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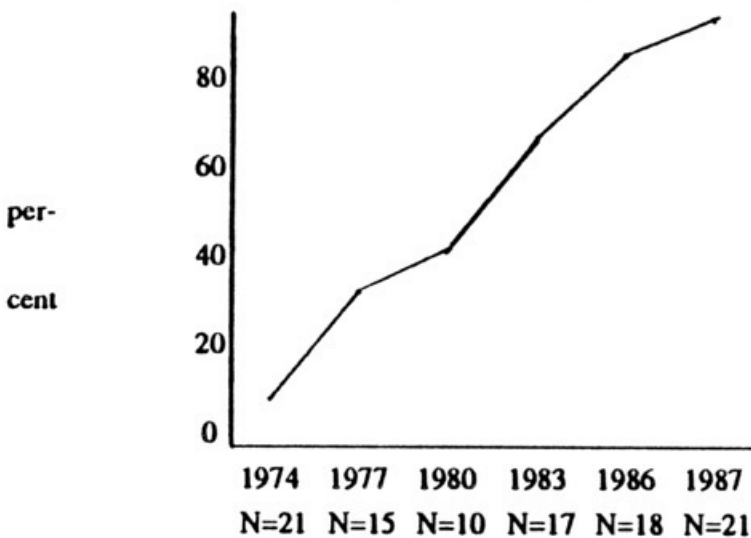
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XX EDITORIAL

The nursing profession has worked to achieve the identity of a scholarly research discipline, while maintaining the traditional roles of educators and practitioners. This development has been represented in the content and presentation of *Nursing Papers*. This is the twentieth anniversary of the founding of this publication, in 1968, by Dr. Moyra Allen. Under her editorship and, more recently, that of Dr. Mary Ellen Jeans, the journal has developed into the only refereed publication in Canada that is devoted almost exclusively to research in the field.

An examination of the contents of the journal over this twenty-year period shows that it has maintained a geographical balance of authorship: 42% from provinces west of Ontario, 44% from the East and 14% from the United States. Our subscribers are equally distributed in Canada, and we have a considerable international readership.

Nursing Papers has published a wide cross-section of nursing literature. In the early years, most of the articles were theoretical or position papers, often dealing with issues in education. At present, virtually all are research papers: either research reports or discussions of methodology.



Research papers as percentage of total contents

This trend has paralleled the expansion of research skills and greater success in obtaining funding. There has been a dramatic increase in the proportion of the profession that is doctorally prepared and this, too, has been reflected in *Nursing Papers*: five times as many of the authors we now publish, have PhD's as did ten years ago.

In a world where existence and growth are often linked to shifting political affiliations or tenuous financial patronism, we strive to maintain objectivity. The journal does not reflect the views of any particular organisation and has not been influenced by the profit motive. We encourage debate in the form of letters to the editor and by soliciting responses to articles on issues of concern to the profession. An increasing focus on research has been our only prejudice.

The exactions of time and energy that the production of a journal such as this requires have been met with generosity. Our manuscript reviewers have been particularly helpful. They have undertaken this serious commitment on top of very busy work schedules. It takes time to do a conscientious evaluation and the comments our reviewers forward to the authors have generally been valuable.

The outgoing associate editors have devoted five years of concern and informed opinion to *Nursing Papers*; we thank them for their dedication. This issues introduces four new associate editors from across Canada. We welcome them to the Editorial Board and look forward to their contributions.

One important individual in this saga is Mrs. Edith Ann Garneau. Edie Ann, who has now retired, was involved in *Nursing Papers* for most of these first twenty years. Through an ingenious combination of charm and coercion, she was able to build an amorphous subscription list into a solid constituency. It is on this kind of extra effort that the journal has survived.

In the course of twenty years the journal has undergone changes in production, presentation and character. *Nursing Papers* is in the technological vanguard. We use a computerised desk-top publishing system and receive articles on diskette and via modem. At the same time, we have been able to maintain an individuality that is not common among research journals. Many of these journals have reduced style and presentation to something that might result from the fusion of a word-processor with a food-processor - a bland, homogeneous substance that is conveniently produced. This technological upgrading has enabled us to reduce the cost of production per article. However, while there were four articles published in 1971, for instance, we now publish at least twenty articles per volume - twenty percent of them in French. This has meant increases in labour and expense, but ones necessary to deal with the increasing number of submissions (this number continues to rise by approximately 15% each year).

The Managing Editor is responsible for the refinement of all aspects of the publication. The cooperation I receive from members of nursing faculties is rewarding. There is none of the pervasive indifference or petty, debilitating posturing that often occur in academic environments. No one has felt that they are too important or busy to be of assistance to *Nursing Papers*.

