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ERRATUM:

Volume 17, Number 4 was the final issue of 1985, and not 1986 as was printed on the cover. The cumulative index, therefore, should appear in the Table of Contents as being for Volume 17, 1985; it appears correctly on page 81.

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EDITORIAL

The responses to the last two editorials have been promising. New subscriptions to the journal have been received, as have gift subscriptions and several letters of support. Canadian nurse scholars seem to be ready to launch a united front and to defend their rights to a scholarly journal. Furthermore, many suggestions and recommendations have been made. Several people believe that the journal should be published under the auspices of the Canadian Association of University Schools of Nursing and many more suggest changing the name of the journal. The most common proposed name is "The Canadian Journal of Nursing Research / Recherche canadienne en nursing".

The Editorial Board is not against a change in the title of the journal. In fact, it would probably increase our numbers of submitted manuscripts and subscribers, as well as increase our ability to compete successfully for funding. This past year we submitted a grant proposal to a national funding agency and have just heard that our proposal was rejected. However, unlike past rejections, this one was much more optimistic and made two specific suggestions that would increase the likelihood of future funding. The first recommendation was for a more rigorous review process. This is already in progress; a larger review board has been appointed, and revised review procedures will be in place within the next six to eight weeks. The second recommendation was to publish more research manuscripts from expert scholars in the field. We recognize that the choice of a journal for submission of research reports is based on many variables. However, we are now making a plea to all Canadian, and some American, expert researchers to submit at least one research report to the journal during the next eight months. There is no question that we need a top quality nursing research journal. The challenge is to pool our resources to make it successful.

We wish to take this opportunity to thank the current reviewers for their time, energy, and constantly careful work over the past several years. Their contribution to the development of this journal has been considerable. We also wish to welcome new reviewers, as we move into an even more demanding period for excellence in scholarly work. The review board has grown immensely, and this is because there are many more qualified scholars in nursing and the range of nursing research has expanded. Reviewers now represent expertise in a wide variety of research areas. The Editorial Board looks forward to a continuing collaborative relationship with the reviewers.

If you have any further recommendations, please forward them to us. We would be happy to publish letters to the editor. We also wish to thank subscribers for their support as we go through this period of change.

Mary Ellen Jeans

ÉDITORIAL

Les réactions qu'ont suscitées les deux derniers éditoriaux sont prometteuses. Elles ont donné lieu à de nouveaux abonnements, à des abonnements cadeaux ainsi qu'à plusieurs lettres d'appui. Les spécialistes canadiens en sciences infirmières semblent prêts à faire front commun pour défendre leurs droits à une revue savante. Par ailleurs, de nombreuses suggestions et recommandations ont été formulées. Plusieurs personnes sont d'avis que la revue devrait être publiée sous les auspices de l'Association canadienne des écoles universitaires de nursing et plus nombreuses encore sont cell2s qui proposent de changer le nom de la revue. Le nom proposé le plus souvent est le suivant: "The Canadian Journal of Nursing Research / Recherche canadienne en nursing".

Le comité de rédaction ne s'oppose pas d'office au changement de nom de la revue. De fait, cette démarche nous permettrait tout probablement d'accroître le nombre des manuscrits qui nous sont soumis et le nombre des abonnés tout en favorisant nos demandes d'aide financière. Au cours de la dernière année, nous avons présenté une demande de subvention à un organisme de financement national et nous venons d'apprendre que cette demande a été rejetée. Toutefois, contrairement aux refus antérieurs, les commentaires qui accompagnaient le rejet de notre candidature étaient beaucoup plus optimistes et comportaient deux suggestions précises nous permettant d'accroître nos chances ultérieures d'aide financière. La première recommandation soulignait la nécessité de faire appel à une démarche de sélection plus rigoureuse. Nous avons déjà donné suite à cette recommandation en augmentant le nombre des membres du comité de lecture; la nouvelle démarche de sélection sera mise en place au cours des six à huit prochaines semaines. En second lieu, on nous a recommandé de publier davantage de manuscrits de recherche rédigés par des spécialistes du domaine. Nous reconnaissons que les auteurs soumettent leurs travaux à des revues en se fondant sur de nombreuses variables. Toutefois, nous lançons un appel à tous les chercheurs éminents, canadiens ou américains, pour qu'ils nous soumettent au moins un travail de recherche au cours des huit prochains mois. Il ne fait pas de doute que nous ayons besoin d'une revue de qualité pour faire état de la recherche en nursing. Pour réussir, nous devrons relever le défi et réunir toutes nos ressources.

Nous tenons à remercier nos lectrices sortantes du temps et de l'énergie qu'elles ont consacrés à accomplir un travail soigné et vigilant tout au long des dernières années. Leur contribution au développement de notre revue a été considérable. Nous désirons également souhaiter la bienvenue aux nouvelles lectrices qui abordent avec nous une période encore plus exigeante sur le plan des travaux de recherche. Le comité de lecture s'est grandement développé; en effet il y a un nombre beaucoup plus important de spécialistes qualifiés en sciences infirmières et la gamme des

travaux de recherche est beaucoup plus étendue. Notre équipe regroupe des lectrices spécialisées dans une grande variété de domaines de recherche. Le comité de rédaction se réjouit de poursuivre sa collaboration avec elles.

Si vous avez d'autres recommandations à formuler, veuillez nous les adresser. Nous nous ferons un plaisir de publier les lettres à la rédaction. Nous tenons également à remercier nos abonnés de leur appui tout au long de cette période de changements.

Mary Ellen Jeans

What's in a Name?

So Nursing Papers you don't like
It's unscholarly and plain
The editorial board has met
To devise a better name

You don't want something common
Nor popular and mundane
But tenure is important
So we'd better play this game

If you want to be promoted
And full professor cherish
Then our Canadian research journal
Is best called Pen or Perish

Mary Ellen Jeans

Inspired by Jannetta MacPhail

VIDEO - A TEACHING STRATEGY FOR LEARNING GROUP PROCESS

Beverly Anderson . Nina Hrycak

Group theory and practice are now an integral part of both diploma and university undergraduate programs (Anderson, Etzel, Kjervik & MacCarthy, 1977; Turner, 1976). As well, they are being instituted in graduate nursing programs (Hannon, 1980). Practice sessions with peers interacting in a group provide a safe environment of experiential learning for students. Feedback generally comes from the personal reactions of other students following group work, as well as from faculty observations on the group process. In addition, videotaping provides immediate feedback for evaluating the group process (Valentine & Saito, 1980).

The use of audio visual equipment in schools of nursing is steadily increasing. Yet, there is little definitive research in nursing to investigate whether or not this technology is at all effective. Townsend (1979) states that, "The use of A.V. media in nursing is marred by misconception about the nature of the medium and its place in the learning process. There is a lot more to using electronic aids than simply switching them on.... Present day usage seems to be in spite rather than because of published evidence, which in any case only seems able to provide the broadest of generalizations" (p.185, 186).

Literature Review

The nursing literature, which, for the most part, is unsubstantiated by research, indicates that videotaping generates increased student satisfaction with regard to learning communication skills. It also provides an opportunity for students to view the effects of their individual behaviours on others, as well as the impact of the group on the individual. Videotapes provide students with the opportunity to review and re-evaluate their progress in communication skills by referring to previous recordings (Christian & Schoonover Smith, 1981; Valentine & Saito, 1980; White & Chavigny, 1975).

In other disciplines, such as education, videotaping has been used to improve teacher-student effectiveness (Yanoff, Allender, & Manuel, 1978), and to promote accountability of teachers for student learning (Ehrgood, 1979). A summary of observations from research in counsellor education indicates that videotape feedback

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is a powerful mechanism for gaining objective self-awareness and for changing self-perceptions in a group setting (Kritzer, 1974; Marks, Montgomery & Davis, 1975; Walz & Johnston, 1963; & Yenawine & Arbuckle, 1971). Conversely, too much focused attention on "self" inhibits task performance (Paulus, Annis & Risner, 1978). Some authors in the counsellor education field found that the self-awareness elicited by videotape recordings produces an element of confrontation that can not be denied (Frankel, 1971; Robinson, 1970).

Some of the psychiatric literature focuses on self-image experiences of psychiatric hospitalized patients. As a result of repeated videotaped self-observations these patients experienced a decrease in negative feelings and became more self-accepting (Paredes, Gottheil, Tausig, Cornelison, 1969). In a study by Marvit, Lind, and McLaughlin (1974), the effects of videotaping within delinquent adolescent groups were analyzed. The results showed that individuals in the groups that were videotaped exhibited an increase in reality-based "self/other" concept, and developed a more reflective attitude. According to the authors, the "videotape experience made the subjects see themselves as others saw them, and the self-confident facade that delinquents wear seems to have fallen away as a confrontation with the reality of themselves and their behavior took place" (p.998).

In another study undergraduate university students participated in a group simulation activity (Allender, 1981). The students were requested to fill out a "self-Perception Questionnaire" in order to compare groups that were and were not videotaped. Results corroborated the Marvit et al. (1974) study in that videotape feedback was influential in increasing self-awareness among individuals in groups.

Conceptual Framework

Wicklund and Duvall's (1971) theory of objective self-awareness has been used to explain the impact of tape recordings, mirror images, and television cameras on self-image. Wicklund (and Duvall) (1979) contend that a person alters his self-image in direct response to incoming information that is relevant to the self. Not only pictures of oneself can create self-focused attention, but awareness of the attention of others can create an impetus for self-observation (p. 465-466). Wicklund (1979) goes on to say that once attention comes to bear on a salient dimension of self, self-evaluation takes place. The self-aware individual is likely to recognize personal short-comings, however, recognition of success factors may increase with this awareness.

Purpose of the project

The purpose of this project was to determine the effect of video playback on post R.N. baccalaureate students' perceptions of their individual and group roles within the group setting.

The following questions were established for the purposes of this study:

1. Are there differences in students' perceptions of their individual and group roles before and after viewing themselves on video tape?
2. Do the students' descriptive self reports support their participations of the individual and group roles, within the group process?

Method

Sample

The study surveyed 119 students enrolled in an introductory nursing course. This represented 98% of the total post R.N. baccalaureate student body at the University of Calgary. The mean age of the subjects was 33 years; 58% were married and the remaining 42% were single. Seventy percent of the students had graduated from a hospital training program and 30% had graduated from a college based nursing program.

Data collection was completed by the co-investigators over a two-year period at the Faculty of Nursing, University of Calgary. A verbal explanation of the research project and consent forms were given to the students by the investigators. Students were given the opportunity to withdraw from the study at any time, without prejudice. The data collection covered four separate terms: Winter, 1983, with 22 students; Fall, 1983, with 24 students; Winter, 1984, with 26 students; and Fall, 1984, with 50 students.

Procedure

In an introductory nursing course, the students received in-class instruction on group process; then, in a laboratory setting a group of four to seven was given a problem to solve. Random seating arrangement in the large classroom dictated selection to the small groups. The majority of the subjects did not know one another because this was their first nursing course.

The two basic objectives of a group are goal achievement and group maintenance. The **group building** or "**maintenance**" roles are:

1. Encouraging, being friendly, responsive to others, praising others and their ideas.
2. Meditating, harmonizing, conciliating differences in points of view, making compromises.
3. Gate keeping, trying to make it possible for another member to make a contribution.
4. Standard setting, expressing standards for the group regarding procedures, conduct, ethical values.
5. Following, going along with the group, serving as an audience during group discussion, a good listener.
6. Relieving tension, draining off negative feeling by joking or diverting attention to pleasant matters.

The group "**task**" roles are:

7. Initiating, suggesting new ideas to look at group problem or goal, proposing new activities.
8. Information seeking, asking for relevant facts or authoritative information.
9. Information giving, providing relevant facts and information.
10. Opinion giving, stating a pertinent belief or opinion about something the group is considering.
11. Clarifying, coordinating, trying to pull ideas and suggestions together.
12. Orienting, defining the progress of the discussion as related to group's goals.

The **self centered** roles (non-functional) are:

13. Blocking, interfering with the group process by citing irrelevant personal experience, tangential.
14. Aggression, criticizing or blaming others, showing hostility.
15. Seeking recognition, attempting to call attention to one's self by excessive talking, boasting, extreme ideas.
16. Special pleading, introducing or supporting ideas related to one's own pet concerns.
17. Withdrawing, acting indifferent or passive, resorting to excessive formality, doodling, whispering to others.
18. Dominating, trying to assert authority in manipulating the group or certain members by giving directions authoritatively, interrupting contributions of others.

Figure 1: Group functions

All students received the same initial instruction from trained facilitators. Each small group was provided with the same case study for the problem solving session. The instructions on the exercise stated that the subjects must come to a group consensus on the problem in the case study. The problem solving sessions, which was approximately thirty minutes in length, was videotaped.

Before the students saw the actual videotape of the group process they were asked to score their perceptions of their own individual and group role functions. They then viewed the entire videotape and were asked to re-score their functioning immediately, and to answer four open-ended questions about the group process. these questions focused on the following areas: individual satisfaction with the group experience; evaluation of the group process from individual and group perspectives; and ways in which students could apply the group experience to a work setting.

Instrument

The instrument utilized in this study addressed three major categories of role functions: maintenance (group building), task, and non-functional (self-centered) roles. These individual and group roles are based on Bales Interaction Process Analysis and Knowles' definition of group roles (Pardue, 1978). From the noted sources, Dr. Pardue developed a group analysis form and a Likert rating scale for scoring individual and group role functions. The rating scale measured the following categories: none of the time, some of the time, most of the time, and all of the time.

Face and content validity were established by Dr. Pardue. Reliability had not been previously established for this instrument. Consequently, the researchers tested reliability and a Cronbach's Alpha of .96 was established.

Data Analysis

The effects of videotape feedback on the students' perceptions of their individual and group roles were assessed by analysis of covariance for each dependent variable (maintenance, task, and non-functional roles). In order to partial out the effects of the variance "term" was identified as a factor and "group size" as the covariate. "Term" was identified as a factor because the students can enter the program either in the Fall or the Winter term.

The qualitative data was summarized and categorized by the co-investigators. From the analysis of the data, themes emerged to support the quantitative data.

0	1	2	3
None of the time	Some of the time	Most of the time	all of the time

Put your scores in the respective columns.

		X Score P	X Score G	X Sum P	X Sum G
Maintenance Roles					
1. Encouraging	0 1 2 3				
2. Mediating	0 1 2 3				
3. Gate Keeping	0 1 2 3				
4. Standard Setting	0 1 2 3				
5. Following	0 1 2 3				
6. Relieving Tension	0 1 2 3				

		Y Score P	Y Score G	Y Sum P	Y Sum G
Task Roles					
7. Initiating	0 1 2 3				
8. Information Seeking	0 1 2 3				
9. Information Giving	0 1 2 3				
10. Opinion Giving	0 1 2 3				
11. Clarifying, Coordinating	0 1 2 3				
12. Orienting	0 1 2 3				

		Z Score P	Z Score G	Z Sum P	Z Sum G
Non-functional Roles					
13. Blocking	0 1 2 3				
14. Aggression	0 1 2 3				
15. Seeking Recognition	0 1 2 3				
16. Special Pleading	0 1 2 3				
17. Withdrawing	0 1 2 3				
18. Dominating	0 1 2 3				

P - Personal
G - Group

Figure 2: Group progress instrument

Results

Maintenance roles

Hypothesis 1: There will be no significant difference in the students' perceptions of their personal maintenance roles before and after viewing themselves on video.

There was no statistical significance noted for the video influence or the interactive effect in the students' perceptions of their personal maintenance roles before and after viewing themselves on video. However, a significant effect was noted for "term" and "group size" (see Table 1). Upon examination of the adjusted means, the Fall 1983 scores were significantly higher than the Fall 1984 scores despite the effects of the covariate being removed (see Table 2). A Scheffé test demonstrated existing differences between Fall 1983 and Fall 1984 term scores.

Hypothesis 2: There will be no significant difference in the students' perceptions of their group maintenance roles before and after viewing themselves on video.

