pregnancy	270	248	161	148	20
37. Management of Normal Labour	292	251	140	146	18
38. Care During Complicated Labour	340	228	120	142	17



Table 2 - concluded

Content Area	Never	Possibly	Probably	Definitely	No Response
39. Mental Health Nursing Update	191	303	196	138	19
40. Nursing Management of the Normal Neonate	280	250	164	138	15
41. Using Audiovisual Aids	198	303	180	129	37
42. Inservice Programing in Small Hospitals	342	249	115	126	15
43. Budgeting Skills for Nurses	300	262	141	121	23
44. Nursing as a Profession	226	310	169	119	23
45. Community Mental Health Nursing	256	301	156	119	15
46. Role of the Nurse Inservice Educator	314	240	146	118	29
47. Evaluating Learning	212	308	189	115	23
48. Political Awareness	235	301	184	109	18
49. Care of Patient with Ostomy	207	323	190	108	19
50. Recent Events in Nursing Research	212	315	195	108	17
51. Coping with Institutionalized Patients' Sexuality	226	309	185	107	20
52. Organizing the Nursing Inservice Department	363	231	125	103	25
53. Writing Skills	206	343	174	100	24
54. Nursing Implications of Problem-Oriented Records	209	344	172	98	24
55. The Nurse & Group Therapy	246	312	170	98	21
56. Introduction to Primary Care Nursing	204	351	168	97	27
57. Introduction to Research in Nursing	276	315	142	95	19
58. Designing Learning Modules	319	264	142	95	27
59. Quality Assurance in Nursing: Practice Standards	185	368	182	87	25
60. Quality Assurance: Use of Nursing Audit	253	308	176	84	26
61. Patient Classification Systems	267	322	158	78	22
62. Writing Learning Objectives	272	298	163	76	38
63. Introduction to Quality Assurance	187	374	185	73	28
64. Application of Nursing Models in Practice Settings	287	334	121	71	34

ed from 1 meaning "would never participate" through 2 and 3 meaning "possibly" and "probably" respectively, to 4, meaning "would definitely participate".

Respondents were also provided with the opportunity to indicate other formats for delivering non-degree continuing nursing education which were not included in the nine formats, but in which they would participate.

Considerable interest in one- and two-day workshops was expressed by respondents. Almost 69% indicated that they would "definitely" attend one-day workshops and 33.3% expressed "definite" interest in two-day workshops. Home-study packages and once-weekly sessions lasting 1 to 6 weeks were also popular, as evidenced by the 28.9% and 24.8% of respondents, respectively, who indicated "definite" interest. Once-weekly sessions lasting 7 to 12 weeks, one-way T.V. programs, and interactive T.V. programs were of considerably less interest to respondents, 21.0%, 20.3% and 18.3% of whom, respectively, indicated that they would "never" participate in these formats.

Very few, only 59, additional suggestions for delivery format were provided by respondents. Almost one-quarter of these were unrelated to format and the remainder either expanded or limited options provided on the questionnaire.

Slightly more than 40% of the respondents indicated that they would "definitely" attend a continuing education activity scheduled between the hours of 0830 and 1630, and slightly more than 25% reported that they would "definitely" participate from 1900 to 2100 hours. Expressed interest in programing scheduled during the late afternoon and late evening was limited, as evidenced by the large proportion of responses in the "never" category — 30.3% for 1500 to 1700 hours, 32% for 1700 to 1900 hours, 21.6% for 1800 to 2000 hours and 24.9% for 2000 to 2200 hours.

Monday through Friday were preferred days for scheduling non-degree continuing nursing education. Weekends were not popular with respondents; almost half indicated that they would "never" participate on a Sunday and 29% reported that they would "never" participate on a Saturday.

The months of July and August were the only months which were clearly not preferred by respondents for participation in non-degree continuing nursing education; December was the third least preferred month for programing.

Respondents indicated less advance notice and notice of specific program details than might have been expected. Slightly more than 75% of them reported that they required up to 2 months' advance notice, and 72.2% of all respondents reported that they required specific program details between 2 and 6 weeks in advance.