Now that we have reached the twenty-year mark of what should be a long-term investment by the profession in its own future, we have reidentified our role. The changes in orientation, presentation and our goals for the future have motivated us to modify the name of the publication in order that it describe the character of this unique journal more percisely. *Nursing Papers* is no longer an adequate title; it does not reflect nurses' growing role as researchers nor our own concentration on research.

Nursing is establishing itself, not just in the eyes of those in the profession, as a field of scholarly research. However, the credibility and validity of investigations by nurse-researchers is continually being evaluated. Fundamentally, the quality of this work is represented by what is published. *The Canadian Journal of Nursing Research* will continue to be a forum for reporting original research and to be a resource for the profession.

DREW FERGUSON

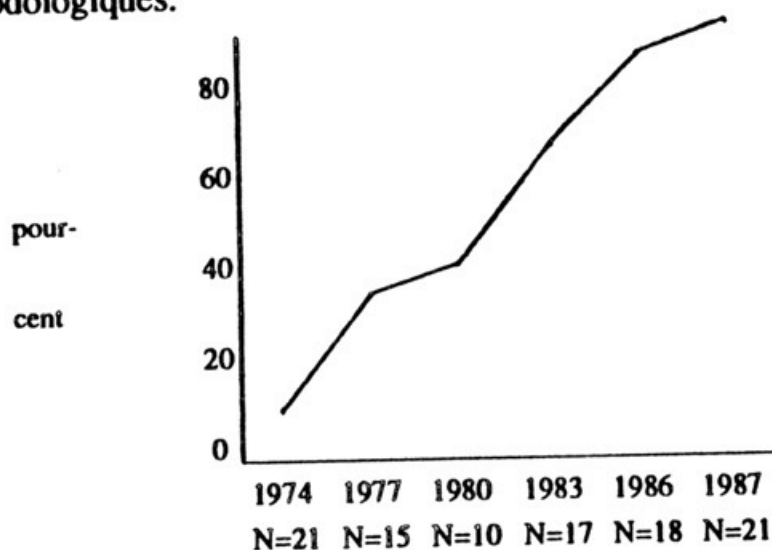
We thank Nancy Grant and Beverly Brown for their work in compiling figures on the content of *Nursing Papers* over the last 20 years.

XX ÉDITORIAL

La profession infirmière a oeuvré pour se doter d'une identité de recherche scientifique tout en maintenant son rôle traditionnel dans l'éducation et la pratique clinique. Ce développement a figuré dans le contenu et la présentation de *Perspectives en nursing*. Nous célébrons aujourd'hui le vingtième anniversaire depuis la fondation de cette publication en 1968 par le docteur Moyra Allen. Sous sa direction et plus récemment celle du docteur Mary Ellen Jeans, la revue est devenue la seule publication au Canada vouée presque exclusivement à la recherche en sciences infirmières et dont le contenu est examiné et jugé par des experts.

En parcourant les numéros de la revue au cours de ces vingt années, on s'aperçoit qu'un équilibre géographique des auteurs a été maintenu: 42% provenant des provinces à l'ouest de l'Ontario, 44% de l'Est et 14% des Etats-Unis. Nos abonnés sont également répartis entre les diverses régions du Canada et nous avons aussi une liste impressionnante d'abonnés internationaux.

Perspectives en nursing a publié un vaste échantillonnage de littérature sur les sciences infirmières. Dans les premiers numéros, la plupart des articles parus se rangeaient plutôt du côté théorique ou positionnels, traitant souvent de questions d'éducation. Aujourd'hui, presque la totalité des articles sont des textes de recherche: soit des rapports de recherche, soit des discussions méthodologiques.



Textes de recherche - % du contenu total

Cette tendance a progressé de pair avec le développement de connaissances chez les chercheurs, qui réussissent de mieux en mieux à se faire subventionner. La proportion des professionnels ayant une formation doctorale a grimpé de façon dramatique; ceci aussi a été démontré dans

Perspectives en nursing: parmi les auteurs que nous publions, il y en a aujourd'hui cinq fois autant qui détiennent un doctorat qu'il y a dix ans.

Dans un monde où l'existence et la croissance sont souvent liées à des affiliations politiques changeantes ou à un appui financier des plus faibles, notre but est l'objectivité. La revue ne reflète pas les opinions d'une organisation quelconque; elle n'est pas motivée non plus par un but lucratif. Nous encourageons le débat sous forme de lettres adressées à la rédaction et nous invitons les réactions aux articles qui traitent de questions importantes pour notre profession. De nous concentrer de plus en plus sur la recherche a été notre seul préjugé.