There was no statistical significance noted for the video influence or the interactive effect in the students' perceptions of their maintenance group roles before and after viewing themselves on video. However, a significant effect was noted for "term" and "group size" (see Table 1).

Task roles

Hypothesis 3: There will be no significant difference in the students' perceptions of their personal task roles before and after viewing themselves on video.

There was no statistical difference noted in the students' perceptions of their personal task roles before and after viewing themselves on video. In addition, there was no statistical difference noted for "term" or "group size" (see Table 3).

Hypothesis 4: There will be no significant difference in the students' perceptions of their task group roles before and after viewing themselves on video.

Statistical significance was noted in the students' perceptions of their task group roles before and after viewing themselves on video. A significant effect was also present for group size. However, no significance was noted for "term" or interaction of "term" and video condition (see Table 3).

Table 1

The Effects of Term, Group Size, and video Influence on Personal and Group Maintenance Scores

	Ancova (Personal) N=119		Ancova (Group) N=119	
Source	F	P	F	P
Term (Independent Variable)	3.72	.0135*	6.06	.0007**
Group Size (Covariate)	4.44	.0374*	12.50	.0006**
Video Condition (Pre-post Video: Independent Variable)	0.42	.5178	0.35	.5534
Term X video Influence (Interaction)	1.41	.2447	2.30	.0805

*p < .05
**p < .01

Table 2

Adjusted Cell Means for Personal Maintenance Scores

Maintenance	Winter '83	Fall '83	Winter '84	Fall '84
Pre Video Personal Scores	8.11512	8.52632	7.77662	6.88769
Post Video Personal Scores	7.54369	8.92632	7.21662	6.87519

Table 3

The Effects of Term, Group Size, and Video Influence on Personal and Group Task Scores

	Ancova (Personal) N=119		Ancova (Group) N=119	
Source	F	P	F	P
Term (Independent Variable)	1.81	.1499	0.93	.4304
Group Size (Covariate)	2.18	.1422	4.33	.0396*
Video Condition (Pre-post Video: Independent Variable)	0.01	.9116	4.42	.0376*
Term X Video Condition (Interaction)	1.25	.2950	0.87	.4613

* $p < .05$
** $p < .01$

Table 4

Table of Interaction Effect for Non-functional Self Scores

Non-functional Scores N=119 Self

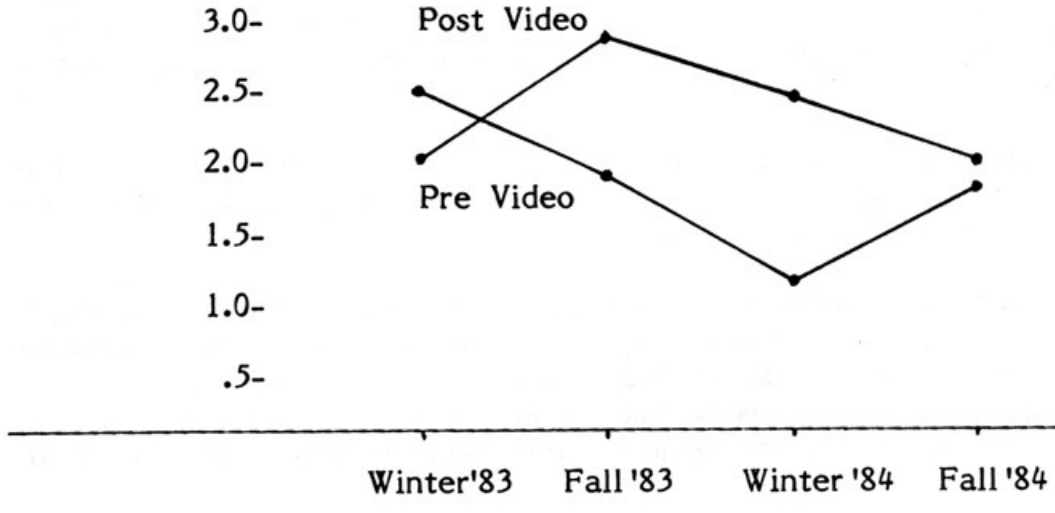

Table 5

The Effects of Term, Group Size and Video Condition on Non-functional Personal and Group Scores

	Ancova (Personal) N=119		Ancova (Group) N=119	
Source	F	P	F	P
Term (Independent Variable	0.52	.6698	1.05	.3728
Group Size (Covariate)	0.80	.3717	11.36	.0010**
Video Condition (Pre-psot Video: Independent Variable)	6.91	.0097**	28.96	.0000**
Term X Video Condition (Interaction)	5.47	.0015**	0.31	.8149

* $p < .05$
** $p < .01$

Non-functional roles

Hypothesis 5: There will be no significant difference in the students' perceptions of their personal non-functional roles before and after viewing themselves on video.

Statistical significance was noted in the students' perceptions of their personal non-functional roles before and after viewing themselves on video. An interactive effect was also present (see Table 4). However, there were no significant effects as a result of term or group size (see Table 5).

Hypothesis 6: There will be no significant difference in the students' perceptions of their group non-functional roles before and after viewing themselves on video.

Statistical significance was noted in the students' perceptions of their group non-functional roles before and after viewing themselves on video. A significant effect was also present for group size. There was no significance revealed as a result of the term or the interaction of term and video influence (see Table 5).

Limitations of the study

1. Findings from this study have limited generalizability.
2. Small laboratory groups were selected on the basis of seating arrangement in the large classroom.
3. Students enrolled in the program could potentially discuss the group experience with each other and with future candidates to the nursing program. The authors believe that this is not a major limitation because each group's interaction is a unique experience to that group.

Discussion

In this sample of subjects the evidence indicated that the students did not change their perceptions of personal and group maintenance roles. Their evaluation indicated that they were satisfied with their individual and group maintenance performance. The students' descriptive reports corroborate the statistical findings with regard to the group building or maintenance roles. A positive affect tone pervaded their general comments. Some of these comments were as follows: "The feeling in the group was good, it was fun, informative, and interesting." "Enjoyable experience in interacting with new people; goal was interesting and fun, non-threatening group experience." "Everyone participated and able to work together without hostility."

The students' perceptions of their personal task roles did not change after the video experience. However, significant differences were evident in the students' perceptions of their group task roles. Diberardinis (1978) indicates that students, when confronted with objective feedback on their performance in task groups, directed their shortcomings to the group rather than towards their individual performance.

In the students' self-descriptive reports on what could have been done differently in the group, the general theme was the following: "Being more organized; for example, provide more structure and prioritize goals." In addition, students felt that there should be more initiation and clarification of task functions within the group. Another salient theme related to opinion giving. On the one hand, students desired more differences of opinion to create interest within the group; other students felt that there should be less opinion giving, to allow quieter members to participate in the group process.

Significant differences existed in the students' perceptions of their personal and group non-functional roles. Video playback offers an accurate and confrontive picture of behaviour. Many authors suggest that persons can not deny the undesirable behavours that are evident from viewing the videotape (Hardin, Stratton, Benton, 1983; Marks et. al., 1975; Frankel, 1971; Robinson, 1970).

In this particular study, students were made aware of their non-functional personal and group behaviours after viewing themselsves on video. Their self-evaluations reflect an objective report. The overriding themes on the non-functional area were identified as follows: interrupting one another, dominating others, joking around, and withdrawing. This is further substantiated by their specific comments of their non-functional behaviours: "I don't feel comfortable in a group, and tend to withdraw somewhat. Then I somehow draw attention to myself with humour. I would like to see myself change this somehow -- it doesn't quite fit." "Give more understanding to other people's ideas, seeing that their ideas are important to them, rather than feeling defensive about my own ideas and thinking it important that they be accepted." "We should listen to each other -- let people finish what they are saying before someone else begins." "Less laughing and joking (i.e. feel more secure within the group). Be able to discuss the issue a little more seriously."

In summary, the findings in the study give credence to Wicklund and Duvall's (1971) theory of objective self awareness. Videotape feedback offered a mechanism to promote self-awareness and concomitantly, self-evaluation took place. The students in this study were able to find shortcomings with their behaviour as well as strengths in their group functioning. In addition, the videotape feedback may have increased the quality of the educational program, given that the same information on group process was provided to all students prior to the video situation.

Group size is another important variable to consider when studying groups. In our research study, because the students were divided into groups of four to seven, group size was considered a covariate. Significant differences were noted in the maintenance (personal and group), task (group), and non-functional (group) scores. Bormann and Bormann (1980) suggest that five is an ideal number for small groups. the reasons offered are that all members can participate equally, and, because five is an odd number, deadlocks can be circumvented.

Significant differences as a result of the term factor (Winter, 1983; Fall, 1983; Winter, 1984; and Fall, 1984) were identified in the area of maintenance (personal and group) scores. There is no definitive explanation for these findings in the literature. Differences may occur because approximately twenty-five post R.N. baccalaureate students entered into the program in Winter, 1983, Fall, 1983, and Winter, 1984. The enrollment doubled to fifty students in the Fall, 1984 session possibly changing the character composition of the student body.

Conclusions

Group process theory and experiential learning is a crucial component of nursing curricula. Nursing students in a university setting have frequent opportunities to utilize group process skills in seminar, group assignments, lecture discussion groups, etc. In addition, these group process skills can be transferred to the clinical setting and applied to professional team work.

Videotape feedback is a useful mechanism for increasing students' self-awareness and self-evaluative skills. Not only were students able to evaluate their positive behaviours, but they were able to assess accurately their negative roles within the group process as well. Only if students have insight into their behaviour can they be committed to behavioural change. As one student so aptly put it: "...I am more aware of certain roles and functions of group members and how an effective group functions. ...I can work on changing the behaviours that are ineffective and learning the behaviours that are more effective."

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RÉSUMÉ

Le magnétoscope - stratégie pédagogique pour la démarche d'apprentissage de groupe

Une étude a été réalisée à l'Université de Calgary au cours de séances pratiques d'acquisition d'aptitudes à la communication de groupe auprès de 119 étudiants infirmiers de niveau post-baccalauréat. L'étude avait pour objectif de déterminer l'effet de la présentation des enregistrements magnétoscopiques sur les perceptions qu'ont les étudiants infirmiers de leur rôle et de ceux du groupe lors d'activités de groupe. On s'est servi de l'échelle d'évaluation de Likert avant et après les enregistrements afin de déterminer les rôles de soutien, les rôles de tâche ainsi que les rôles non fonctionnels au cours d'une séance de résolution de problèmes. On a en outre demandé aux étudiants de répondre à quatre questions non dirigées concernant la démarche de groupe, ce après visionnement de l'enregistrement magnétoscopique.

Une analyse de covariance a fait apparaître des différences significatives au niveau des rôles non fonctionnels pour les résultats individuels et les résultats de groupe de même que pour les rôles de tâche pour le groupe avant et après l'enregistrement magnétoscopique. Les données qualitatives corroborent les résultats statistiques.

LEARNING GROUP PROCESS SKILLS

Darle Forrest

A response to "Video: A teaching strategy for learning group process," by Beverly Anderson and Nina Hrycak

The authors of the article, **Video: A teaching strategy for learning group process,** are to be congratulated for their interest in teaching group process content, and for their willingness to experiment with a teaching strategy that incorporates videotape feedback. Too often practice in the theory and skills of group process is given minimal attention in both undergraduate and graduate nursing curricula. Yet, as faculty we frequently claim that we prepare students to "function collaboratively with colleagues" and to "engage in mutual problem solving with patients and families." Such learning outcomes require teaching strategies that deal with the content of group process in ways that help students transfer the theory and skills to the realm of professional nursing practice. The use of video, as the authors point out, and as I have discovered myself, provides students with means for the assessment of both individual and group behaviour. Further, videotape feedback, considered objective feedback, can initiate the vital process of self-examination that is the forerunner to behaviour change.

Some comments and questions about the study relate to the method and conclusions reported by the authors. Considering method first, it is important, for the reader as well as for investigators interested in replicating the study, to know the extent and nature of the "in-class instruction on group process" (p.7). For example, did this consist of one session in which instructions for the project were delivered? Or, did the session or sessions involve instruction or practice, or both, in identifying the group functions outlined in Figure 1? The extent to which students understood the specific functions and were able to identify them accurately has direct bearing on the results.

Another question has to do with the decision to vary the size of the groups rather than to keep the critical variable of group size constant. The authors provide rationale supporting five as the ideal number for small group problem-solving. Yet, it is indicated that the groups varied in size from four to seven numbers. One suspects that factors affecting the decision to vary group size had to do with the enrollment each term and with the voluntary participation of students in the study. Given these factors, it becomes apparent that an opportunity was present for the separate analysis of "group" and "self" functions in relation to group size.

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In other words, the proposition that "five is an ideal number for small groups" could have become a working hypothesis, open to testing in this study. Research on the question of group size, in relation to effective problem solving, has significance for nursing educators who want to maximize the results that can occur from small group learning strategies.

One last comment pertaining to the method has to do with the collection of data from the four open-ended questions that students were given following the videotape viewing. It is assumed that the questions and responses were in written format. It would have been helpful had the authors indicated, perhaps in a figure presentation, just how these questions were posed and the format in which they were presented to the students. Again, such information is useful not only for a reader to determine the soundness of method, but it is also useful to other investigators who are interested in conducting similar research. Incorporating open-ended questions in the study was a prudent move. The qualitative data arising from this source could obviously extend the meaning of the findings and provide further validation of the quantitative results.

Turning to conclusions, the reporting of results is succinct and the discussion is relevant to the literature review. Reference to the findings from other studies, particularly those of DiBerardinis, offer the reader a broader perspective on the authors' conclusions. Quoted material from the responses to the open-ended questions presents an authentic picture of the experience from the students' point of view, and in turn offers corroboration for the statistical findings.

The open-ended question focuses on "ways students could apply the group experience to a work setting" (p.9). It is unfortunate that the themes arising from this question were not discussed as it is a key issue. Analysis of responses to the question may well have indicated the extent to which students were transferring and applying their classroom experience to the professional setting.

A final comment is a suggestion for consideration by feature researchers concerned with examining the teaching of group process content. The major purpose for teaching nursing students group process theory and skills is to improve their professional functioning with colleagues and with patients. It then becomes important to assess the means and the extent of students dissemination of knowledge and understanding. Should faculty fail in this analysis, group process content may very well be viewed by students as a "fun and games" event that has little to do with nursing. A key role for the nurse educator is to assist the student to translate and integrate the meaning of the group process experience, including videotape feedback, to nursing practice. For researchers, a key variable to examine is to what extent nursing students can meaningfully apply the group process experience to "real life" nursisng situations.

ÉVALUATION DE LA PERTINENCE DES OBJECTIFS DE PROGRAMME: UNE MÉTHODOLOGIE APPROPRIÉE

Mariette Blais . Marthe Lavergne

De plus en plus à la mode, "l'évaluation" se retrouve sur toutes les lèvres et est déjà bien présente dans la plupart des milieux. Les institutions de soins n'échappent pas à cette vague, ce qui reflète le souci des dirigeants et des intervenants d'offrir des services de qualité. Un examen de la méthodologie utilisée lors de l'évaluation de la pertinence des objectifs poursuivis par un programme de formation peut donc s'avérer très utile, cette méthodologie pouvant être adaptée par la suite à d'autres contextes.

Mis sur pied en 1972, le programme de Certificat en santé communautaire de l'École des sciences infirmières de l'Université Laval avait alors pour mandat de satisfaire aux besoins de perfectionnement des infirmier(e)s déjà engagé(e)s dans l'exercice de leur profession. Répondant aux attentes du milieu et à l'évolution de la société en général, ce programme s'est toutefois au cours des ans orienté peu à peu vers une formation en santé communautaire axée plus spécifiquement sur une approche collective des problèmes de santé.