#### Differences in Content Preferences

There were statistically significant differences among respondents categorized by specific personal and professional characteristics in their expressed preferences for content of non-degree continuing nurs-

ing education. Respondents' employment setting, age, total number of years of experience in nursing, highest level of completed education, and employment status (full-time or part-time), had the most impact on expressed content preferences, while population of respondents' employment locale, size of employing hospital, if applicable, and A.A.R.N. District, had less impact.

Expressed interest in program content tended to reflect the nature of respondents' employment. Respondents employed in hospitals preferred content related to nursing care of ill individuals, while respondents employed in public health agencies preferred content focused on nursing assessment skills, particularly as these related to the assessment of families. Respondents employed in educational institutions preferred content related to patient, staff and student teaching. Respondents employed in "other" settings, the majority of whom were involved in occupational health and home care, preferred programming focusing on health-promotion and prevention of illness.

Respondents expressed particular interest in non-degree continuing nursing education content that dealt with events in the life cycle that approximated those characteristic of the respondents' age. Thus, expressed interest in maternal and neonatal nursing care was greatest among respondents 31 years of age and younger, and decreased as respondents age increased. Similarly, the level of expressed interest in physiologic and psycho-social aspects of aging and nursing care of the terminally ill increased as respondents' age increased, and was greatest among those 51 years and over.

Younger respondents tended to be interested in clinically oriented content, e.g., neurologic nursing and introduction to cardiac arrhythmias, whereas older respondents expressed interest in content focusing on the management and teaching aspects of nursing practice, e.g., meaningful staff performance appraisals, quality assurance and the role of the nursing inservice educator.

Expressed interest in the following content areas varied directly with number of years of experience in nursing; that is, interest increased as number of years of nursing work experience increased: the role of the nurse inservice educator; organizing the nursing inservice department; meaningful staff performance appraisals; staff motivation for nurse managers; quality assurance: nursing practice standards; evaluating learning; budgeting skills for nurses; legal and ethical issues for nurses; patient classification systems; and using audiovisual aids. Like respondents thirty years of age and younger, *respondents with 5 or fewer years of nursing work experience expressed the greatest interest in programing focused on childbearing, e.g., pregnancy, labour and delivery, and neonatal care, and on clinically*

oriented topics, e.g., nursing management of burns, pharmacology update and emergency nursing of trauma patients. The greater their number of years of experience in nursing, the more likely were respondents to prefer programing focused on managerial, teaching, and professional aspects of nursing practice, and on life cycle events associated with aging, e.g., nursing the gerontologic patient, psychosocial aspects of aging, and nursing the terminally ill.

As respondents' formal level of education increased, so did their expressed interest in professional aspects of nursing, e.g., quality assurance and nursing models in a practice setting. Expressed interest in the following topics varied indirectly with increasing level of education; that is, interest decreased as respondents' educational level increased: nursing aspects of intravenous therapy; nursing care of intravenous infusions; drug interactions; patient with ostomy; emergency nursing of multiple trauma patients, nursing care during complicated labour; and nursing management of pain. Respondents with a diploma as their highest level of completed education expressed greater interest in clinically oriented content than did respondents with either a post diploma certificate or respondents with a baccalaureate or higher degree.

Full-time employed respondents expressed greater interest in programing focusing on the professional, managerial and teaching aspects of the nurse's role, while part-time employed respondents expressed greater interest in programing focused on the clinical aspects.

Respondents employed in small (less than 9,999 population) and medium-sized towns (10,000 to 99,999 people) expressed interest in a greater variety of content than did respondents employed in cities of 100,000 or more (Calgary and Edmonton).

Expressed interest in the following content varied inversely with hospital size, that is, interest decreased as hospital size increased: normal neonate; oncology nursing update; nursing management of pain; diabetic update; the gerontologic patient; the ill neonate; management of normal labour; physiologic aspects of aging; psychosocial aspects of aging; care during high risk pregnancy; mental health nursing update; inservice programing in small hospitals; care during complicated labour; management of burns; care of the terminally ill; organizing the nursing inservice department; and coping with institutionalized patients' sexuality. Respondents employed both in hospitals of 1-100 beds and 101-500 beds expressed interest in a wider variety of content than did respondents employed in hospitals of 500 or more beds.