Les exigences en temps et en énergie que demande une revue comme la nôtre ont été rencontrées avec générosité. Les critiques des manuscrits ont été tout particulièrement serviables. Ils ont accepté ce sérieux engagement par-dessus et en plus de leur lourde charge de travail. Effectuer une évaluation consciencieuse demande des heures de travail et les commentaires que fournissent les critiques aux auteurs sont généralement très utiles.

Les rédacteurs associés sortants se sont voués pendant cinq années à donner de leur temps et expertise à *Perspectives en nursing*; nous les remercions de leur dévouement. Dans le présent numéro, nous vous présentons quatre nouveaux rédacteurs associés de diverses parties du Canada. Nous leur souhaitons la bienvenue au conseil de rédaction et nous anticipons avec plaisir la contribution qu'ils nous apporteront.

Dans l'histoire de la revue, nous retrouvons une personne d'importance en particulier, c'est Madame Edith Anne Garneau. Edie Anne, qui a récemment pris sa retraite, a été impliquée dans *Perspectives en nursing* durant la plus grande partie de ses vingt premières années. Par le biais d'un mélange ingénieux de charme et de pression, elle a réussi à transformer une liste d'abonnements informe en banque de noms solide et continue. C'est grâce à ce genre de générosité que la revue a survécu.

Au cours de ses vingt années d'existence, la revue a vécu des changements de production, de présentation et de caractère. *Perspectives en nursing* est chef de file dans le domaine technologique. Nous utilisons un système d'édition informatisé sur disquette par modem. En même temps, nous avons pu maintenir une individualité peu commune dans une revue scientifique. Bon nombre de ces revues ont réduit style et présentation à un niveau qui pourrait ressembler à la fusion entre traitement de texte et robot culinaire - substance pâlotte et homogène de production facile. La haute technologie que nous utilisons nous a permis de réduire nos frais de production par article. Cependant, alors qu'en 1971, par exemple, nous avons publié un total de quatre articles, nous publions aujourd'hui au moins vingt articles par

volume - dont vingt pour cent en français. Cette progression a entraîné des augmentations dans la charge de travail et dans les coûts, augmentations inévitables pour accueillir le nombre toujours croissant de soumissions reçues (ce nombre continue à grimper à l'allure d'à peu près 15% par an).

Le rédacteur en chef adjoint est responsable des fins détails de chaque aspect de la publication. La coopération que je reçois des membres des facultés des sciences infirmières est très appréciée. Je n'ai pas eu de preuves de cette indifférence englobante ou de cette suffisance mesquine et maladive qu'on rencontre si souvent dans les milieux universitaires. On ne m'a jamais fait sentir qu'on était trop haut placé ou trop occupé pour rendre service à *Perspectives en nursing*.

A ce moment où nous marquons le vingtième anniversaire de ce qui représente vraisemblablement un investissement à long terme par la profession dans son propre avenir, nous avons ré-évalué notre propre rôle. Les changements survenus dans l'orientation, la présentation et nos objectifs d'avenir nous ont motivés à modifier le nom de la publication afin qu'il reflète plus précisément le caractère de cette publication unique en son genre. *Perspectives en nursing* n'est plus le titre qui lui convient; il ne reflète pas le rôle croissant que jouent les infirmiers et infirmières dans le secteur de la recherche; il ne reflète pas non plus notre propre concentration sur la recherche.

Les sciences infirmières s'établissent et ce, non seulement aux yeux des membres de la profession, comme domaine de recherche scientifique. Toutefois, la crédibilité et la validité des projets de recherche menés par des infirmiers ou infirmières/rechercheurs sont toujours remis en cause. Fondamentalement, la qualité de ces projets est représentée par ce qui est publié. La *Revue canadienne de recherche en sciences infirmières* ne cessera d'être un forum pour les recherches originales ainsi qu'une ressource essentielle pour la profession.

DREW FERGUSON

Nous remercions Nancy Grant et Beverly Brown pour la compilation des chiffres sur le contenu de *Perspectives en nursing* pour les 20 dernières années.

ASSESSING AN INSTRUMENT IN A PILOT PROJECT: THE SELF-CARE AGENCY QUESTIONNAIRE

Joan L. Bottorff

The use of sound measurement instruments and practices in nursing research is fundamental to the advancement of nursing knowledge. By using clearly developed and effective approaches to measure variables, internal validity is improved and error in investigations is reduced (Strickland & Waltz, 1986). Without this precaution, any research study is uninterpretable, and the results are questionable (Campbell & Stanley, 1963).