Suite à une demande institutionnelle de réévaluation des orientations du Certificat, les responsables du programme décidaient à l'automne 1982 de réaliser une étude portant sur la pertinence des objectifs de formation poursuivis par le programme en regard de l'évolution des professions et des besoins de la société. Cette évaluation constituait un moyen de vérifier si le programme répondait toujours à des besoins et s'ajoutait aux données déjà fournies tant par l'analyse des demandes d'admission que par les évaluations continues effectuées annuellement par le Comité de programme. Le but du présent article, tiré du **Rapport d'évaluation de la pertinence des objectifs de formation du programme de Certificat en santé communautaire** (Blais & Lavergne, 1983), n'est pas de mettre l'accent sur les résultats obtenus lors de cette étude, mais plutôt d'insister sur l'originalité de la démarche méthodologique.

Le Certificat

Le Certificat en santé communautaire vise à aider l'étudiant(e) à améliorer ses interventions en santé en utilisant une approche globale face aux individus et à la communauté. De façon plus

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spécifique, l'étudiant(e) est amené(e) à développer, à travers différentes connaissances reliées aux dimensions sociologiques et culturelles de la santé et de la maladie, des habiletés lui permettant entre autres de poser un diagnostic approprié sur les besoins de santé des individus et des groupes. Ces diverses acquisitions lui permettent par la suite de planifier des interventions en santé selon une démarche logique et cohérente et ce, dans une perspective de promotion de la santé et de prévention de la maladie. S'adressant à des adultes venus se perfectionner dans l'exercice de leur profession, le Certificat privilégie, par sa démarche pédagogique, le développement de leur autonomie et leur prise en charge personnelle. Afin de respecter les principes qui régissent l'éducation aux adultes, des méthodes andragogiques viennent donc favoriser la participation de l'étudiant(e) à sa formation.

Plus particulièrement, ce programme s'adresse à des adultes possédant un diplôme d'études collégiales ou l'équivalent et qui ont cumulé un minimum de deux années d'expérience professionnelle dans le domaine de la santé. Même s'il est composé en majorité d'infirmier(e)s, ce programme rejoint une clientèle multidisciplinaire. Ce faisant, l'Ecole des sciences infirmières a voulu rapprocher le Certificat de la réalité du domaine de la santé communautaire où prévaut de plus en plus le travail en équipe multidisciplinaire. Chaque intervenant(e) étant susceptible d'y côtoyer des professionnel(le)s d'autres disciplines, le certificat est ainsi devenu un lieu privilégié de rencontres, où tous peuvent partager leurs expériences et développer un terrain commun d'entente et de collaboration.

Le Certificat est offert selon les deux formules du temps complet et du temps partiel. Cette dernière mesure a attiré la faveur d'un grand nombre d'intervenant(e)s du domaine de la santé pour qui il peut être difficile de quitter le marché du travail durant toute une année académique.

Par ailleurs, même s'il constitue en soi un programme terminal, le Certificat offre également d'autres possibilités: d'une part, les crédits accumulés peuvent être comptabilisés à l'intérieur du Baccalauréat en sciences infirmières et, d'autre part, ce programme peut tenir lieu de mineure et conduire éventuellement à l'obtention d'un Baccalauréat général. Finalement, il importe d'ajouter qu'annuellement se tient un processus d'évaluation continue dont les résultats servent à guider les décisions du Comité de programme concernant les changements et les améliorations à apporter au Certificat.

Méthodologie

Tel qu'il est précisé précédemment, suite à une demande institutionnelle de réévaluation des orientations du Certificat, les responsables du programme ont décidé de procéder à l'étude de la pertinence des objectifs poursuivis par ce programme de

formation en regard de l'évolution des professions et des besoins de la société.

Suite à l'examen de différents modèles d'évaluation des objectifs d'un programme, le Comité a finalement opté pour un modèle centré sur l'analyse des besoins de formation, ces besoins étant nécessairement le point d'origine de la formulation des objectifs. Une des particularités du modèle retenu est de considérer le besoin de formation comme étant l'écart ou la distance qui existe entre une situation désirée et une situation actuelle (Lapointe, 1982a). Tel que précisé par Lapointe (1982b, p.5):

> Cette pratique (l'analyse des besoins) consiste en l'expression des finalités anticipées et désirées par les différents groupes engagés dans un système (situation désirée) et en leur comparaison avec les buts actuellement poursuivis (situation actuelle) pour ensuite distribuer, par ordre de priorité, les écarts (besoins) pouvant exister entre ces deux situations.

Dans la présente étude, la situation désirée a été identifiée comme étant l'importance que le Certificat **devrait accorder** à l'atteinte des objectifs de formation poursuivis alors que la situation actuelle a été définie comme étant l'importance que le programme leur **accorde** effectivement. Il s'agissait donc de déterminer l'écart ou la distance pouvant exister entre ces deux situations.

L'opérationnalisation de ce modèle d'analyse des besoins s'est faite à l'aide d'un instrument comportant une liste de 33 énoncés à laquelle quelques distracteurs avaient été insérés afin de vérifier l'attention des répondants. Chacun de ces énoncés était unidimensionnel et univoque tout en découlant directement des objectifs spécifiques poursuivis par le programme de formation. Ces objectifs provenaient du dossier présenté lors de l'élaboration du Certificat. Ils ont parfois été reformulés afin de les rendre plus concrets et aussi plus accessibles aux répondants tout en respectant leur sens originel. Des expressions telles "renseigner l'individu et le groupe sur les mesures à prendre pour conserver et améliorer la santé", "identifier les obstacles qui empêchent la réalisation de la tâche d'une équipe de travail" ou encore "expliquer les rapports qui existent entre la maladie, la population et l'environnement" sont quelques exemples d'énoncés sur lesquels les répondants devaient se prononcer.

De façon concrète et tel que présenté au tableau 1, les répondants devaient d'abord se prononcer sur l'importance que le Certificat devrait accorder à l'objectif de formation concerné (question A) et ensuite donner leur avis sur l'importance que le programme lui accorde effectivement (question B). L'information a été récoltée à l'aide d'une échelle d'appréciation à quatre positions, le répondant n'ayant qu'à encercler son choix de réponse. Enfin, l'instrument avait été pré-testé auprès de dix diplômé(e)s.

Tableau 1

Consignes accompagnant l'instrument de cueillette des données

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Question A:

Selon votre expérience et en vous rappelant que le Certificat en santé communautaire est un programme de premier cycle équivalant à une année d'études universitaires et qu'il s'adresse à des intervenant(e)s en santé qui désirent acquérir une formation complémentaire à leur formation de base, QUELLE IMPORTANCE LE PROGRAMME DU CERTIFICAT **DEVRAIT-IT ACCORDER** A CET OBJECTIF DE FORMATION? Vous ne répondez donc pas en fonctin de la santé communautaire en général, mais en vous référant à ces intervenant(e)s et à ce type de programme de formation.

Question B:

Selon votre expérience, QUELLE IMPORTANCE LE PROGRAMME DU CERTIFICAT **ACCORDE-T-IL** A CET OBJECTIF DE FORMATION?

Echelle d'appréciation:

Pas du tout d'importance	1
Peu d'importance	2
Assez d'importance	3
Beaucoup d'importance	4
Ne sais pas	x

Exemple:	QUESTION A	QUESTION B
	LE PROGRAMME DEVRAIT ACCORDER DE L'"IMPORTANCE	LE PROGRAMME ACCORDE DE L'IMPORTANCE
1. Expliquer les rapports que existent entre la maladie, la population et l'environnement.	1 (2) 3 4 __	1 2 3 (4) __

Dans cet exemple, un répondant qui a fait le Certificat en santé communautaire a encerclé 2 à la question A parce qu'il considère que le programme devrait accorder peu d'importance à cet objectif de formation. Pour la question B, il a encerclé 4 parce qu'il considère que le programme accorde beaucoup d'importance à cet objectif.

La population cible était composée de deux catégories de répondants. La première catégorie était formée de ceux et celles qui connaissaient le programme du certificat pour l'avoir vécu, c'est-à-dire tou(te)s les diplômé(e)s des années 1981, 1982, et 1983, soit une possibilité de 145 répondants. La deuxième catégorie regroupait les personnes qui, sans connaître le programme de Certificat, connaissaient par contre le champ d'intervention qu'est la santé communautaire. Ce groupe "d'experts" était composé en grand partie d'intervenant(e)s des D.S.C. et des C.L.S.C. exerçant des fonctions de gestion et/ou de planification, de professionnel(le)s du ministère de la Santé et des Services sociaux, de responsables de comités de formation dans des corporations professionnelles et, enfin, de professeurs de l'Ecole des sciences infirmières qui interviennent directement ou indirectement dans le programme. Dans la deuxième catégorie, on dénombrait 71 répondant(e)s. Il importe de préciser que dans l'instrument de cueillette des données, les diplômé(e)s ont reçu la consigne de donner leur avis sur les deux facettes des objectifs de formation, c'est-à-dire sur la situation désirée et sur la situation actuelle alors que les "experts" ont, pour leur part, reçu celle de fournir une opinion seulement sur la situation désirée.

La cueillette des données fut réalisée au cours du mois de juin 1983. Un envoi par la poste incluant un questionnaire et un enveloppe de retour pré-affranchie fut adressée à chacun des répondants. Après un délai de dix jours, un rappel téléphonique fut effectué auprès des gens qui n'avaient pas retourné leur questionnaire. Cette dernière démarche a permis d'obtenir une quarantaine de réponses supplémentaires. La collaboration des répondants fut jugée très satisfaisante compte tenu d'un taux de participation de 77,5 pour cent chez les experts (55 répondants) et de 75,2 pour cent chez les diplômé(e)s (109 répondants).

Les données recueillies ont, par la suite, fait l'objet d'une analyse descriptive cohérente avec la méthode retenue. A partir des résultats, la moyenne et l'écart-type (mesure de dispersion autour de la moyenne) ont été calculés pour chacun des 33 énoncés et ce, pour chacun des aspects de la situation (situation désirée et situation actuelle). Le calcul de la moyenne a été fait à partir de la valeur accordée à chacune des positions de l'échelle d'appréciation. Ainsi, la position "beaucoup d'importance" recevait la valeur 4, alors que la position "pas du tout d'importance" obtenait la valeur 1. Une autre mesure a également été calculée et c'est celle du coefficient de besoin. Ce coefficient a été calculé pour chaque énoncé et il correspond à l'écart qui existe entre la moyenne obtenue pour la situation désirée et la moyenne obtenue pour la situation actuelle. Il représente donc l'importance du besoin de formation non comblé et ce, pour chaque énoncé. Ainsi, à titre d'exemple, un énoncé ayant obtenu une moyenne de 3,66 pour la situation désirée et une moyenne de 2,88 pour la situation actuelle s'est vu attribuer un coefficient de besoin de 0,83. Dans ce cas précis, il s'agit de l'énoncé 12 qui apparaît à la figure 1. Il importe cependant de

mentionner que parmi toutes les mesures calculées, la moyenne a été de loin la plus utilisée.

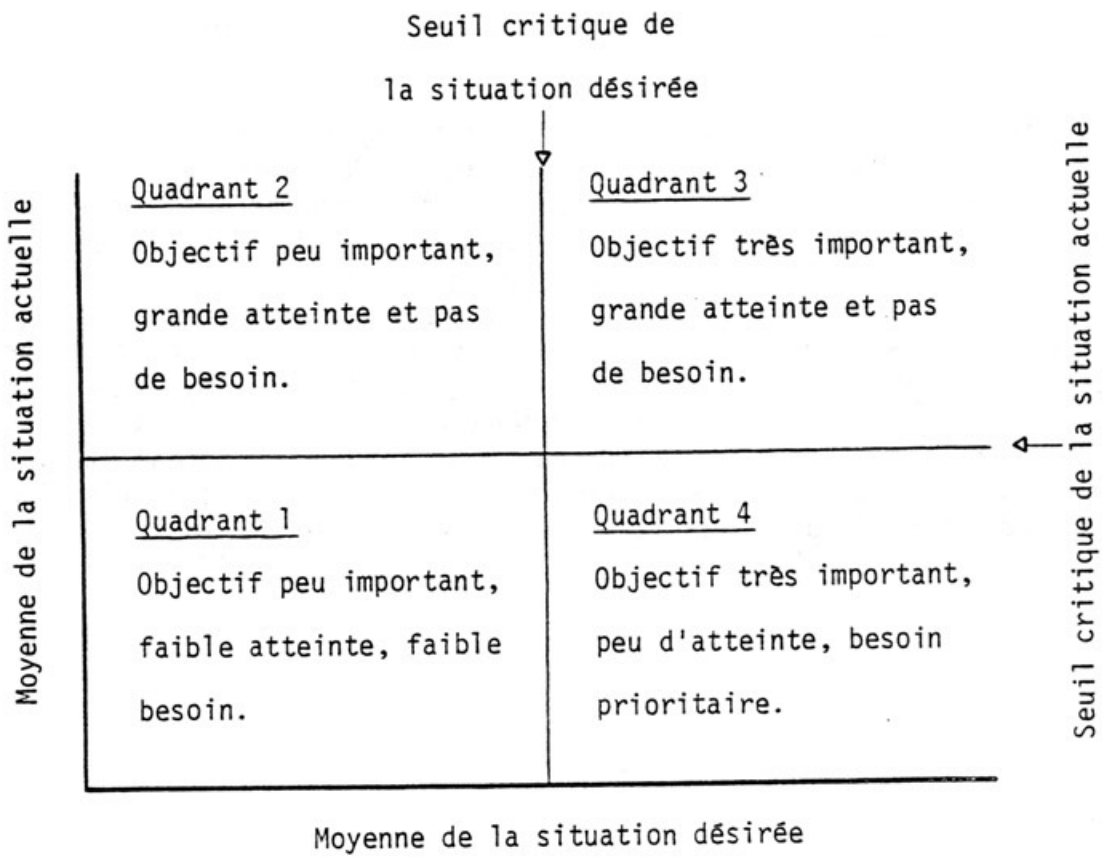
Ces différentes mesures ont été calculées pour l'ensemble des diplômé(e)s et également pour certains sous-groupes de cette catégorie de répondants. Ainsi, le sous-groupe de diplômé(e)s provenant des milieux de santé communautaire a fait l'objet d'une attention particulière. Il en est de même pour chaque sous-groupe de diplômé(e)s selon l'année de graduation.

Procédure de présentation des résulats

Les résultats des mesures descriptives ont conduit à la construction de différents tableaux. Cependant, c'est un procédé graphique particulier à l'analyse des besoins qui a été le plus utilisé pour mettre en relation la situation désirée et la situation actuelle; il s'agit de la technique des axes critiques (Witkin, 1975, p.141). Cette technique offre la possibilité de déterminer les différents niveaux d'atteinte des objectifs et permet d'établir un ordre de priorité entre les besoins de formation comme le montre le tableau 2.

Tableau 2

Axes critiques d'Hershkowitz



Selon cette technique, pour chaque énoncé, on place en abscisse la moyenne obtenue pour la situation désirée, et en ordonnée la moyenne obtenue pour la situation actuelle. Le point de rencontre des lignes élevées perpendiculairement à chaque axe détermine la position de chaque énoncé dans le système d'axes. La moyenne globale (moyenne des moyennes) de la situation désirée et celle de la situation actuelle sont utilisées comme seuils critiques et divisent l'ensemble des points obtenus en quatre quadrants spécifiques. Le tableau suivant décrit la contribution de chaque quadrant dans la détermination d'un ordre de priorité des besoins. Grâce à cette technique, il devient possible de départager les objectifs importants (pertinents) de ceux qui le sont moins. Un autre de ses avantages est de disposer les objectifs déjà réalisés dans la partie supérieure du système d'axes alors que dans la partie du bas, on retrouve les objectifs non atteints, c'est-à-dire les besoins de formation.