Most of the 15 statistically significant differences in programing content preferences among respondents, categorized by A.A.R.N. District, involved topics preferred by the predominantly rural districts

— North, Central, and, to a lesser extent, South. These topics focused on clinically oriented content, e.g., management of burns, management of the normal neonate. North District respondents expressed definite interest in programing focusing on care during high risk pregnancy, inservice programing in small hospitals, care during complicated labour, nursing implications of drug interactions, and staff development for nurse-managers.

### *Differences in Format Preferences*

Respondents' personal and professional characteristics had less effect on expressed interest in various programing formats than on programing content. Age, population of employment locale, employment status (full-time or part-time), number of years of nursing work experience, size of employing hospital and respondents' highest level of completed education had the greatest impact on format preferences. Employment setting and respondents' A.A.R.N. District had the least impact on format preferences.

Expressed interest in participation in programing offered during the months of July, August, and December, and in programing offered as a two-day workshop, varied indirectly with age; that is, as respondents' age increase, their interest decreased. Overall interest in July and August programing was limited, however.

Respondents from cities of 100,000 or more population (Calgary and Edmonton) and towns of 10,000 to 99,999 population expressed greater interest in programming offered weekly for 1 to 6 weeks, than did respondents from small towns of 9,999 or fewer, and from rural areas. Non-urban respondents expressed more interest in both one-way and interactive TV programing than did urban respondents. Interest in the workshop followed by home study followed by a workshop sequence, in three-day workshops, in programing scheduled from 1800-2000 hours, in programing scheduled from 1900-2100 hours, and in programs offered either during January or September varied indirectly with population of employment locale; that is, interest decreased as population increased.

Respondents employed part-time expressed more interest in one-way TV programing, once-weekly sessions for 1 to 6 weeks, and programing scheduled from 2000-2200 hours, than did respondents employed full-time. Respondents employed part-time also requested less advance notice of non-degree continuing nursing education events. Respondents employed full-time were more in favour of three-day workshops and May, July, and August programing, although overall expressed interest in July or August scheduling was limited.



Expressed interest in programing offered during July or August tended to vary indirectly with years of nursing work experience; that is, interest decreased as experience in nursing increased.

Respondents with a post diploma certificate expressed greater interest in programing offered during the months of January and February, programing offered weekly for 7 to 12 weeks, and programing scheduled from 2000-2200 hours, than did either respondents with a diploma or respondents with a baccalaureate or higher degree as their highest level of completed education.

Respondents employed in hospitals of 1-100 beds expressed greater interest in one-day workshops, home study packages, one-way TV programs and the workshop - home study - workshop sequence than did either respondents employed in hospitals of 101-500 beds or more than 500 beds; however, they expressed less interest in programing scheduled during either September or October. Amount of advance notice of events required by respondents varied directly with size of employing hospital.

There were only three of a potential 47 statistically significant differences in format preferences among respondents categorized by employment setting.

Only two statistically significant differences in format preferences were demonstrated among respondents categorized by A.A.R.N. District.

#### Summary of Differences In Content and Format Preferences

There were more differences among respondents, categorized by selected personal and professional characteristics, in their expressed preferences for content of non-degree continuing nursing education, than in their expressed preferences for formats. Numerous of the respondents' personal and professional characteristics that were associated with differences in content preferences were less often associated with differences in format preferences, e.g. nature of employment, number of years of nursing work experience, highest level of completed education and employment status (full or part-time). Respondents' age was the only personal characteristic associated frequently with both differences in content and format preferences. Table 3 summarizes the frequency of statistically significant differences in content and format preferences among respondents categorized by selected personal and professional characteristics.