Increasing interest in developing tools to measure phenomena from a nursing perspective has produced an increasing number of published instruments. However, despite this effort, many tools have not been tested in a variety of settings or with different populations, and they have not been used extensively in subsequent investigations. Strickland and Waltz (1986) argue that it is inefficient for researchers to construct their own measures. They believe that progress in measurement would be facilitated if efforts were directed toward developing and testing existing instruments. Increased rigor in measurement resulting from these efforts would allow increased confidence in the findings and interpretations drawn from nursing studies.

Although reliability and validity of an instrument may have been established, it can not be assumed that these are a stable property in all situations, with all subjects. Evaluating the appropriateness of an existing tool prior to completing data collection is, therefore, an important step. Instruments that fit the theoretical framework and design of the study can and should be assessed in a pilot study (Van Ort, 1981). Using this approach, reliability and validity of the instrument can be established and measurement problems identified. If the instrument is found to be unsuitable, efforts to design a new instrument are then warranted.

The pilot study has been described as one of the most important steps in the research process (Van Ort, 1981). Although it is more limited in scope and

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sample size than the major study, the pilot study should be conducted with just as much care and precision. A pilot study provides an important opportunity for researchers to determine whether or not the proposed design and method of a major study will yield appropriate data for the research question. Ultimately, the results can prevent problems in the major project.

The contributions that pilot studies can make in evaluating the potential of existing nursing measures to collect data in other settings or with other populations have not been clearly described. To illustrate the process of evaluation of a tool prior to its use in a major study, a description of the author's experience in piloting an instrument designed to measure self-care agency will be presented.

Background to the major study

Many nurses who are involved with older adults in nursing homes are now incorporating the promotion and support of self-care practices as an important part of their nursing interventions. In planning an investigation to see if these interventions were effective in increasing ability to care for themselves, instruments to measure changes in self-care abilities were sought. As Orem's Self-Care Model (1979, 1985) provided the theoretical framework for the study, persons were viewed as possessing self-care agency. Orem refers to self-care agency as a "learned human capacity" for engaging in self-care, which includes certain human powers that must be existent or capable of being put into operation before an individual can engage in self-care activities. The Nursing Development Conference Group (Orem, 1979) theorized that self-care agency consists of ten "power components" or prerequisite capabilities for engaging in self-care operations. As such, the ability to perform actions to meet individual health needs can vary at different times, according to the values of each of the ten components. Assessment of self-care agency may be more complete if objective assessments of functional ability are combined with an assessment of the patient's own perceptions of self-care agency (Kuriansky, Gurland & Fleiss, 1976); therefore, an instrument was sought to measure older adults' perceptions of self-care agency.

The only instrument available that measured all ten power components of self-care agency was the Perception of Self-Care Agency Questionnaire (PSCAQ) developed by Bickel and Hanson (1981). This questionnaire consists of 53 items, of which 32 items are positively worded and 21 are negatively worded (i.e., reversed items). Subjects are asked to respond to each item using a five-point Likert Scale that ranges from "never like me" to "always like me." Examples of the kinds of items subjects are asked to respond to include:

"I can select what is important to solve a problem."

"I forget what I've learned that will help me take care of myself."

"I have good muscle strength."

"It doesn't matter to me if I take care of myself or not."

"I have the abilities I need to care for myself."

Validity and reliability estimates for the PSCAQ were reviewed to examine the potential usefulness of this instrument with older adults in nursing homes. No investigations were found that used this instrument specifically with this population. However, estimates had been reported for non-hospitalized adults. Some individuals from senior citizen groups were included in this research, but the proportion of individuals over 65 years making up the sample was not reported.

Content validity for this questionnaire was established with the rating of an item pool by five experts in self-care deficit theory (Hanson & Bickel, 1985). On the basis of their evaluation, 120 items were selected and tested in a pilot study. Items were selected for a reduced form of the questionnaire using item correlations and item standard deviations. Results of a second pilot study, which included 100 persons of both sexes who were over the age of 21 years and were not hospitalized, found the 53-item questionnaire internally consistent with an alpha coefficient of 0.93. The instrument includes ten sub-scales, each measuring a different power component of self-care agency; as such it is unusual that the alpha coefficient is this high. The authors also report that alpha coefficients for statements representing each of the ten power components indicate internal consistency when the instrument is used with adults, although actual coefficients were not reported. These results are not consistent: a multidimensional instrument cannot be internally consistent as a whole, and with respect to its sub-scales, at the same time.