Afin de mieux saisir l'application de cette technique, la figure 1 présente les résultats obtenus lors de l'étude pour une des catégories de répondants, les diplômé(e)s, et rend compte de la relation qui existe entre la situation désirée et la situation actuelle selon leur point de vue. Cette figure montre d'abord que 21 des 33 objectifs poursuivis par le programme de formation sont jugés importants et donc pertinents. Ces objectifs sont concentrés dans les quadrants 3 et 4. Par ailleurs, la plupart des objectifs considérés peu importants se retrouvent dans le quadrant 1, qui est également celui des faibles besoins. Il s'agit des objectifs 5, 7, 8, 13, 15... Le programme semble donc se préoccuper peu de ces objectifs et, aux yeux des répondants, ils constituent également des objectifs négligeables.

Pour sa part, le quadrant 4 permet d'identifier les objectifs importants, mais qui de l'avis des répondants ne sont pas suffisamment atteints. On observe donc pour ces derniers un écart entre la situation désirée et la situation actuelle. En effet, les répondants émettent l'avis que le programme devrait accorder de l'importance à ces objectifs, mais que dans les faits, il ne leur en accorde pas suffisamment. Dans ce cas, il pourrait s'avérer opportun d'envisager le déplacement des ressources utilisées pour atteindre des objectifs peu importants (quadrant 2) vers des objectifs considérés importants, mais peu atteints (quadrant 4). On peut donc se rendre compte que cette procédure de catégorisation des résultats tend également à favoriser la prise de décision.

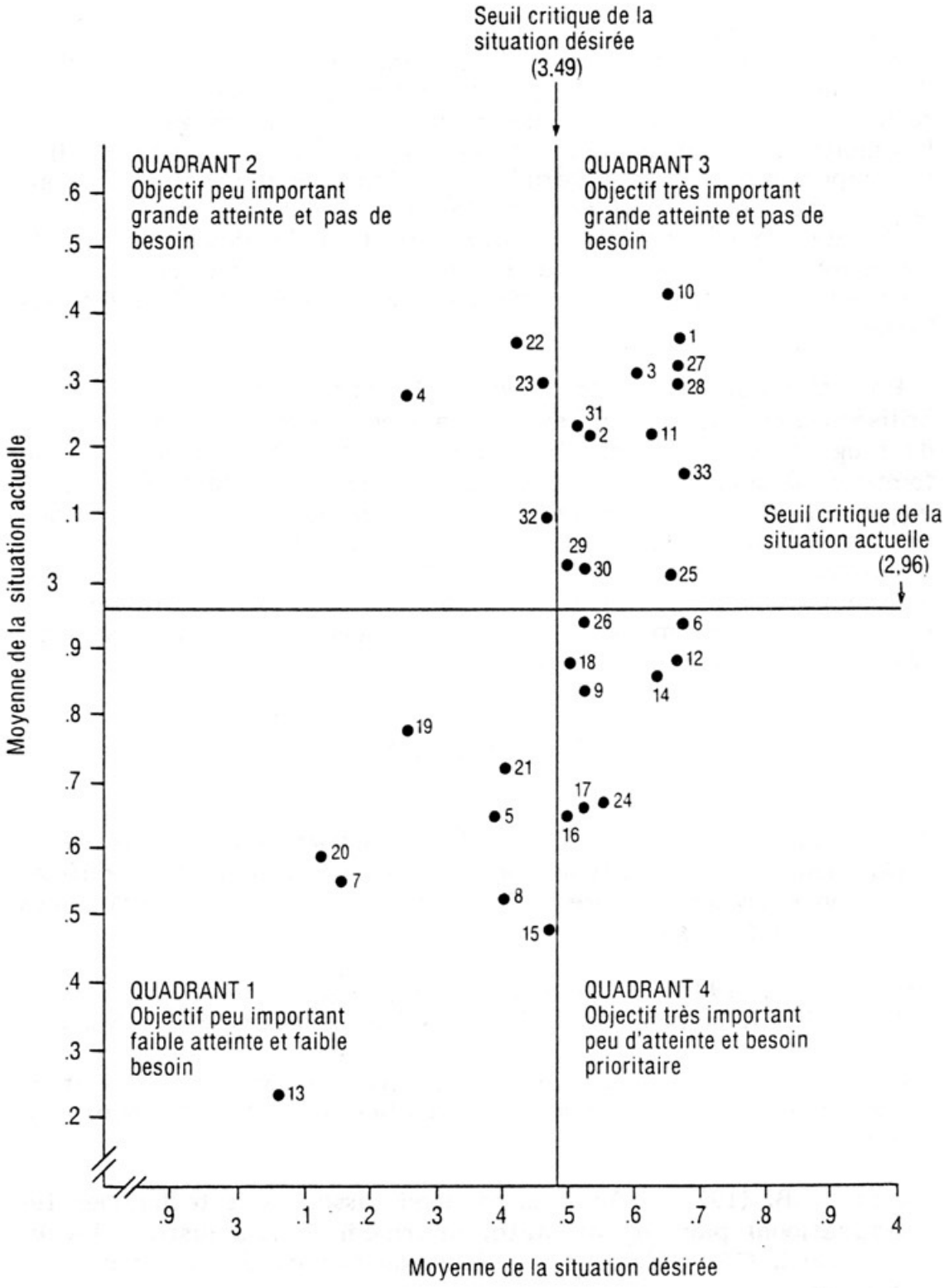


Figure 1

Axes critiques de la situation désirée et de la situation actuelle chez les diplômé(e)s.

Conclusion

En définitive, le taux de participation élevé, le comportement des répondants vis-à-vis les distracteurs, la faible dispersion dans les opinions émises ainsi que la cohérence observée dans les résultats ont constitué des indices qui apportent des garanties sur la validité de cette démarche d'évaluation. Toutefois, l'échantillon des répondants soumis à l'étude comportait certaines limites dont la principale concerne le fait que les "experts" choisis n'avaient pas à donner leur avis sur la situation actuelle des objectifs de formation. Au cours de l'analyse des résultats, il n'a donc pas été possible de confronter les opinions des diplômé(e)s à celles des "experts".

Par ailleurs, le modèle d'évaluation retenu et les procédures utilisées pour catégoriser les résultats ont permis aux responsables du programme de se prononcer sur la pertinence des objectifs de formation poursuivis. Cette démarche a permis de faire le partage entre les points forts et les points faibles du programme tels que perçus par les diplômé(e)s et, en ce sens, a facilité les décisions du Comité de programme. De cette expérience, il s'est dégagé que le Certificat en santé communautaire est dans l'ensemble en excellente santé, même si certains besoins de formation se sont révélés partiellement comblés.

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ABSTRACT

Goal relevance assessment: An appropriate method

This article discusses the method used in a study reevaluating the objectives of a training program. First, there is a brief description of the program to help the reader grasp the context of the evaluation. The model retained for goal relevance assessment involves analyzing the need for training, since goal-setting is of necessity based on such a need. This need is defined as the gap between the desired situation and what currently exists. The desired situation is defined as the importance the program should accord to reaching training objectives, while the current situation is defined as the importance the program actually accords to reaching them. Data were collected using a list of training objectives, which made it possible to collect information on the desired as opposed to the current situation. Finally, a specific procedure for needs analysis and a critical path technique were used to categorize the results obtained. This technique is useful in determining the comparative relevance of objectives and identifying training needs which remain to be met.

THE WOMEN'S VALUE ORIENTATION QUESTIONNAIRE: AN INSTRUMENT REVISION STUDY

Sharon Ogden Burke . Rita Maloney

The combined influences of transcultural nursing (Leininger, 1978) and feminism have motivated nurses to consider carefully both their own and their clients' cultural behaviours, beliefs, and values. Of these, values are the least apparent and the most difficult feature to assess.

An individual's cultural values are at least in part the basis for health beliefs, attitudes, and behaviours. The importance of such data for nurses is evident in nursing theories such as that of B. Neuman (1982) which stress the importance of socio-cultural factors. For example, many middle class North Americans have a future time value orientation which, according to nurse anthropologist Tripp-Reimer (1984), is compatible with health promotion and illness prevention behaviours; however, persons with a present or past time value orientation will not be as motivated by such concerns.

This paper will describe the theoretical basis of and problems inherent in the assessment of cultural value orientations, using the approach developed by Kluckhohn and Strodtbeck (1961). Further, the development of an updated women's version of the questionnaire is described. Finally, our uses of the questionnaire in current research and in clinical settings are discussed.

The Kluckhohn and Strodtbeck Value Orientation Questionnaire (VOQ)

The VOQ was developed in the 1950s by Florence Kluckhohn (Kluckhohn & Strodtbeck, 1961). The classic study compared Navaho, Zuni, Spanish-American, and what she called "Yankee-American" value orientations. The VOQ has since been used with diverse groups (see Brink, 1984 for an overview), and is often discussed in texts for health professionals (Orque, 1983; Tripp-Reimer, 1984).

Kluckhohn saw the number of types of problems encountered by any cultural group as being finite, and each type of problem had a finite number of types of solutions. Central to theses constructs is the postulate that, in any culture, there is a preferential ordering of solutions, and that this creates the distinctive profile of a culture (Brink, 1984).

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It can be argued that these concepts are too narrow and rigid. However, the internal consistency of study results, as well as 25 years of use of the VOQ by many diverse scholars and clinicians, argues for some validity of the concepts and of their measurement.

Kluckhohn isolated five common human problems, although we would argue that there are others. The four that she was able to measure validly are:

1. The relationship of the **person to nature;**
2. The temporal (**time**) focus of human life;
3. The modality of human **activity;** and
4. The modality of a person's **relationship** to other people.

Each problem is seen to have three classes of solutions. Briefly, these are stated in Table 1. Further discussion of the philosophical bases for these classes of solutions may be found in Brink (1984) and in Papajohn and Spiegel (1975).

Table 1

Value Orientation

Problem Modalities	Classes of Solutions (1)		
PERSON-NATURE (2)	Mastery over nature	Subjugation to nature	Harmony with nature
TIME	Past	Present	Future
ACTIVITY	Doing	--	Being
RELATIONAL	Lineal	Collateral	Individual

(1) No preferential order is implied here.
(2) All previous work refers to this modality as man-nature.

The VOQ is a 22-item interview schedule. Each item contains a situation embodying one of the value problem modalities. A person rank-orders the solutions that embody the classes of value orientations for each modality. An example of an item for time orientation is as follows:

Example 1

Child Training (Time Orientation Item)*

Some people were talking about the way in which children should be brought up. Here are three different ideas.

1 (Past)	Some people say that children should always be taught the traditions of the past (the ways of the old people). They believe the old ways are best, and that it is when children do not follow them too much that things go wrong.
2 (Present)	Some people say that children should be taught some of the old traditions (ways of the old people) but that it is wrong to insist that they stick to these ways. These people believe that it is necessary for children always to learn about and take on whatever of the new ways will best help them to get along in the world of today.
3 (Future)	Some people do not believe that children should be taught much about past traditions (the ways of the old people) at all, except as an interesting story of what has gone before. These people believe that the world goes along best when children are taught the things that will make them want to find out for themselves new ways of doing things to replace the old.

*The value orientation and solutions in brackets do not appear on the questionnaire. This unrevised VOQ item is No.3 in the WVOQ.

The dominant North American middle-class value orientation profile is displayed in Table 2. This is based on Kluckhohn and Strodtbeck's (1961) study of Texans and Mormons, on Brink's (1984) report of DeMay's 1982 study of American nurses in the Philippines, and on Burke's study (1985) of student nurses. The similarity in these results supports the validity of the theoretical constructs and their measurement in the VOQ. The similarity of results is remarkable in that the studies span 25 years, each study used slightly different versions of the VOQ, and the subjects were in very different settings.

Table 2

Dominant North American Value Orientations in Three Studies

Problem Modalities	Solutions Preference Profile
TIME	Future > Present > Past (1) or Present > Future > Past (2,3)
PERSON-NATURE	Over > Harmony > Under (1,2) Over = Harmony = Under (3)
RELATIONAL	Individual > Collateral > Lineal (1,2,3)
ACTIVITY	Doing > Being (1,2,3)

(1) Kluckhohn & Strodtbeck, 1961
(2) DeMay, 1982
(3) Burke, 1985

The Women's Value Orientation Questionnaire (WVOQ)

To gain insight into the similarities and differences in aspects of cultural values, the Kluckhohn and Strodtbeck (1961) Value Orientation Questionnaire seems to have potential as an assessment tool. Indeed, Brink's (1984) recent research review and Burke's clinical (Ogden, 1971) and teaching uses of the VOQ demonstrate its utility and validity. Nevertheless, for use with women today the original and other versions (Egeland, 1978) have two problems. First, the wording of many items has a strong gender bias and secondly, some of the content is well outside the experience of most people today. The benefits of using the VOQ, however, outweigh these limitations. Thus, we decided to modify the tool for our cross-cultural research, which compares health beliefs and values among Euro-Canadian, rural Cree, and urban Indian women and nurses.

Egeland's (1978) findings, as she attempted to develop a health value orientation schedule with several ethnic groups in Florida, were incorporated into our modifications. Her results suggest that VOQ stories or situations can be changed while retaining essentially the same value orientation responses or solutions. This revised tool we call the Women's Value Orientation Questionnaire or WVOQ.

Procedures

The revision process moved almost simultaneously and interatively through four separate processes. These were: experts' assessment of the face validity; a criterion validity study comparing the WVOQ with the VOQ; a content analysis; and conceptual and editorial work. The cumulative results are summarized in Table 3.

Table 3

WVOQ Changes from the Original VOQ

	Original Story	Revised Situation	Edited to Remove Sexism or Updated	Orientation (1)
1.	Job Choice	--	X	A
2.	Well Arrangements	Prenatal & Well Baby Clinic	X	R
3.	Child Training	--	--	T
4.	Livestock dying	Miscarriages	--	N
5.	Expectations about Change	--	--	T
6.	Facing Conditions	--	X	N
7.	Help in Misfortune, Accident	Help in Misfortune, difficult birth	X	R
8.	Choice of Delegate	--	X	R
9.	Use of Fields	Child Health Care	X	N
10.	Philosophy of Life	--	--	T
11.	Wage Work		X	R
12.	Belief in Control		X	N
13.	Ceremonial Innovations	Health Care Services Innovation	--	T
14.	Ways of Living	--	--	A
15.	Land Inheritance	--	--	R
16.	Care of Fields	Care of Children	--	A
17.	Length of Life	--	X	N
18.	Housework	--	X	A
19.	Nonworking Time	--	X	A

(1) A = Activity; R = Relational; T = Time; N = Person-Nature.

Face validity

The face validity of the WVOQ was assessed for appropriateness and sensitivity to the value orientation constructs by three nationally recognized experts in maternal and child health or Canadian Native health, and by four Canadian Indian women. Minor wording and format changes were made, as suggested by

these experts, to increase the face validity. For example, Story 6 used the term "God" and was changed to read "God, god, gods, or the Creator".

In addition, Burke (1985) administered an abbreviated version of the VOQ to 41 Third Year female nursisng students. Each student interpreted her responses; the consensus that emerged in class discussion was that the VOQ assessed their personal values accurately. The group's results (as displayed in Table 2) were shared with faculty, and again the consensus was that this was a valid representation of the Third Year female students' value orientations.

Criterion validity

A criterion validity study was conducted with a group of 10 middle class women of childbearing and childrearing age. In varying order, both the WVOQ and the VOQ were given to each subject.

According to Brink (1984), this purposive, non-probability sample is of adequate size for the VOQ, with only one sex strata. Given the small sample size and study design, percentages were used in the analysis. More elaborate statistical procedures would be appropriate for larger samples and cross-cultural studies (Kluckhohn & Strodtbeck, 1961; Brink, 1984).

When the ranking of responses was compared, item by item, there was 65% absolute agreement between versions. This is well above that which could be accounted for by chance with the six possible combinations. The agreement for the most preferred value orientation options was 84%. High agreements would be expected because of the test-retest effect. However, that the women were attending to the differences between the versions is clear because agreements were higher for the items that were only edited than for the items with new situations. Person-nature items had the highest agreements.