Table 3  
Frequency of Statistically Significant Differences  
in Content and Format Preferences Among Respondents  
Categorized by Personal and Professional Characteristics

	Content Preferences		Format Preferences	
	Frequency		Frequency	
	Absolute (N = 64)	Percent	Absolute (N = 47)	Percent
Nature of Employment	44	68.75	3	6.38
Age	42	65.63	14	29.79
No. of Yrs. of Nursing Work Experience	39	60.94	9	19.15
Highest Level of Completed Education	36	56.25	8	17.02
Employment Status	31	48.44	9	19.15
Population of Employment Locale	27	42.19	11	23.40
Size of Employing Hospital	25	39.06	8	17.02
A.A.R.N. District	15	23.44	2	4.25

#### *Respondents' Additional Comments*

Approximately one-third of the 847 study respondents offered a total of 571 individual comments or suggestions. The large number of comments and substantial proportion of the respondents who offered comments were interpreted as indication of interest in the subject of non-degree continuing nursing education.

Slightly more than one-half of all comments related to respondents' perception of conditions that would facilitate or impede their participation in non-degree continuing nursing education. Locating programs, in or near the work place, paid educational leave, and financial assistance with registration fees and other participation expenses were identified as facilitators to participation. Barriers to participation were identified as: fatigue, shift-work, "burnout", lack of academic credit, family responsibilities, and insufficient advertising of events.

Slightly less than one-half of all comments related to suggested content for non-degree continuing nursing education, perception of the value of non-degree continuing nursing education and this study, suggestions for improvements in programming and miscellaneous topics, many of which were unrelated to non-degree continuing nursing education.

## Conclusions

Based on the finding of this survey of non-degree continuing nursing education needs of Alberta's registered nurses, the following conclusions are presented:

1. The 54% response rate to the study, the respondents' interest in all content areas, and the large number of suggested topics offered by respondents was indicative of the respondents' interest in non-degree continuing nursing education. Sufficient interest was expressed in participating in non-degree continuing nursing education to warrant continued support for its delivery in Alberta.

2. The most preferred content areas were those related to the nurse's role as a clinician. For example, of 12 most preferred content areas, ordered by frequency of response in the "definitely" category, 8 were related to the clinician role. These were: emergency nursing of multiple trauma patients; pharmacology update; drug interactions; diabetic update; care of the terminally ill; implications of alcohol and drug abuse; management of pain; and health assessment of children.

3. Sufficient interest was expressed in all listed content areas to warrant the delivery of specific topics to certain segments of the nurse population in Alberta. For example, even for the least preferred content area, application of nursing models in practice settings, 71 of the 813 respondents to this item indicated that they would definitely attend and 121 indicated that they would probably attend.

4. The length of the non-degree continuing nursing education offering influences the commitment to participate. As the length of the program increases, the degree of interest in participation decreases.

5. Personal and professional characteristics of potential participants influence their content and format preferences for non-degree continuing nursing education. For example, respondents' age accounted for 42 of a potential 64 statistically significant differences in preference for content area and for 14 of a potential 47 statistically significant differences in format preferences.

6. Preferences for scheduling non-degree continuing nursing education parallel the months during which Alberta's post-secondary educational institutions offer courses; that is, fall and winter scheduling is preferred over spring and summer.

7. Limited interest exists in non-traditional scheduling, e.g., weekend, late afternoon, late evening, and in non-traditional format, e.g., one-way TV programs and interactive TV programs, for non-degree continuing nursing education.

8. A minimum of 2 months' advance notice and 6 weeks' specific programming notice is desirable for advertising non-degree continuing nursing education.

### Implications

The findings of this study have implications for providers of non-degree continuing nursing education in Alberta, for employers of registered nurses and for further research.

#### *Implications for providers*

Sufficient interest in all 64 provided content areas for non-degree continuing nursing education was exhibited by respondents to warrant attention by providers. It was clear that even for topics in which the least interest was expressed there were certain categories of respondents who would participate. Providers need to identify clearly the categories of Alberta registered nurses for whom they program and should offer content preferred by those categories of nurses. Statements of program mission and philosophy will guide providers in identifying their clientele. Findings of this study related to differences in content preferences for non-degree continuing nursing education, among Alberta registered nurses, categorized by selected personal and professional characteristics, will assist providers in selecting program content relevant to their clientele's expressed needs.