The factorial structure of the PSCAQ was also assessed with a sample of 456 healthy adults (Hanson & Bickel, 1985). The mean age of the sample was 37.9 years (S.D.=14.6 years). Five factors with eigenvalues greater than 1.0 were revealed, accounting for 86.4% of the variance. The factors were identified as cognitive, cognitive limitations, motor, motivation and repertoire of skills. Hanson and Bickel report that these factors corresponded to all but three of the power components of self-care agency, which included the ability to maintain attention and exercise vigilance, the ability to prioritize self care actions and the ability to integrate self-care actions within one's life. While the factors revealed do not completely mirror the ten power components of self-care agency, they are consistent with the construct of self-care agency. However, the emergence of Factor 2, termed "Cognitive Limitations", suggests that the technique of asking questions, rather than cognition, may be a factor being measured by the questionnaire. The fact that seven negatively-worded items that were related to cognitive abilities clustered to form this factor adds further weight to this position.

Despite these obvious limitations, the tool appeared to have face validity, from the researcher's perspective, in that it attempted to assess all ten components of self-care agency, and it was decided to pursue evaluation of the appropriateness of the PSCAQ with older adults in a pilot study. If the instrument showed potential for use with older adults, further testing and development would be warranted, and the instrument would be selected for use in the proposed study.

The pilot study

The purpose of this pilot study was to evaluate the appropriateness of the PSCAQ with older adults residing in nursing homes. Efforts were directed at determining whether the instrument would yield data that would be useful in testing hypotheses and in identifying measurement problems related to characteristics of the instrument or the measurement process. The pilot sample, setting and methods were selected to reflect those of the proposed major study. Weakness detected could, therefore, be expected to be representative of the target population and setting for the major study.

Method

A convenience sample of 34 nursing home residents who were 60 years or older, able to speak and read English, able to give informed consent and who had no serious psycho-geriatric symptomatology were asked to participate in this study. Seven residents meeting the study criteria refused to participate, leaving a study sample of 27.

Each subject was given instructions as to how to complete the PSCAQ. For the 21 participants who indicated a need for assistance, the questionnaire was administered in an interview format with the researcher reading each question to the subject. Some guidance was given to help subjects choose an appropriate response to negatively worded items when they understood the question but had difficulty choosing a correct response. Following completion of the questionnaire subjects were interviewed to obtain their reactions to it. Comments of subjects who responded to the items in an interview format were also recorded.

Results

Sample

The mean age of the sample was 78 years, with ages ranging from 63 to 94 years. Seventy percent of the group was female. The largest proportion of subjects (38.5%) had resided in this nursing home for less than one year.

Seventy-four percent of the subjects had not graduated from high-school, with two-thirds having completed less than nine years of schooling.

Data yielded by the Perceptions of Self-care Agency Questionnaire

A complete description of older adults' perceptions of self-care agency was not obtained with this measurement tool as many sub-scales included items that respondents found difficult to answer or understand. Only four of the 27 participants were able to complete all 53 items of the PSCAQ. Therefore, it was evident that, if this instrument was used in the main study, little usable data would be obtained.

From the limited data provided by the PSCAQ and subjects' comments prompted by the items of this instrument, several observations were made. Some components of self-care agency appeared to be more important than others for these individuals. Not surprisingly "one's ability to move body parts" was very important, and, for many, it was a major factor determining the amount and kind of assistance required. However, respondents' perceptions of their abilities or desires to participate in determining the most appropriate kind of assistance required varied greatly. Of less importance for many was the ability to reason or make decisions, especially if they viewed "caring for themselves" as something they had done automatically for years. Several who considered themselves "capable of solving problems and making decisions" (related to self-care) believed that nursing home staff did not recognize these abilities. Losses of ability to care for themselves associated with advancing age or health problems were clearly recognized and, in some cases, expected. For some, this denoted a need for increased assistance; for others, it denoted a need for new skills. Confusion among ability, needs and desires was often evident. For example, some patients, who clearly wanted to be involved in their own self-care, described themselves as capable of caring for themselves despite clearly visible physical handicaps that would suggest otherwise. On the basis of these observations, it appeared that perceptions of self-care agency among the elderly can vary considerably and may be useful in explaining or predicting their participation in self-care activities. However, the PSCAQ, in itself, was not sensitive enough to identify these differences.

Problems in measurement

During the process of administering this questionnaire, several problems were identified in relation to measuring self-care agency using the PSCAQ. Problems encountered related to comprehensibility, accuracy and administration of the instrument. Each of these problems will be discussed in further detail, concluding with opinions shared by the respondents concerning the instrument as a whole.

Comprehensibility. In four of the ten sub-scales, less than 50% of the sample completed all items. Words and phrases, such as "signal" and "messages from my body," were unclear to many. At other times, the entire question was found to be vague. For example, 13 subjects were unable to understand the item, "When solving a problem my thinking is not directed by the type of problem I have" (#48). Twelve subjects were not able to answer question #14, "How I think through a problem is influenced by the type of problem I have," or question #32, "Other aspects of my life do not fit in with things I do to take care of myself." At best, in two sub-scales, 88% and 85% of the sample were able to complete all items.