Based on this analysis, the two items with the lowest agreements were omitted. One other item was retained, but we reverted to the original wording. Several minor wording changes were made that were based on subjects' comments.

Content analysis

In view of the issues we wished to examine in our study, an analysis was done of the subject content of each item beyond the value orientation. As can be seen in Table 4, we arranged for a range of subjects which covered our interests, notably: general health care, maternal and child health, work, lifestyle, childrearing, and family life issues.

Table 4

Content Analysis

No.	Story	Health			Work	Lifestyle	Childrearing-Family Life	Community
		General	Mother	Child				
1.	Job Choice				X			
2.	Prenatal & Well Baby Clinic		X	X				
3.	Child Training						X	
4.	Miscarriages		X				X	
5.	Expectations About Change					X	X	
6.	Facing Conditions					X		
7.	Help in Misfortune, Difficult Birth		X				X	
8.	Choice of Delegate							X
9.	Child Health Care			X		X		
10.	Philosophy of Life				X	X		
11.	Wage Work				X			
12.	Belief in Control					X		
13.	Health Care Innovations	X						
14.	Ways of Living					X		
15.	Land Inheritance						X	
16.	Care of Children			X		X		
17.	Length of Life	X						
18.	Housework						X	
19.	Non-working Time				X	X	X	

Story Development, Editorial and Format Changes

The suggestions of the researchers, experts, and subjects all contributed to the stories and format of the final WVOQ. Each VOQ item was reviewed for relevance to women of childbearing and childrearing age, gender appropriateness, and currency.

An example of a story change for relevance can be seen in Story 2 which follows.

VOQ

When a community has to make arrangements for **water, such as drilling a well,** there are three different ways they can decide to arrange things like location, and who is going to do the work.

WVOQ

When a community has to make arrangements for **a prenatal and well baby clinic,** there are three different ways they can decide to arrange things like location, and who is going to do the work.

An example of the types of **editorial** work done to remove gender specificity is seen in Story 1.

VOQ

One boss was a fair enough **man,** and **he** gave somewhat higher pay than most **men,** but **he** was the kind of a boss who insisted that **men** work hard, stick on the job.

WVOQ

One bass was a fair **person,** and give a little higher pay than most **employers,** but was the kind of boss who insisted that **people** work hard and stick on the job.

An example of rewording for ease of understanding and **currency** is seen in Story 11.

VOQ

There are three ways in which men **who do not themselves hire others may work.**

WVOQ

There are three ways in which women **may work for money.**

Note that we used the term women whenever appropriate throughout the WVOQ as it is a sex-specific questionnaire for females. However, whenever referring to classes that could be either male or female, as in Story 1, non-sexist terms or generic terms were used (Eichler & Lapointe, 1985).

The WVOQ

The final version of the WVOQ contains five of the original VOQ items, eight items that were edited, and six stories that were revised. These revisions are summarized in Table 3. One item was omitted as redundant, based on Egeland's (1978) findings, and two more were dropped after the criterion validity study.

An example of a full revised item from the WVOQ is Number 13.

Example 2

Health Care Services Innovations (Time Orientation Item)*

Some people in a community like yours think that health care services are changing from what they used to be.

A (Future)	Some people are really pleased because of the changes in health care services. They feel that new ways are usually better than old ones, and they like to keep everything - even health care - moving ahead.
B (Past)	Some people are unhappy because of the change. They feel that health care services should be kept as they were in the past.
C (Present)	Some people feel that the old ways for health care services are best, but you just can't hang on to them. It makes life easier just to accept some changes as they come along.

Which of the three said most nearly what you believe is best?

Which of the other two do you believe is next best?

Your ideas: (optional) _____

*Note that the orientation and solutions in brackets do not appear on the questionnaire.

A Study in Progress

Indian women and their nurses

The need for culturally sensitive care is particularly acute in work with such indigenous peoples as the Cree women and children who have been one focus in our work over the last few years. These women and their children are known to be at a very high risk of accidents and handicapping conditions (Government of Canada, 1980). Assessment of cultural values is a first step in the provision of culturally sensitive care.

Thus, we are currently using the WVOQ to describe the value orientations of a group of maternal and child nurses, Euro-Canadian women, rural Cree Indian women, and urban Indian women. The purpose is to describe, compare, and identify areas of disagreement and agreement in value orientations among these four groups. The function of such information will be to improve our understanding of current areas of conflict and to identify areas of potential conflict. Areas of agreement will be useful in planning more effective health care interventions. Areas of slight divergence will be useful in alerting nurses and clients to issues that must be more carefully thought out and planned, in order to move toward acceptable health care pratices and outcomes for all parties involved. Early results show the WVOQ's effectiveness toward this goal (Burke, Maloney & Baumgort, 1986).

To give an example, time orientation is likely to be quite different with nurses operating primarily within the present and future orientation whereas Native Indian clients may place greater emphasis on the present and the past. The enthusiastic novice nurse who is committed to preventive health teaching may become exasperated when such health teaching is disregarded, because her client is present oriented rather than future oriented. Similarly, older studies suggest a "doing", as opposed to a "being" orientation in both the Indian and the dominant North American value orientations. However, in our experience the areas of one's life in which this "doing" is focused seem quite different: one culture stresses "doing for oneself", the other "doing for others".

Within the context of the total study, however, this somewhat narrow and rigid WVOQ data is only used as one part of a group of data that was collected using several strategies. For example, a partially open-ended questionnaire is used to elicit a history of the recent illnesses of each mother and one of her children, using Chrisman's health-seeking process (1977) as the conceptual framework. Also, child bearing and rearing practices data are gathered using a modification of Yoshida's (1984) interview guide.

We have now used the WVOQ with over 100 women and find it an excellent introduction to cultural differences between these women. Most of the women were able to rank-order the options. Only three were unable to do so, and they used the space provided

to give their own alternate solutions extensively.

Usefulness of the WVOQ

The WVOQ could be used in nursing practice with individuals or families, nursing education (Triandis, 1983) and nursing research (Brink, 1984). To study and nurse women, the cultural underpinnings of their lives have to be understood (Tripp-Reimer, 1984; Neuman, 1983).

A quantitative tool such as the WVOQ can sample some of the underlying values. However, since culture consists of such a rich fabric of traditions and ways of interacting with the world, neither Kluckhohn nor the authors would argue that the WVOQ defines the content - it simply abstracts some of it. Those who respond to the instrument not only draw from their own cultural experience, but also from their individual family's experience as well. It is therefore important to augment the quantitative WVOQ data with qualitative data collection. We would argue that qualitative methods, when used alone, would sacrifice generalizability, but in combination with the WVOQ will improve contextual meaning.

It is with some caution that one must interpret the responses. While it can be said that people within a particular group have tended to give similar responses, the notion that there is a single set of value orientations for all members of an ethnic group is too rigid for the cultural mix and rapid change in Canadian culture today.

With these reservations and cautions then, we believe that this version of the Kluckhohn and Strodtbeck Value Orientation Questionnaire can be used with women more effectively than the original version. The WVOQ seems to be an appropriate, pertinent, and useful tool when studying some of the cultural values governing women's lives.

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The full interview and interpretation forms of the Women's Value Orientation Questionnaire can be obtained by writing the authors.

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RÉSUMÉ

Le questionnaire d'orientation des valeurs des femmes: Étude sur la révision de l'instrument

Le questionnaire d'orientation des valeurs de Kluckhohn et Strodtbeck (QOV) (1961) suscite un regain d'intérêt chez les anthropologues spécialisés en sciences infirmières (Brink, 1984; Tripp-Reimer, 1984). Toutefois, son utilisation auprès d'une population féminine aujourd'hui pose deux problèmes: sa formulation axée spécifiquement sur le genre masculin et le fait que le questionnaire s'appuie sur des histoires qui ne s'inscrivent pas dans les expériences courantes de la plupart des gens. Nous avons donc révisé le QOV.

Les critères qui nous ont permis d'examiner chaque élément original ont été les suivants: a) la pertinence pour les femmes en âge d'avoir des enfants et de les élever, b) la formulation adéquate sur le plan du genre et c) la modernité. Quatre des éléments originaux ont été retenus. Sept autres ont fait l'objet d'une révision visant à retirer les allusions sexistes et à mettre à jour les histoires. Étant donné que les travaux d'Egeland (1978) semblent indiquer que les histoires du QOV peuvent être modifiées tout en évoquant des réponses axées sur l'orientation des valeurs, nous avons révisé les histoires dans sept cas.

Les résultats d'une étude de validité des critères réalisée chez dix femmes euro-canadiennes ont démontré qu'il y avait une bonne correspondance entre les versions sur le plan des orientations de valeur. La validité à prime abord de la nouvelle version du point de vue des femmes nées au Canada et des spécialistes qui se penchent sur le cas des mères et des enfants était également acceptable. La discussion est axée sur son utilisation en recherche trans-culturelle de même que sur ses applications cliniques et pédagogiques.

DETERMINANTS OF PERCEIVED LIFE SATISFACTION IN THE INSTITUTIONALIZED ELDERLY

Barbara Downe-Wamboldt . Deborah Lynn Tamlyn

An understanding of the variables that affect life satisfaction of the institutionalized elderly can assist health professionals to assess individual needs, and to identify and implement appropriate interventions to meet these needs. The question of which variables best predict high life satisfaction among the elderly has been a focus of much investigation in gerontological research. Studies have measured overall satisfaction levels for the institutionalized and non-institutionalized elderly, and have determined internal and external variables which influence life satisfaction. There is, however, a lack of studies that examine the relative contribution of predictor variables to the improved life satisfaction of the institutionalized elderly.

Literature Review

Life satisfaction has been investigated under indices of morale, happiness, and adjustment (Tesch, Whitbourne, & Nehrke, 1981). Two major approaches have been used to study the subject: an investigation of the overt behaviours of the individual, such as range of activities and social participation; and the person's subjective evaluation of his present and past life (Neugarten, Havighurst, & Tobin, 1961). Three general areas are relevant to the life satisfaction of the institutionalized elderly: the characteristics of the elderly person, the relocation process, and the characteristics of the institutional environment. Many researchers believe that the personal characteristics of the elderly person who relocates to an institution are the primary factors contributing to low levels of life satisfaction. Fawcett, Stonner, and Zeplin (1980) found that the life satisfaction scores of 56 institutionalized elderly women related significantly to a belief in personal influence, and that they related inversely to perceived institutional restraint. Reid, Haas, and Hawkings (1977) found that elderly persons, whether institutionalized or non-institutionalized, who had a low sense of control had a more negative self image and reported themselves to be less happy and content than did those with a high sense of control. Felton and Kahana (1974) found that an external locus of control was significantly related to successful adjustment among institutionalized elderly. Chang (1978) found, however, that residents had higher morale when they perceived they had control over daily activities, regardless of

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whether or not they had external or internal locus of control. Noelker and Harel (1978) identified the primary predictors of personal well-being for residents in a long term facility as being subjective factors relating to resident perceptions of the facility and staff.

The relationship of demographic characteristics to life satisfaction has also been investigated. For example, Edwards and Klemmack (1973) found that the best predictors of life satisfaction in the age group 45 years and over were socio-economic status, perceived health status, and informal participation with nonkinsmen. Perceived health status appears to be a more important determinant of life satisfaction than actual health status (Medley, 1976).

Some researchers consider the process of relocating from one's home to an institution to be the primary contributor to the decline noted in the institutionalized elderly (Blenker, 1967; Miller & Lieberman, 1965). Blenkner (1967) noted a markedly increased mortality rate during the first year after admission to an institution. Miller and Lieberman (1965) noted that negative effects are reduced when the elderly are prepared for a move from home to an institution. Coffman (1983) suggests that relocation is neither inherently beneficial nor inherently harmful to survival among the institutionalized elderly. Rather, he concludes that most of the relocations involving significant changes in mortality rates have involved major alterations in caretaking and support systems, and hence do not indicate effect of relocation per se on survival.

The impact of the institutional environment on life satisfaction is not fully understood. Kahana and Harel (1971) suggested that negative behaviours, such as depression and physical decline, are precipitated by the process interaction between staff and residents. Schultz (1976) attributes the negative effects of institutionalization to loss of control.

Tesch et al. (1981) found a positive correlation between morale and the frequency of social interaction with persons who live outside the institution, but found no significance between morale and friendship within the institution. In contrast, Walsh and Kiracofe (1981) concluded that a shift in relationships from the family to friends may assist adjustment to institutional living. Smith and Bengtson (1979) describe positive effects of institutionalization on family relationships. They noted that alleviation of acute strains on the family may be related to the improved family relations described in 70 per cent of the 100 parent-child interviews they conducted. No analysis of the relationship between improved relations and the life satisfaction of the institutionalized elderly was made.

From among the many factors that appear to influence perceived life satisfaction of the institutionalized elderly, we focused, in this

study, on characteristics of the individual and the institutional environment.

We sought to ascertain the relationship between the perceived life satisfaction levels of the institutionalized elderly and perceived health status, as well as selected demographic and psycho-social variables.

Method

The respondents

Subjects selected through the use of tables of random numbers met the following eligibility criteria: 65 years of age and over; able to read, understand and write English; institutionalized for more than one year; semi- to fully-ambulatory; aware of time, place, and person; and able to give informed consent for participation in the study. Group I contained 26 women and 2 men, (mean age 78 years and mean period of institutionalization 3 years), who resided in nursing home care units where professional nursing care and medical attention was provided as needed. Group II contained 18 women and 3 men, (mean age 75 years and mean period of institutionalization 3 years), who resided in domiciliary or personal care units where a nurse provided assistance with and supervision of daily living activities as needed. The majority of subjects were widowed (88%), and in the lower to middle socio-economic bracket (80%). Eighty per cent of the subjects reported having an average intensity of religious belief, and 14% reported high intensity. Fifty-one per cent of the subjects reported having a high school education or better. This unusually high education level for this segment of the general elderly population may be related to subjects responding in a socially desirable manner.

The setting

The study took place in a large, modern complex in a metropolitan area of atlantic Canada. It included independent apartment living and skilled nursing facilities that were geographically connected by spacious and attractive solariums and walk throughs. The physical environment of the facility reflected current concepts in the care of the institutionalized elderly: encouragement of the use of furnishings from the resident's home, use of bright contrasting colours, home-like dining areas, handrails in the hallways, hand supports on toilets and tubs, and wheelchair accessability to all areas including the lounges, bar, and games room.

Measures

Data on perceived life satisfaction were obtained using Life Satisfaction Index Z (LSIZ) (Wood, Wylie, & Sheafer, 1969); a modification of the Life Satisfaction Index A developed by Neugarten et al. (1961). It is a thirteen-item questionnaire that reflects the respondent's zest for living, congruence between desired and achieved life goals, positive self-concept, resolution and fortitude, and optimistic mood tone (Adams, 1969). Scores are determined by alloting two points for agreement with a positive item or for disagreement with a negative item. Uncertain responses are given one point. The potential score is 26. The LSIZ has a split-half reliability coefficient of .79 (Wood et al., 1969), and a validity correlation of .94 with the LSIA and .792 with the Philadelphia Geriatric Center Morale Scale (Lohmann, 1977). Both the LSIA and the LSIZ were developed for use with the elderly and each has a substantial amount of empirical support. (Neugarten et al., 1961).

The interview schedule "Situational Control Over Activities of Daily Living" (SCDA) (Chang, 1978) was used to measure subject perception of situational control. It consists of twenty-two items, reflecting eight categories of daily activities; (ambulating, dressing, eating, grooming, toileting, group participation, one-to-one inter-actions, or solitary activities) and an "other" category. The scoring results in an overall self-determined category, or other-determined category, and a total score. In the case of a tie, the overall scores are designated as self-determined (Chang, 1978). Inter-rater reliability has been reported at .98, and retest reliability at .96. Content validity has been determined by a panel of judges (Chang, 1978). The subjects were also asked to list their first, second, and third priorities in terms of activities of daily living outlined in the SCDA tool that they would most want to control.