Providers should pay particular attention to their clientele's employment setting when selecting content, and to the population of their clientele's employment locale when selecting delivery format. These characteristics most affected the respondents' expressed preferences for content and format of non-degree continuing nursing education offerings.

The findings indicated that the respondents were most interested in non-degree continuing nursing education content related to the clinical aspects of the nurse's role. Providers should plan and deliver programs focusing on the clinical practice of nursing and should increase the accessibility of these programs to all areas of the province of Alberta.

Additionally, a broad range of clinically oriented non-degree continuing nursing education should be offered, since respondents expressed interest in content related to almost all aspects of clinical nursing. Providers should consider prioritizing clinically oriented offerings to focus initially on content in which respondents indicated definite participation.

Content related to the professional, managerial, and teaching aspects of the nurse's role should also be addressed by providers of non-degree continuing nursing education. Priority should be given initially by providers to programing focusing on topics in which the most respondents would definitely participate.

In relation to the statistically significant differences which were revealed in preferences for the 64 content areas, nurses employed in small (1-100 bed) hospitals, rural areas, and the more rural A.A.R.N. districts expressed greater interest in a broader range of topics than respondents in larger hospitals and urban areas. Lack of accessibility to continuing nursing education, including in-service programing, could be reflected in this finding. If this is the case, providers could focus their efforts in two areas. There could be an increase in the provision of programs related to the respondents' expressed needs, using a variety of delivery formats, and a focus on preparing nurses in small hospitals and rural areas to plan and deliver their own programs.

Based upon study respondents' expressed preference for one- and two-day workshop methods of delivery, providers of non-degree continuing nursing education would do well continue using the format. Additionally, the workshop format could be employed throughout the province and with all categories of registered nurses.

Study respondents may have been especially familiar with workshop format delivery of non-degree continuing nursing education and may also have perceived it as readily accessible, since two-thirds of the respondents resided in Calgary and Edmonton where the majority of workshops are held. Therefore, providers should not ignore other continuing nursing education delivery formats.

Three-day workshops and TV programing are delivery methods that providers should employ with care. Older and rural respondents expressed greater interest in both one-way and interactive TV programing than did younger and urban study respondents. Providers with adequate technical and financial resources may wish to attempt some non-degree continuing nursing education programing, particularly for nurses in rural areas, using these delivery methods.

To encourage participation in non-degree continuing nursing education, providers should schedule programs from Monday to Friday, 0830 hours to 1600 hours, for two-hour sessions from 1900 to 2100 hours, and for two-hour sessions lasting 1 to 6 weeks. Programs may be scheduled every month of the year except July and August.

To facilitate participation in non-degree continuing nursing education, providers should advertise programs a minimum of 2 months in advance and provide up to 6 weeks' notice of specific program details.

### *Implications for employers*

The 54% response rate to the study, the respondents' expressed interest in all content areas, and the large number of suggested topics offered by respondents were taken as indicative of the respondents' interest in non-degree continuing nursing education. Employers could encourage participation in continuing nursing education as a work incentive.

The finding that indicated that the respondents would be most likely to participate in non-degree continuing nursing education which focused on clinical topics has two major implications for employers related to cooperation with providers.

Employers could strengthen their cooperative efforts with post-secondary educational providers by examining the respondents' preferred content areas in light of the needs of their agencies for in-service education. Where the needs of the agency fit with the respondents' expressed needs, employers could support programs developed by post-secondary educational providers by encouraging their nurses to participate, rather than developing content through their own in-service programs. Additionally, the cost-effectiveness of these approaches could be examined and compared.

Cooperative efforts between the providers and employers in nursing practice settings could be strengthened in relation to developing clinical programs for non-degree continuing nursing education. The efforts could relate specifically to the sharing of clinical nursing expertise from practice settings with expertise in the development of teaching and learning strategies and program planning and delivery available in the major educational institutions which provide non-degree continuing nursing education.

Since nature of respondents' employment had considerable impact on content preferences, employers could reasonably expect participation of employees in non-degree continuing nursing education programing that related to the employees' area of expertise. For example, hospital-employed respondents tended to prefer content related to nursing care of ill individuals, while respondents employed in public health agencies preferred content focusing on nursing assessment skills, particularly as these related to families. Employers could attend to the differences in content preferences expressed by part-time and full-time employed nurses for non-degree continuing nursing education programing.