Accuracy. When subjects encountered items they clearly understood, they often had difficulty selecting a response that accurately reflected their ability to take care of themselves. For example, some respondents had difficulty choosing a response to items such as "I can make my body and limbs move in order to care for myself." When their legs were stiff or not functional and their upper body was fine, none of the response categories accurately described their situation. Other items were problematic in that they did not allow subjects to take into consideration factors they believed to be important in influencing their ability to take care of themselves. For example, in response to the statement, "I cannot do all my self-care because I don't have enough skills," several respondents indicated that it was not their level of skill but rather their disability (e.g., arthritis) that prevented them from doing their self-care. They believed they had the necessary abilities or skills but could not use them. The different approaches subjects took to handling these items served to distort further this measure of self-care agency.

The accuracy of the PSCAQ was also threatened by the occurrence of double-negatives in reversed items. Determining an appropriate response to these items when subjects believed the opposite to be true was extremely difficulty for most.

Administration. Reviewing response categories for each item proved to be an unwieldy repetitive and awkward task for both subject and interviewer. It was noted that a majority of respondents found it easier to remember and use the response categories if they were shortened to just one word, for example, "sometimes" instead of "sometimes like me." This facilitated memorization of response categories and also provided a more appropriate response to items framed in the first person, as found in this questionnaire.

Subjects' opinions of the PSCAQ. Opinions expressed about the questionnaire suggested that polite subjects thought it was "thorough," "not too personal" and "useful" (n=7) but that it was hard to understand (n=9). Six of the 27 respondents thought that the questionnaire was too long. The other 21 respondents believed the length to be "about right". One subject indicated it

was necessary to have a questionnaire of this length to "get at the problem deeper". Another suggested that the length of the questionnaire was not a problem because he had "lots of time". Respondents took 20 to 60 minutes to complete the questionnaire. For many subjects, a longer administration time was necessary because they requested that items be repeated several times as they struggled to understand them. Periodic rests from answering the questions were also taken to recount events related to their own self-care with the researcher. A few subjects made specific suggestions for ways the questionnaire could be improved. One subject commented that it was necessary to "clear up the language." Another believed the questionnaire could be improved by asking "less questions more clearly."

In summary, major problems in relation to comprehensibility, accuracy and administration have been identified when the PSCAQ is used with those older adults in nursing homes who are interested in and able to describe their perceptions of their ability to care for themselves. These problems pose a serious threat to both reliability and validity, suggesting that the PSCAQ, in its present form, has limited use as an instrument to measure the self-care agency of older adults.

Discussion

The results of the pilot study indicate that the PSCAQ is not appropriate for use with older adults and does not provide a useful basis for development of an instrument to obtain subjective assessments of self-care agency with older adults. Although some of the items provided a stimulus for discussion of individuals' perceptions of their ability to care for themselves, the majority of the items did not. In these instances, respondents spent time guessing what the item meant or trying to determine a response that described their situation (when none of them did), rather than providing the interviewer with information about their ability to care for themselves.

The problems related to instrument clarity identified in this pilot study are not new and are commonly referred to in discussion on development of self-report measures. The question that should be asked is why do these problems keep reoccurring. Although the educational background of subjects in this pilot study ranged from those having little formal education to those with post-secondary education none were ignorant about what it meant to be able to take care of themselves. However, use of technical words and professional jargon, poorly constructed items and inappropriate response categories reduced respondents' ability to interpret items, rendering the instrument irrelevant for the majority of this group. The practice of using nurse experts as the sole evaluators for content validation contributes to this problem and should be questioned. While experts can make important judgements on the suitability of the content, as well as the structure of the items or test, it is

clear from this pilot study that respondents themselves can provide invaluable information on the technical quality of items that was overlooked by professional experts. Although the PSCAQ was tested with adults, including some from senior citizen groups (Hanson & Bickel, 1985), these problems were not identified. It is likely that many of the problems encountered by the sample in this pilot study in completing the PSCAQ would be experienced by other respondents, including younger adults.

Since completion of this pilot study, results of an additional evaluation of the PSCAQ have been published by Weaver (1987). He concluded that observed measurement discrepancies reflected in estimates of reliability and validity may have resulted from problems inherent in the measuring tool itself. Weaver notes, for example, that some of the PSCAQ items encompass two or more abilities which may contribute to confusion and response inconsistency. However, as in the case of Bickel and Hanson (1985), Weaver did not observe test performance and therefore, missed some important data that could have been used to explain the results of this evaluation.