We collected information on selected psycho-social characteristics: age; sex; marital status; years in an institution; education; income level; perceived intensity of religious belief; perceived health status; number and length of contacts ($\geq$ 5 minutes) in two consecutive weekdays (Monday to Friday) with staff, volunteers, family and friends; and the weather. These variables, with the exception of weather, had been included in the studies reported in our literature review; weather, (as coded by interviewers), was added because we felt it might affect the resident's psychological state on the day of the interview. We also attempted to quantify contact time, by obtaining information on all contacts that lasted longer than five minutes, on two days. This meant that data were not collected on Monday, since staffing is usually reduced on week-ends.

Locus of control was not included as a variable in this study as it was not found to influence SCDA scores in Chang's study, and we were building on her method.

Perceived health status was elicited by asking the residents to rate their health as excellent, good, fair, poor, or very poor.

Procedures

Subject eligibility was decided by the researchers by means of review of patient kardexes, in consultation with the head nurse of the respective units. Using the inclusion criteria, 84 nursing care residents and 64 personal care residents were identified. Randomly selected subjects, who met the inclusion criteria, were approached individually, and were explained the purpose of the study. They were informed that they were being asked to volunteer for the study, and that if they should decide not to participate, or to withdraw from the study, this would in no way affect their care. Anonymity was ensured.

Proportional random sampling of this population secured 56 residents who were invited to participate in the study. Of these, less than five per cent refused to participate. The number of subjects was less than anticipated, primarily because potential subjects were unable to meet the inclusion criteria of awareness of time, place, and person, and were unable to give informed consent for participation in the study.

The interview schedules SCDA, LSIZ, and the questionnaire to collect selected psycho-social and demographic data were administered individually, in the subjects' rooms. All interviews were conducted using the same sequence of interview schedules, requiring approximately one hour to administer. (Using simulated client interviews, we had established decision rules for coding responses before data collection).

To determine the relative contribution of the predictor variables to the criterion variable of perceived life satisfaction scores, we computed linear, step-wise, and hierarchical multiple regressions using the Statistical Package for the Social sciences (SPSS) (Nie, Hall, Jenkins, Steinbrenner, & Bent, 1975). Data were analyzed for each group separately and for the groups together.

Results

The split-half reliability coefficient for LSIZ in the study sample was calculated to be .60 using SPSS. Subjects in Group I reported their self-assessed health status as follows: 2 excellent; 10 good; 9 fair; 5 poor; and 2 very poor. The mean LSIZ score was 13.5, with a range of 4-22. The majority of subjects were categorized overall as self-determined for activities of daily living.

Subjects in Group II reported their self-assessed health status as follows: 1 excellent; 7 good; 9 fair; 1 poor; and 3 very poor. The mean LSIZ score was 13.2, with a range of 2-21, and the

majority of subjects were categorized overall as self-determined for activities of daily living.

Multiple regression analysis on the combined data of Group I and Group II yielded an R^2 less than the mean R^2 of the groups computed separately. This may most likely be explained because the linear slopes of the two groups were too dissimilar, and therefore all subsequent data analysis was done separately for each group.

Predictor variables, which were statistically significant (alpha = 0.001) in accounting for the variance in the criterion variable scores, were determined by initial step-wise and hierarchical multiple regression analyses. Subsequently, these selected predicdtor variables were entered into separate step-wise multiple regression analysis. (Tables 1 and 2).

The proportion of variance in LSIZ scores that was accounted for by each of the predictor variables is indicated by the R^2 change statistic. A comparison of total R^2 statistics in Tables 1 and 2 indicates that the select predictor variables accounted for 79% and 47% of the variance in the LSIZ scores of Groups I and II, respectively.

It is known that the relative magnitude of contribution of each predictor variable may, to some degree, be influenced by its order of entry into a multiple regression. Therefore, perceived health status and SCDA scores were entered first and secondly into separate hierarchical regressions. Results indicated that perceived health status accounted for 32-46% of the variance, and that SCDA scores accounted for 6-13% of the variance in Groups I and II, depending on the order of entry ($p. < 0.001$).

The simple r statistic (see Tables 1 and 2) indicate correlation between each of the predictor variables and the LSIZ scores. There was a strong to moderately positive correlation between perceived health status and LSIZ scores for Groups I and II respectively ($r=.67$, $r=.53$, $p. < 0.001$). SCDA scores were positively correlated to LSIZ scores ($r=.36$, $r=.26$, $p. < 0.001$) for Groups I and II, respectively, as were contact times with family and friends ($r=.33$, p.xx0.001), and weather ($r+.22$, $p. < 0.001$) for Group II. There was no systematic relationship evident between LSIZ scores and either financial status, or priorities of daily living, or contact time with CNA's, for Group I; and financial status, or number of letters, or religious intensity of belief for Group II (Tables 1 and 2).

Respondents in Group I generally selected either dressing, ambulating, or eating as one of their first three priorities for the activities of daily living. Respondents in Group II generally selected either solitary activities, ambulating, or dressing as one of their first three priorities (Table 3). Forty-eight per cent of the subjects in Group II and 18 per cent in Group I chose solitary

Table 1

Summary of Stepwise Regression Analysis for Predictor Variables on Perceived Life Satisfaction for Group I

Variable	Beta	R^2	R^2 Change	r	F
Health Status	.743	.455	.455	.674	20.842*
SCDA	.306	.517	.063	.362	12.853*
Financial Status	.419	.564	.047	.112	9.908*
Priority A.D.L. (2nd choice)	.478	.646	.083	.076	10.047*
Religion	.465	.736	.089	-.149	11.686*
Age	.266	.753	.017	.190	10.143*
Contact Time	.248	.782	.029	-.040	9.724*
C.N.A.					

*p.< 0.001 N=28 Constant=23.265

Table 2

Summary of Stepwise Regression Analysis for Predictor Variables on Perceived Life Satisfaction for Group II

Variable	Beta	R^2	R^2 Change	r	F
Health Status	.549	.285	.285	.533	17.902*
Weather	.307	.342	.057	.215	11.424*
Contact Time Family/Friends (Phone Calls)	.107	.381	.040	.333	8.317*
SCDA	.346	.407	.026	.263	7.192*
Financial Status	.273	.435	.028	.041	6.313*
Letters	.248	.457	.022	.096	5.614*
Religion	.149	.474	.020	-.001	5.021*

*p.<0.001 N=221 Constant=30.724

Table 3

Ranking by Importance of Activities of Daily Living by Group I and Group II

Activities	Group	First Importance N	%	Second Importance N	%	Third Importance N	%	Total N	%
Ambulating	I	10	(35.7)	5	(17.9)	4	(14.3)	19	(67.9)
	II	6	(28.6)	4	(19.9)	2	(9.5)	12	(57.1)
Dressing	I	4	(14.3)	10	(35.7)	6	(21.4)	20	(71.4)
	II	1	(4.8)	5	(32.8)	4	(19.0)	10	(47.6)
Eating	I	4	(14.3)	3	(10.7)	4	(14.3	11	(39.3)
	II	2	(9.5)	1	(4.8)	3	(14.3)	6	(28.6)
Grooming	I	0	(0)	2	(7.1)	2	(7.1)	4	(14.3)
	II	)	(0)	3	(14.3)	2	(9.5)	5	(23.8)
Toileting	I	2	(7.1)	3	(10.7)	3	(10.7)	8	(28.6)
	II	1	(4.8)	1	(4.8)	4	(19.0	16	(28.6)
Group Participation	I	1	(3.6)	0	(0)	3	(10.7)	4	(14.3)
	II	0	(0)	1	(4.8)	0	(0)	1	(4.8)
Interaction (one-to-one)	I	5	(17.9)	1	(3.6)	2	(7.1)	8	(28.6)
	II	1	(4.8)	1	(4.8)	1	(4.8)	3	(14.3)
Solitary Activity (T.V., reading)	I	4	(17.9)	1	(3.6)	2	(7.1)	8	(18.6)
	II	10	(47.6)	2	(9.5)	1	(4.8)	13	(61.9)
Other	I	0	(0)	0	(0)	0	(0)	0	(0)
	II	0	(0)	0	(0)	0	(0)	0	(0)
No Response	I	2	(7.1)	3	(10.7)	3	(10.7)	8	(28.6)
	II	0	(0)	3	(14.3)	4	(19.0)	7	(33.3)
Total		49	100	49	100	49	100		

activities as their primary interest in daily living. Sixty-two per cent of the subjects in Group I and 29% of those in Group II selected solitary activities as one of their first three priorities of ADL; however, priorities of ADL was not indicated as a statistically significant predictor of LSIZ scores for either group.

Discussion and Recommendations

We found perceived health status to be the principal factor accounting for variance in perceived life satisfaction scores (Tables 1 and 2); a finding consistent with those of Edwards and Klemmack (1973) and of Medley (1976). Although most health problems associated with aging are chronic in nature, rather than acute, and generally can not be cured, only controlled, an elderly person's perception of these health problems may be altered by appropriate interventions.

SCDA scores were not found to be strong predictors of life satisfaction. This result differed from that of Chang (1979) who found that SCDA was a strong predictor of morale, using the revised Philadelphia geriatric Center morale scale. We found that the SCDA schedule had strong potential as an assessment tool for determining the elderly institutionalized person's perception of his control over his activities of daily living. Further, it was useful for identifying possibilities for activities of daily living that the elderly person may have previously been unaware of.

The amount of time in contact with registered nurses was too small to be included in the regression analyses. This is probably explained by the high numbers of administrative duties associated with the role of the nurse in the study setting. Data collected with respect to time in contact with care givers were affected by the accuracy of reports by the subjects, over a two-day period. Possibly future studies should include observers or participant observers who would collect quantitative and qualitative data that could be related to contact time.

The nursing staff working with subjects in Group II expressed concern about the amount of time this group spent in solitary activities. In the opinion of the nurses, the large proportion of solitary activity time contributed to social isolation, depression, and general unhappiness. Nonetheless, 62% of the respondents in this study considered solitary activities to be the most important aspect of their daily lives (see Table 3).

One limitation of this study concerned the small sample size that resulted from our inability to collapse the two groups, and from the difficulty we had in finding potential subjects who met all of the inclusion criteria. We suggest further qualitative study to examine the origins of the elderly individuals perceptions of their health status and life satisfaction in order to develop more insight in these areas. In addition, staffing policies and the roles and

functions of the registered nurse in homes for special care of the elderly should be examined in order to determine optimal use of staff.

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RÉSUMÉ

Déterminants de la satisfaction de vie perçue chez les personnes du troisième âge vivant en établissement

Il s'agit d'une étude à corrélations multiples de 49 personnes du troisième âge réalisée pour approfondir la relation entre la satisfaction de vie perçue et la santé perçue, la maîtrise de la situation ainsi que certaines variables psychosociales et démographiques choisies. La perception qu'a le sujet de sa santé est apparue comme l'indice de satisfaction de vie le plus fort. La maîtrise de la situation dans le cas des activités quotidiennes n'est pas apparue comme une indice fort, mais l'outil utilisé a permis d'aider les résidents à identifier des choix dont ils n'avaient pas pris conscience auparavant.

ANALYSIS OF PENDER'S HEALTH-PROMOTION BEHAVIOUR MODEL

Ann Hilton

Pender's Health-promotion Behaviour Model (HPBM) will be the focus of this paper. The model components will be analyzed, research related to the model will be presented to examine its validity, perceived benefits will be synthesized, and new questions and issues that assess the model's usefulness and approximation to the real world will be outlined.

Analysis of Components

Pender's model (Figure 1) attempts to provide a complementary counterpart to models of health-protecting behaviour, specifically the Health Belief Model developed in the 1950s by Rosenstock, Hochbaum, and Kegeles (Becker, 1984). Salient dimensions of the Health Belief Model are goal-setting that is based on perceived consequences, subjective estimates of desired outcomes, and decision-making under uncertainty. The Health Belief Model is disease and action-sepcific. Rather than focusing on behaviour that is directed toward decreasing the probability of encountering illness, Pender's model focuses on movement of the individual toward increased health and well-being. She developed the model because of her belief that health is a positive state in its own right, rather than simply the opposite of a negative state (illness).

According to Pender (1982), the goals of health-promotive behaviour are growth, maturation, and expression of human potential. She claims that while the Health Belief Model has predictive potential useful for developing preventive behaviours, it is inadequate to explain positive health actions that are directed toward the achievement of higher levels of health, self-actualization, and fulfillment. Similar to the Health Belief Model, Pender's model includes individual perceptions, modifying factors, and variables affecting the likelihood of action, and has both a decision-making and action phase.

The underlying beliefs in the HPBM include the following:

1. A phenomenological orientation is evident. It assumes that the subjective world of the perceiver determines behaviour rather than the objective environment, except as the objective environment comes to be represented in the mind of the behaving individual.

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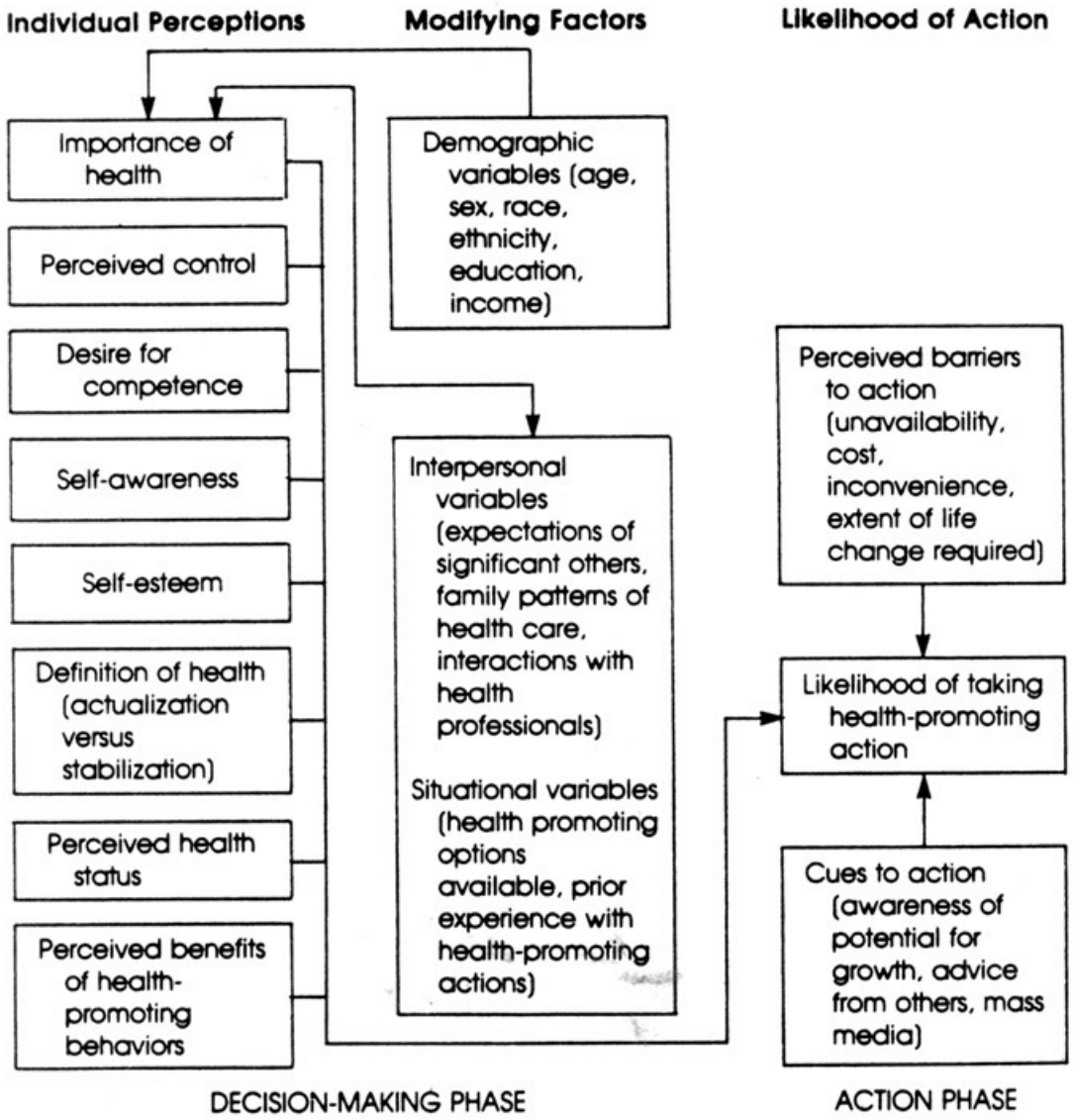

Figure 1. Pender's proposed Health Promotion Model (Pender 1982, p.66)

2. The individual exists in a life space composed of regions, some of which are positively valued (positive valence), others negatively valued (negative valence), and still others relatively neutral.