Overall preference for workshop activity and two-hour sessions from 1900-2100 hours have implications for work scheduling for employers who wish to encourage participation in non-degree conti-



ning nursing education. Within the constraints of collective agreements and delivering patient care, employers could allow for time-off for their nurse employees to participate.

### *Implications for research*

Although this study has provided useful information concerning the need for non-degree continuing nursing education, further research would expand the existing data base.

1. Using their statements of mission and philosophy, providers of non-degree continuing nursing education may wish to focus on determining specific format and content preferences for non-degree continuing nursing education of discrete groups of their nurse-clientele, e.g., nurse educators, nurse administrators.

2. Further exploration and investigation to identify specific facilitators and barriers to participation by Alberta's registered nurses in non-degree continuing nursing education could be undertaken.

## REFERENCES

- Advisory Committee of the Continuing Nursing Education Program of the University of Alberta. (Continuing education for Alberta nurses). Unpublished raw data, 1971.
- Andrews, H. *Educational needs of registered nurses: A report commissioned by the Alberta Association of Registered Nurses*. Edmonton, Alberta: Alberta Association of Registered Nurses, 1978.

## NOTE

A complete survey report is available to readers, at cost, from the authors.

## RÉSUMÉ

### **Formation infirmière continue ne menant pas à un grade: besoins des infirmières de l'Alberta**

Un questionnaire de sondage visant à élargir la base de données disponibles pour la planification de la formation continue libre en sciences infirmières en Alberta est décrit. Un échantillon randomisé de 10% de toutes les infirmières exerçant leur profession en Alberta, réparti proportionnellement (district A.A.R.N.) et stratifié selon le milieu d'emploi, a été utilisé. Le taux de réponse a été de 54%.

Le questionnaire a servi à expliquer les données sur les caractéristiques professionnelles personnelles des répondantes ainsi que leurs préférences quant au contenu et au type de formation continue libre en sciences infirmières. Les caractéristiques des répondantes et leurs préférences quant au contenu et au type de cours ont été résumées en fonction de la fréquence des choix. Pour déterminer l'existence de différences significatives sur le plan statistique quant au contenu et au type de cours chez les répondantes classées par caractéristiques professionnelles spécifiques, on a utilisé l'analyse statistique au chi carré.

Le sondage a révélé un intérêt suffisant pour la formation continue libre en sciences infirmières pour justifier de lui apporter un appui suivi en Alberta. On a noté des différences significatives sur le plan statistique parmi les répondantes classées selon les caractéristiques professionnelles et personnelles quant aux préférences de contenu et de type de cours de formation continue libre en sciences infirmières. Les caractéristiques professionnelles et personnelles des répondantes ont eu davantage d'effets sur les préférences de contenu que sur les préférences de type de cours.

**The Transcultural Nursing Society** is sponsoring its Eleventh Annual Conference, "Transcultural Nursing: A Futuristic Field of Health Care," on Oct. 9-11, 1985 in San Diego, Calif., USA.

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Seattle, WA. 98195

**The Council on Nursing and Anthropology and  
the Transcultural Nursing Society**

A one-day conference "International Nursing: The Cross-Cultural Context" will take place on May 6, 1986 at the Convention Center, Edmonton, Alberta, CANADA. This conference precedes the Second International Nursing Research Conference. Abstracts of one page or less should be received by February 1, 1986.

Send abstracts to: Dr. Janice Morse  
Faculty of Nursing  
Clinical Sciences Building  
University of Alberta  
Edmonton, Alberta  
Canada T6G 2G3

**WORLD CONFERENCE**

**The Association of Operating Room Nurses, Inc. (AORN)** will be sponsoring The World Conference of Operating Room Nurses — IV, September 16-20, 1985, at the Hague in the Netherlands Congress Center.

**CONTACT:** Sylvia Rottman  
Director, Meeting Services Department  
Theme: "Competent to Care — The World Over".

## 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*, École 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 œuvres 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

À 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.