Researchers who develop and evaluate instruments without requesting feedback from respondents, or who do not observe performance while subjects complete the test, fail to gather important information that has direct implications for the reliability and validity of the instrument. Dialogue with respondents both during and following completion of the PSCAQ, combined with observations of test performance, proved to be effective and necessary strategies for eliciting information with regard to the appropriateness of this instrument for this population.

The difficulty many participants experienced interpreting and responding to questions may also be related to the way the PSCAQ was constructed. In this case, the PSCAQ was developed deductively with items being derived from a theoretical framework (Orem, 1985) that is still largely untested. While it is recognized that self-care ability varies over the life cycle, as do demands for self-care, the contribution of age or stage of development to self-care agency remains relatively unexplored. Attempts to describe a self-care model of nursing for the elderly that recognizes the unique demands for self-care that are associated with aging, such as the work of Sullivan and Munroe (1986), are, therefore, important. However, to identify and describe age-specific power components of self-care agency fully for this population, use of inductive descriptive research approaches may be necessary. For example, Golander's (1987) use of participant observation techniques in a nursing home has revealed some important findings related to the dynamic role disabled adults engage in as they adjust to caring for themselves in nursing home environments. On the basis of this kind of understanding, theory related to self-care agency can be refined, and more appropriate and accurate measures of self-care agency for this group could be developed.

Researchers should be alert to measurement problems that threaten the reliability and validity of the instruments they are using. Feedback from respondents can provide important information about the comprehensibility of the instrument and its appropriateness for use with a particular population or setting. In addition to the usual practice of administering an instrument in accordance with its intended use, face-to-face dialogue with at least some of the respondents should take place. Observations of some respondents while completing the instrument should also be included. Findings from pilot studies that are designed to collect this kind of information can be used to facilitate the development of measurement instruments at the time of construction, as well as when the instrument is being considered for use with different populations and settings.

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RÉSUMÉ

Evaluation d'un instrument dans une étude pilote: Le questionnaire des auto-soignés

Les chercheurs doivent être très alertes aux problèmes qui menacent la fiabilité et la validité des instruments dont ils se servent. Même si la fiabilité et la validité d'un instrument ont été établis, il ne faut pas assumer pour cela que ses propriétés seront valables pour chaque situation et pour chaque sujet. La contribution d'une étude pilote dans l'évaluation de l'utilité de mesures existantes pour la cueillette de données dans d'autres situations et avec d'autres populations est illustrée dans une discussion de l'expérience de l'auteur même dans le pilotage d'un instrument conçu pour mesurer les auto-soins. Les renseignements obtenus des répondants se sont avérés contenir des informations importantes sur la compréhensibilité de l'instrument et la justesse de son emploi pour les adultes âgés, ce qui avait été négligé par les experts professionnels. La discussion porte sur l'importance d'inclure des dialogues en tête-à-tête avec au moins une partie des participants, ainsi que des observations sur la performance des tests dans les études pilotes conçues pour évaluer les instruments de mesure des auto-rapports.

COMMUNITY NURSING PRACTICE IN A FACULTY OF NURSING HEALTH PROMOTION PROJECT

Carol Brehaut

Over the past three years the Faculty of Nursing of the University of Toronto has developed a health promotion project to provide unique community practice for nursing students and to offer health promotion services to the Faculty of Nursing and to the broader university community. This project was also intended to demonstrate the role of nursing in health promotion by putting into practice within the university community some of the Faculty of Nursing's beliefs about health. A review of the literature suggested that faculties of nursing have rarely taken advantage of the health promotion opportunities on their own campuses to provide community nursing practice for their students. This article will describe the project's aims, objectives, implementation, and evaluation.

Principal Objectives of the Project

To provide community nursing practice

Students in the project are in their final year of a four year baccalaureate program. All senior students practise in the community three days a week for a 12-week term. During this practice students work with individuals, families and, where possible, with groups and aggregates. Some students, however, have limited experience with groups and many do not practise in agencies where the needs of aggregates are addressed. Students rarely become involved in the planning, implementing and evaluating of community health programs. They are not often directly exposed to the social, political and environmental factors influencing the development of such programs. These are serious omissions in the preparation of nurses to be active participants in a health care system in which there is a growing focus on health promotion through community programs that are directed at population groups (DeBella, Martin & Siddall, 1986). Although some writers suggest that the

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nursing of population groups and aggregates is the domain of the Master's prepared community nurse (Anderson & Meyer, 1985), in reality, few community nurses currently have graduate preparation. It seems clear, therefore, that baccalaureate graduates should be prepared to function in an expanding community health nurse role. (Blank & McElmurry, 1986; Registered Nurses' Association of Ontario, 1985).