3. Unlike the Health Belief Model where a person is pulled by positive forces and repelled by negative forces, in the HPBM a person acts on the environment rather than reacting to external influences or threats posed by the environment.

4. The individual behaves in ways that maximize positive tension in order to promote change, growth, and maturation; these health-promoting behaviours are expressions of the actualizing tendency.

5. Health-promoting behaviours are directed toward increasing well-being and toward expressions of human potential.

The model assumes that motivation is a necessary condition for action, and that readiness to take action is related to the following individual perceptions: perceived importance of health; perceived control of health, with clarification needed between the desire for control and the perceived probability of control; the desire for competence as differentiated into motives such as mastery, achievement, power, and autonomy; self-awareness and self-esteem; and personal definition of health, perception of personal health status, and perception of benefits of health-promotive behaviour. These components are interdependent and are influenced by demographic, interpersonal, and situational variables.

The outcome or likelihood of action is influenced by such internal or external cues and barriers, real or imagined, as perception of unavailability, inconvenience, or the difficulty of a particular option. Pender emphasizes the inherent, dynamic, cyclical process in which the individual moves back and forth between phases of decision-making and action.

Discussion of the logical adequacy, testability, usefullness, and generalizability of the model will follow in subsequent sections.

Prior Findings

Several research reports were noted as theoretical development support in the Pender presentation of the model. Reference will not be made to those studies since they are readily available in the book. Because the model is new (it was not published until 1982), its empirical adequacy and testability have not yet been reported, but its components can be analyzed. Studies related to health value, control, health beliefs, perceived benefits, modifying factors, and outcomes can support or challenge its validity.

A number of findings dealing with the internal/external locus of health control provide support. Pender's assumption is that an individual's perception of control of health leads to better health outcomes. Wallston, Wallston, Kaplan, and Maides (1976) analyzed health value, taking into account that the value of the outcome is a determinant of behaviour. They found an improved response to weight-reduction programs when those programs were tailored to meet the differing expectancies of those subjects with internal control and those subjects with external control. This illustrates the importance of correct assessment of the individual. Kaplan and Cowles (1978) reported that individuals who had an internal health locus of control, and who valued health highly, were most successful in achieving and maintaining changes in their smoking behaviour. In Sonstroem and Walker's (1973) study, internally oriented undergraduate men had a more favourable attitude toward physical activity; they participated more in planned sports programs than externally oriented men. These findings demonstrate that internal locus of control is more effective for achieving certain changes in behaviour, and they support the importance of

control in health-promoting behaviour.

Wallston and Wallston (1978) verified the predictive value of the Multidimensional Health Locus of Control Scale (MHLC), using health status as the criterion for community men and women, for YMCA Health Fair participants, and for graduate, professional, and clerical women. Correlations between health status and internal control were positive (r=.403); between health status and chance they were negative (r=.275); and between health status and powerful others they were not significant. Brown, Muhlenkamp, Fox, and Osborn (1983) found correlations between internal locus of control and powerful others and between internal control and chance were negative, but that they were strongly positive between powerful others and chance. This is logical, since individuals who believe they have little personal control over events would have little reason to engage in health-promotion activities. Health value was not related to any other variable. No relationships between internal control or high health value and health-related information-seeking behaviour were found; a possible explanation given was that an individual's intention to engage in an activity may not become the actual behaviour. This finding lends support to Pender's two phases of decision-making and action. It also supports Sandelowski's (1981) statement that individuals do not always act on their beliefs. McCusker and Morrow's study (1979) however, offers no support for Pender's model. They found no relationship between locus of control, alone or in combination with health value, and the subject's engagement in breast self-examination.

Demographic and interpersonal variables are also important in the determination of health-promoting behaviour. Palmore and Luikart (1972) found that life satisfaction in middle age was largely influenced by self-rated health, rather than by career anchorage, income, education, or social activity.

Laffrey's (1983) study on factors related to choice of health behaviour choice tested relationships among self-actualization and health conception in adults. A significant relationship (r=.44) was found between health conception and health behaviour choice, but neither factor was significantly related to the personal orientation inventory. Laffrey suggested possible incongruity between self-actualization theory and the nursing framework from which the tools were developed. This study supports the component relationships in Pender's model.

Heinzelmann and Bagley (1970) reported on reasons for participation in physical activity programs and on perceived outcomes. The two most important reasons given for participation were the desire to feel better and the desire to lessen the chance of a heart attack. One of the major perceived outcomes of participation was a feeling of decreased vulnerability to specific health threats, including heart attacks. To this writer, this finding illustrates a shortcoming of Pender's model that is related to the

interaction between health protection and health promotion: this relationship is not delineated, but it should be. In addition, statistics on illness indicate that, from mid-life on, a large percentage of individuals will have some form of long-term disability with which to cope. According to Crase, Hamrick, and Rosato (1977), who refer to several large research studies, the goal of youth fitness is on the wane, but, there is a growing quest for adult wellness through physical exercise that is a result of an individual desire for self-expression and health maintenance. How can one differentiate clearly between avoidance and approach behaviour, particularly when the participating group is at risk?

Researchers in the Soviet Union (cited in Crase et al., 1979) have documented the economic benefits of exercise and have found that workers who exercised regularly were more productive, visited the doctor less frequently, were far less prone to industrial accidents, and were absent from the job three to five days less per year than other workers. Communities that are devoted to physical fitness for the elderly have been compared to others that do not emphasize fitness activities; results indicate that the active people live longer than the inactive. It appears that exercise contributes to health attitudes and to behaviours commensurate with preventive and holistic health (Crase et al., 1977). This finding supports Pender's view of the dynamic cyclical process between decision-making and action.

Brown et al., (1983) had opposing support for Pender's model. They studied the relationships among health beliefs, health values, and health promotion activity. No significant relationships were found between income, education, or age and the MHLC sub-scales, nor between those demographic variables and health value. However they did find that 30% ranked health as their highest value, and that no one ranked health lower than third. No significant difference was found between church and secretarial groups. The level of health promotion activity was not associated with socio-economic status. This differs from McCusker and Morrow's (1979) results. Brown et al., (1983) also found that married subjects engaged in more health-promotion activity than do widowed, separated, divorced, or single people.

Other researchers looked at modifying factors. Douglass (1971) stated that individual interaction with the health care environment can influence health attitudes and behaviours; these in turn influence the other variables in the system. Coburn and Pope (1974) studied interpersonal variables and found family ties were influential in establishing the values of family members. Knutson (1969) stated that women seem to pursue health as a goal more than men.

The model, therefore, receives some support for the influence of several of its components and their relationships to each other; for its cyclical, dynamic interaction; and for its phases of decision-making and action.

Synthesis of Perceived Benefits

The benefits and potential of the model far outweigh its liabilities. Through a holistic approach, it has systematically identified relevant components in a significant area where study is needed. Because it focuses on the individual and involves a myriad of variables, generalizability will be difficult, although possible. The model has potential for application to a wide variety of health-related actions; its various concepts are broad, but have been pulled together logically.

The model stimulates thinking and provides direction for research. Many hypotheses can be derived from it for study, such as:

. Individuals who regard themselves highly are more likely to be involved in health-promoting behaviours than are those with low self-esteem.

. Increased well-being and improved health status lead to more extensive lifestyle changes which the individual perceives as being more difficult to make.

. Individuals who perceive their health to be a static condition use more more health-protecting behaviours than health-promoting behaviours. Individuals who perceive that their health may be modified through their actions use more health-promoting than health-protecting behaviours.

The model also provides direction for practice. A useful theory should enable the practitioner to exert control in a situation by manipulating or influencing the major variables that are part of the theory (Mikhail, 1981). This model's orientation to such concepts as motivators, barriers, and trigger cues, and to factors in decision-making and action provide direction for encouraging health-promoting behaviour.

New Questions and Topics

Despite the logical structure of the model's concepts and statements, some questions do come to mind. Pender acknowledges the dynamic interaction between decision-making and action, but in the description of the components, it is not clear how self-esteem and self-awareness are part of the decision-making phase. The examples Pender gives portray self-esteem and self-awareness as increasing with action and leading to continued participation, rather than as being the initial motivators of participation. Further exploration is needed into the direction of influence: do attitudes precede behavioural change, or vice versa, or do they alternate?

This writer questions why it is that pender's diagram of the model displays interaction between interpersonal/situational

variables and individual perceptions, but only shows a one-way influence of demographic variables on individual perceptions. Although most of the demographic variables she lists cannot be manipulated, income and education can be.

The writer also questions Pender's statement that health threats that are relevant to health-protecting behaviours have little relevance to health-promotion behaviours (p.65). No research supports this dichotomy: in fact, research leads to the opposite conclusion (see Heinzelmann, 1970). Indeed, Pender does acknowledge that individuals who initially begin jogging because they are at risk for cardiovascular disorders (avoidance motive) may just as likely start jogging as a health-promoting (approach motive) function.

Pender claims that while the Health Belief Model has predictive potential that is useful for developing preventive behaviours, it is inadequate to explain behaviour that is directed toward health promotion. Although she states that the HPBM is a complementary conterpart, there is no further development of that relationship and no indication as to how the models can link together. To fulfill this need for a link between the two models, the writer attempted an elementary conceptualization of the models in interaction, which is displayed in Figure 2. This link would provide for the interaction between health promotive behaviours that are a result of avoidance motive and those resulting from an approach motive. It enlarges the modifying factors, combining those in the Health Belief and Pender's model. It also illustrates the linkages among all components in a cyclic, interacting manner.

Summary and Conclusion

This paper has analyzed the Pender model of health promotion in terms of its components, research support, benefits, and missing linkages. The model has potential for helping health professionals to assist people in wellness orientation.

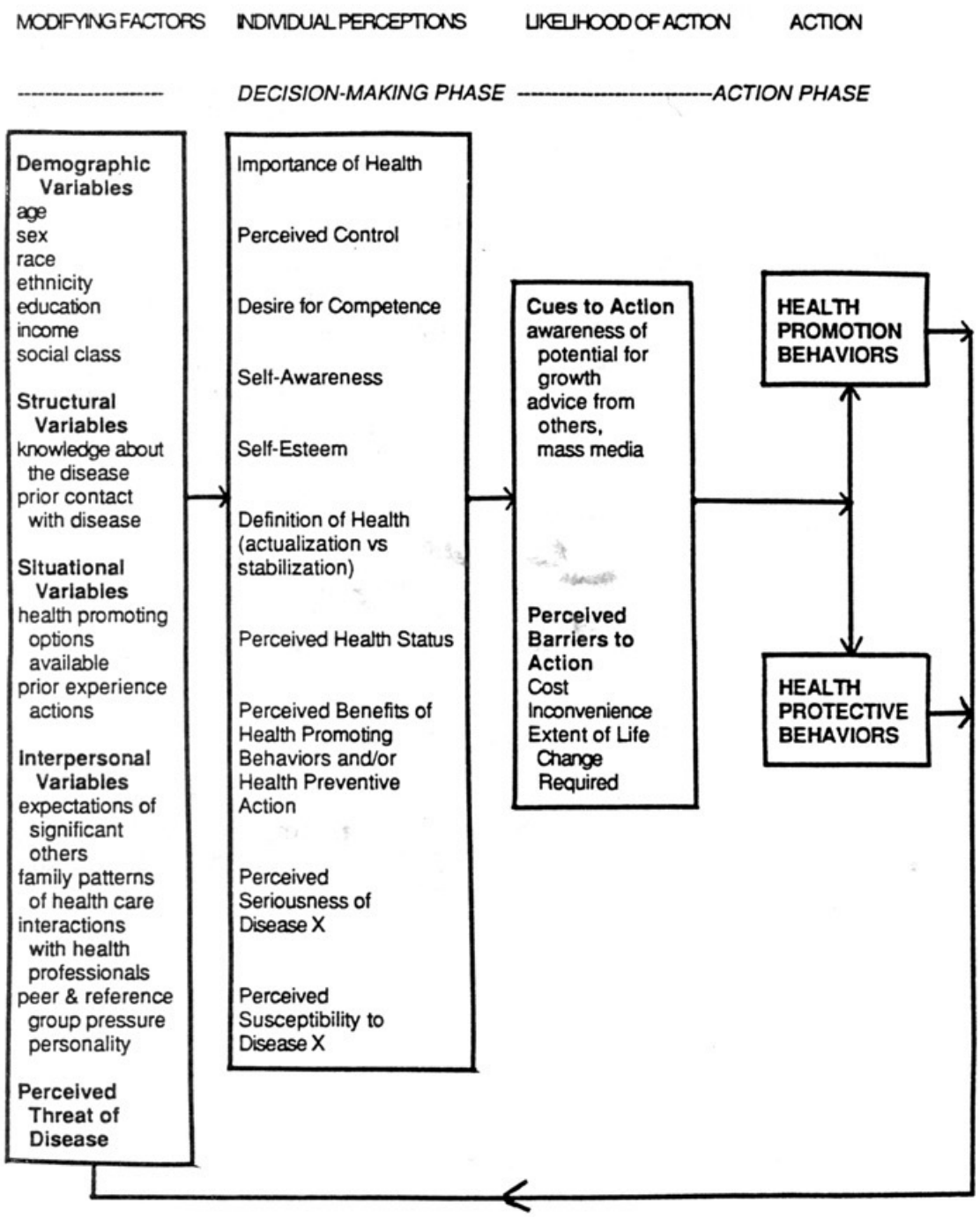

Figure 2. Hilton's perception of interaction between health promotive and protective models

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RÉSUMÉ

Analyse du modèle de comportement de Pender favorisant la santé

Le modèle de comportement de Pender favorisant la santé, qui est la contrepartie des modèles de comportement visant la protection de la santé, met l'accent sur les conditions et les aptitudes à prendre rapidement des mesures pour améliorer la santé et le bien-être. On étudie le modèle afin de s'assurer s'il est logique, vérifiable, utile, et généralisable. L'interaction entre les modèles favorisant la santé et les modèles protégeant la santé se reflète dans la description que l'auteur fait d'une nouvelle conceptualisation qui incorpore les deux modèles.

ADOLESCENT COMMUNICATION: UNDERSTANDING IT'S DYNAMICS AND FOSTERING IT'S DEVELOPMENT

M. Judith Lynam . Louise Tenn

The manner in which people communicate influences the nature of the interpersonal relationships that they are able to establish. Although the processes involved in establishing interpersonal relationships and in developing communication skills are lifelong, these processes are particularly important in adolescence.

During adolescence, teenagers are not only expected to expand the number and variety of their social contacts, but to negotiate a change in the nature of the contacts as well. Relationships with parents and peers, for example, must alter if the adolescent is to succeed in accomplishing the developmental tasks of this age group (Duvall, 1971).

Successful negotiation of changes in interpersonal relationships places a greater demand on the teenager's ability to communicate. As Newman (1976) indicates, "One would expect that the adolescent becomes increasingly skillful at conveying his meaning and at expressing himself under a variety of environmental conditions" (p.129).

Review of the Literature

Although communication, in general, has been the focus of much research, little attention has been paid to adolescent communication. The studies we have located have had a variety of foci. Newman (1976) examined the adolescent's ability to establish closeness with others or to use language effectively, and then related it to the adolescent's level of cognitive maturation. Tuss and Greenspan (1979) identified the positive effect of one style of communication on the aquisition of values by a group of teenagers.

In an extensive study in the Isle of Wight, Rutter (1979) compared teenagers without psychiatric problems to those with psychiatric problems, and identified difficulties with communication as one characteristic of the latter group. The incidence of communication problems among the adolescents that he studied was approximately 15% in the non-psychiatric population, but almost 50% in the population of teenagers with a psychiatric disorder.

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Further studies provide evidence that an improvement in the communication skills of teenagers who were receiving treatment for anti-social behaviour is associated with more positive outcomes in therapy. Alexander and Parsons (1973), for example, demonstrated that improvement of family communication skills in a population of delinquent adolescents was associated with a decrease in runaway and truancy incidents. O'Brien (1963) reported positive outcomes in therapy when the importance of interpersonal relationships was emphasized.

Although these studies give us some understanding of the importance of effective communication to individuals and provide descriptions of patterns of communication, we do not have an understanding of teenagers' reasons for communicating as they do. It has been argued that communication plays an important role during the period of adolescence, and there is some research that suggests that increasing the effectiveness of communication may contribute to better therapeutic outcomes. However, no studies seeking teenager's descriptions of the meanings that communication patterns hold for them, and how that meaning is assigned, have been located.

This study then, was designed for three purposes:

1. To describe the communication behaviours of teenagers in interaction with other people in a residential treatment facility;

2. To elicit teenagers' perceptions of the patterns of communication used in the setting; and

3. To describe the meaning that was assigned by the teenagers to communication behaviours.

Theoretical Framework and Method

The theoretical framework for the study was developed using Kleinman's (1978) explanatory model. The model conceptualizes the health care system as being a cultural system composed of three sectors: professional, popular, and folk. Individuals in each sector are depicted as having their own explanations of health, illness and health care. Although there is overlap between the different sectors, or domains of care, each sector has its own explanation for, and understanding of, health related concerns:

> From the standpoint of our model these clinical realities are culturally constructed. They differ not only for different societies, but also for different sectors or arenas of the same health care system, and often for different agencies or agents of care in the same sector. (Kleinman, 1978, p.87)

Kleinman (1978) proposes that, by understanding the perceptions of individuals in each sector, one may bridge gaps in understanding between sectors more effectively.

The kinds of questions derived from this perspective are best addressed using the phenomenological approach (Merleau-Ponty, 1964). The researcher approaches the setting with the aim of understanding "both the cognitive and the subjective perspective of the person who has the experience, and the effect that perspective has on the lived experience or behaviour of that individual" (Morris, 1977). The goal of the method is an accurate description of the experience or phenomenon under study (Omery, 1983).

Understanding the client's per6pective 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. To take direction from clients, however, one must seek to understand the meaning and value clients attach to events, and to describe how this influences their behaviour (Lynam, 1985).

By studying communication in a social context and by exploring, with teenagers, their understanding of the environment, we hoped to gain insight into the adolescents' understanding of communication and how it subsequently influences the pattern of communication that they adopt.

Data collection and analysis

The participants were residents in two child care units of a residential treatment facility. The facility was developed to treat behaviour disorders of adolescents who were described as being delinquent, having school or family problems, being unmanageable, or having suicidal potential. The facility's two major goals for the adolescent residents focussed on developing interpersonal relationships and on increasing their level of personal responsibility. The study setting was chosen because the staff recognized the importance of communication skills in developing and maintaining interpersonal relationships. As well as having specific child care workers or nurses assigned to work with them, the teenagers were involved in school, athletic, and arts and crafts programmes.

The data were collected over a period of twelve weeks, for two groups of teenagers. The study complied with all the requirements set out by the University's ethics committee, and by the agency's research committee. Prior to obtaining written consent from the teenagers, from their parents and guardians, and from staff members, information meetings were held with groups of teenagers and with staff to explain the purpose of the study and to explain the researchers' roles in the setting. Twenty adolescents participated; 13 boys and 7 girls, each between the ages of 12 and

17 years. The length of stay of each participant, at the time of the study, varied from newcomer to 13 months. During the data collection period, each of two researchers spent an average of 14 hours per week in the setting, participating with teenagers and staff in daily planned activities.

When conducting qualitative research of this nature, use is made of "all data presented or made available in the research experience.... The data are reported in the natural language of the event" (Omery, 1983). In the study being reported here both observation and interview data were collected.

Interviews with individual teenagers were used to elicit their perspectives on the observations made in the setting, and to validate the accuracy of the impressions formed by the researchers. Formal interviews were audio-taped, and later transcribed. As well as assisting the researchers in the provision of an accurate description of events, the interviews were also used to ensure that the descriptions reflected the meaning that was assigned to events by the teenagers.

The purpose of collecting observational data was to record informal verbal exchanges between the teenagers and others in the setting, and to describe the context in which either observed or audio-taped interactions occurred. By recording observations, we were able to document behaviours associated with communication. Observations were collected by audio-video taping group sessions, or by keeping hand-recorded notes.

As data were collected, the researchers met to review transcripts and to discuss emergent themes. Subsequent interactions in the setting were used to validate impressions and to clarify conceptualizations that were being developed. The concurrent collection and analysis of data acts to ensure that conceptualizations are grounded in the data.

Presentation of the Findings

As has been mentioned earlier, staff of the facility worked towards having the teenagers develop and maintain interpersonal relationships. As we explored the teenagers' experiences in the setting, it became evident that when they first began treatment they felt as if they had been immersed in a new environment where expectations and practices were unfamiliar. All of the adolescents recounted events and personal experiences that helped them as they "learned to get along" with others in the setting.

As the teenagers were observed and interviewed, they helped us to understand their ideas about the role that communication skills played in their treatment. Two themes emerged: they have been labelled "understanding" and "relevancy". Their relationship to the facility's goals and expectations will be explored.

One of the approaches used by the facility to achieve their treatment goals was to encourage the adolescents to develop skills in communicating. Example categories of communication behaviours that we perceived were valued in the study setting, and that were later validated with the teenagers, included: being able to express one's feelings about other persons or events; demonstrating respect for the feelings of others in the facility; and learning how to resolve conflicts or issues with others by communicating in a co-operative fashion. Such behaviours are compatible with "therapeutic communication" (Egan, 1982; Gazda, Walters, & Childers, 1975). Effective identification and management of everyday "problems" is often dependent upon being able to establish relationships, to understand others' points of view and to communicate effectively (Egan, 1982).

The performance expectations that the staff held for the teenagers in the study included demonstrating they were able to work with others on tasks; to resolve conflicts with others or make requests by "talking things through", either in groups or in one-to-one encounters; and to plan and account for daily activities. Such behaviours might be demonstrated by teenagers who were learning to get along with others.

The "understanding" component

The first theme related to developing communication skills that will be explored is "understanding". This theme, as it has been conceptualized from the study data, was developed from the teenagers' explanations of their perceptions of the communication norms of the facility. The teenagers' "understanding" included being aware of the conditions that made desired communication behaviours situationally appropriate, and their ability to articulate comprehension of the purpose of the communication norm.

One goal of interactions in the study setting was to encourage individuals to speak up about their needs, and to exercise responsibility towards one another. One way of doing this was to "support" one another. This following account illustrates one teenager's understanding of this goal.

> When we say, "I need support," it's an easier way to say help. It might mean different things to different kids. Such as, "I want some time with staff, or don't bother me at this time." Kids and staff have to figure out what the person means. But at least they know if people ask for support they need help, or something or other.

This account demonstrates that the teenager has not only developed an understanding of the meaning of a key word in the setting ("support"), but also of the broader principle that the word may hold a somewhat different meaning for each individual. In order to understand exactly what a person is saying, it is necessary to

clarify or check out the meaning of a message with the sender.

As new persons in the setting, we tried to make sense of the rules of communication that were operating. So did the teenagers. The next account provides insight into the process of developing an understanding of communication norms.

> Well, in the beginning you, sort of, just try to say things that you hear other kids say; but just enough so it's okay for you. You try to play the game. But then they (the staff and kids) put some pressure on. I don't know whether you noticed a change; it takes quite a while. But that's what it's all about. Coming out with your feelings and working on things that are inside you. Taking a risk and working on things that are important to you.

The account depicts one teenager's explanation of expectations with regard to speaking in a group. It also describes another communication behaviour valued in the setting: expressing feelings to others. The teenager points out that his learning to adopt the expected behaviour pattern took time. There were two components to this. First, learning behaviours that are appropriate or expected, and secondly, developing an understanding of when and why the staff might have such expectations. As well as perceiving that his communication behaviours had changed, the teenager also perceived that this was beneficial and, therefore, he placed positive value on this expected behaviour.

The relationship of the "understanding" to subsequent communication behaviours becomes more clear when one reflects upon the accounts. The adolescents stated that, initially, they tended to copy the behaviours of others. There was a structural element to deciding what was appropriate to say, and no corresponding understanding of why people were being asked questions in the way that they were or why certain information was being solicited. Several teenagers expressed initial frustration at not having a specific set of rules or precise instructions to follow. However, once they developed an understanding of the principles underlying the expectations or the norms of communication, they were more able to adapt their behaviours to changing situations.

In the following example one adolescent explained how he came to understand why the staff would assume from a teenager's behaviour that there was something going on that should be talked about.

> Once they (the kids) do start talking, then everybody gets a clear understanding of what's going on. Like today, he was running around and disrupting meals and stuff. Well there must be something going on; that's what it tells me. In group we clear out the issues, you know, make sure everybody understands why a kid is feeling a certain way.

Understanding in this case was achieved by observing others and by reflecting upon personal experiences.

The "relevancy" component

Upon validating observations and talking with teenagers about their ideas concerning expectations in the setting or the meaning that observed interactions had for them, we identified a progression in the adolescents' adoption of the communication behaviours that were desired by the staff.

For example, while the teenagers might recognize the merits of modifying communication behaviours while in the setting, in order for the change to become permanent there was also a need for them to perceive the communication behaviours as applicable to their experiences outside of the setting.

The "relevancy" component of the communication process identifies the adolescents' perceptions of the value and relevance, or lack of relevance, of the communication norms to their own situations. It is characterized by their varying expressions of desire or lack of desire to modify communication behaviours. In the previous account the adolescent indicated that he perceived that the expected communication behaviours were beneficial to him. The following examples also illustrate relevancy: "What they are trying to teach us here is a middle class way of talking. It would be crazy to use that at home," or, "what family sits around and asks each other how they're feeling today? I mean you just don't do that at home." It is evident that those making the statements do not believe that the communication norms in the facility (consulting with others, demonstrating concern for others by asking how they are feeling) have relevance outside the setting. Nonetheless, the adolescents may be able to modify their behaviours to meet the expectations within the setting as is evident in the following account:

Researcher:	Do you notice any changes in yourself since you've been here?
Adolescent:	Yes, I'm more careful about what I say.
Researcher:	Why is that?
Adolescent:	You get put in your room a lot.
Researcher:	For.....?
Adolescent:	For mouthing off.
Researcher:	So there are clear rules about what can be said?
Adolescent:	Yes.

For the teenagers in these facilities such perceived norms as "don't mouth off" or the constructive resolution of conflicts may eventually become "relevant" by being associated with a restriction in activities. The teenager identifies a decision to adopt new

communication behaviours when in the setting. Staff were able to provide adolescents with incentives for modifying their behaviours by virtue of their relationships with teenagers, and by means of their ability to award privileges.

The teenagers' accounts indicated that relevance could also be reinforced when personal satisfaction resulted from "taking a risk" by communicating in the manner valued in the setting.

> I thought I was the only kid in here with my problem. I found every kid in here has experiences that leave them feeling angry and alone.... A lot of times people won't talk about things because they're afraid of how people would react.... I'll take a risk, I don't care as long as I get it out and people know what I'm up to....

In this account the teenager indicates that the benefits of communicating his feelings outweigh the risks.

In summary, as the study sought to explore communication behaviours from the teenagers' perspectives, we gained insight into the role that communication played with regard to how the adolescents learned to get along with others in the setting. Two themes, understanding and relevancy, were identified. We would now like to discuss how nurses and others working with adolescents might modify their own interactions in order to foster the development of more effective communication skills by teenagers.

Discussion

What direction does the conceptualization proposed herein provide for nursing? Several points may be made in relation to the goals of our interactions with adolescent clients and how we interact with them.

The study's findings urge us to articulate clearly our goals or purposes in interacting. The teenagers' accounts indicated that being able to articulate the "norms" or principles guiding communication behaviours involved more than observing role-modelled communication behaviours. It seems evident that developing an "understanding' requires repeated role-modelling in a variety of contexts. The findings also indicate that learning would be facilitated if the underlying principles (i.e. why we discuss feelings or values or why we think it is important to respect others' feelings) are made explicit, and are used to reinforce role-modelling. Effective communication and role-modelling by the staff will speed up the process of developing the understanding required to demonstrate the behaviours. An approach such as the one just described could also identify and reinforce behaviours that an adolescent is using that are valued and/or desired.

It is our contention that this conceptualization gives direction to

the manner in which we interact with adolescents. The theoretial framework for the study directed us to elicit the teenager's perspectives; it assumes that there may be differences between how the adolescents view a topic, such as communication, and how the staff view the same topic. It was argued that there is a need to be aware of the teenager's perspectives on communication, in order to provide care in a manner that they perceived as being meaningful. This argument is supported by the study's findings. There were discrepancies between the staff's and teenager's interpretations of the same events. The accounts indicated that teenagers did not always understand or agree with the purpose of interactions or the value of adopting specific communication behaviours.

It was clear that in this setting, as in any other therapeutic setting, certain communication behaviours were valued. Such values, over a period of time, become the assumed knowledge of the staff, and set the everyday standard of care we are providing. This study supports the premise that we cannot presume to share understanding with our clients. We also need to build into our interactions behaviours such as validating affect and clarifying the intent of messages received and sent. There appears to be a need to ensure that information or expectations are conveyed to those in the facility in a process-oriented manner. In this way, we may be able to bridge the gap between what the professionals in the setting view as desirable behaviours and the meaning the same behaviours hold for the teenagers.

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RÉSUMÉ

La communication a l'adolescence: Comprendre sa dynamique et favoriser son développement

L'importance de la communication dans l'établissement et le maintien de rapports interpersonnels efficaces est bien documentée. L'adolescence est vue comme une période au cours de laquelle l'établissement des rapports interpersonnels et le développement des aptitudes à la communication jouent un rôle particulièrement important. Cette étude qualitative avait pour objectif d'explorer les schèmes de communication utilisés par les adolescents dans un service résidentiel de traitement. En participant aux activités quotidiennes de l'établissement, les chercheurs ont recueilli des données sur deux groupes d'adolescents pendant une période de douze semaines.

Les données comprennent des notes prises à la main en observant des interactions, des bandes magnétiques d'entrevues entre les chercheurs et chacun des adolescents ainsi que des bandes magnétoscopiques d'interactions de groupe. La cueillette des données et leur analyse se sont faites simultanément. Des données ont été examinées par les chercheurs et les conceptualisations de départ ont été mises au point. Des entrevues et des observations subséquentes avaient pour but de préciser et de justifier les conceptualisations auprès des adolescents.

Tout en étant observés et interviewés, les adolescents nous ont aidés à comprendre leurs idées sur le rôle de la communication et sur le rôle que jouait l'acquisition d'aptitudes à la communication dans le cadre de leur traitement. L'analyse des données a fait apparaître deux thèmes que l'on a appelés la "compréhension" et la "pertinence". La compréhension est caractérisée par la prise de conscience des normes de communication du milieu qui se manifestent chez l'adolescent. Pour vérifier la pertinence, l'adolescent a examiné la compatibilité entre les comportements de communication souhaités et leur propre situation. Les répercussions de ces observations pour les infirmiers font l'objet d'une discussion.

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