Recognition of these gaps in the preparation of our students was an important reason for seeking supplemental community nursing experiences outside the usual settings. A survey of the campus indicated that health and counselling services were already available to all students in the university, but resources for health promotion were limited. Here, then, was a defined, accessible community that had inadequate health promotion. This setting appeared to offer opportunities for considerable creativity and independence in carrying out the nursing process at the community level. The presence on campus of student services and other health science faculties also suggested a potential for interdisciplinary collaboration. Such collaboration, especially among health science students, is not easy to arrange. It is, notwithstanding, valuable preparation for the cooperative planning necessary in present day community health services. (Ministry of Health of Ontario, 1983; Mustard, 1982).

To offer health promotion services in the faculty of nursing and to the broader university community

The literature notes several potential benefits that could result from the provision of health promotion services in universities. Life-style patterns confirmed or developed during young adulthood may have a significant impact on health status in later years. The young people in our universities will be among the future parents and health professionals who will influence the health habits of this and other generations. Furthermore, as educational institutions, universities should be concerned with promoting the health of their members (Minister of National Health and Welfare, 1987). Health educators are also aware of the need to take advantage of the teachable moment. Lawrence Green (1984) suggests that such moments are found in the transition period between adolescence and adulthood when young people are developing autonomy in all areas, including increased responsibility for their own health behaviours.

To demonstrate nursing's role in health promotion

Another consideration that prompted the development of this project was concern about the Faculty of Nursing's lack of visibility on the University of Toronto campus in the area of health promotion. This situation on the campus reflected a similar one in the community where the image of nursing

in health promotion is ill-defined. A project designed to demonstrate Nursing's role in health promotion on the campus would help to strengthen Nursing's image in this regard.

Conceptual Framework

In the first year of the project, assumptions and beliefs upon which to base an educational experience in health promotion were identified by the participating students and the faculty coordinator (University of Toronto Faculty of Nursing, 1986). These were reviewed and revised yearly. This framework was organized around the two main goals of the project: health promotion programming as a learning experience for students and the development of programs to promote health on the campus. Some of the beliefs and assumptions were adopted from the faculty's conceptual framework. They included, for example, the statement that, "In nursing, professional caring is expressed in the aims of promoting optimal health and wellness and in activities which facilitate the development of persons as their own most valuable resource for achieving the well-being that is possible," (University of Toronto Faculty of Nursing, 1981, p.1) and the assumption about health that, "Biological, cognitive and environmental factors interact to influence health at any given time" (University of Toronto Faculty of Nursing, 1981, p.3). The framework includes assumptions that reflect current thinking about health promotion, such as the following: changes in health behaviour may be easier to make during periods of transition in our lives (Green, 1984); and growth and change are often facilitated by social support (World Health Organization, 1984). The Faculty of Nursing philosophy of education is evident in the belief that students need opportunities, like those provided in the project, to participate in the development of their own learning experiences. Concepts such as self-responsibility, peer support and the importance of a healthy environment, which were derived from these assumptions and beliefs, became intrinsic to project activities. These assumptions, beliefs and concepts are reflected in the following specific objectives, which were formulated, and revised each year as a basis for program development.

Specific Objectives of the Project

1. To make the project known in the Faculty and to establish its credibility as a health promotion resource.
2. To encourage students to participate in the project as providers and consumers of health promotion services.
3. To associate the project closely with the curriculum.
4. To expand the project to serve other members of the University community.
5. To identify the health interests, risks and problems of the Faculty population.

6. To develop health promotion programs based on this assessment.
7. To collaborate with other health promotion services, health professionals and health science students in developing programs.
8. To increase awareness of the environmental, social and political factors affecting health and health promotion programming.
9. To explore health promotion strategies to increase awareness, provide information and support change at the individual, group and aggregate levels.
10. To examine the theory and research base for health promotion.
11. To provide experiential learning for the project participants in improving their own health practices.
12. To continue to develop a conceptual framework for the project.
13. To develop a proposal for external funding for a study derived from the project.

Development of Programs

After the first year, about 20% of the class were involved in the project, devoting to it from one half to two out of the three days per week allotted to community clinical practice. Initially, students developed programs that addressed the health interests identified in a faculty-wide survey of students, staff and faculty. These were stress, fitness, nutrition and sexuality. Programs were directed primarily at the student body. Students were encouraged to establish objectives consistent with those of the project for each of the programs they developed. Strategies were designed to increase health awareness, provide information and promote change in health behaviours in these areas. The two most fully developed programs, stress management and sexuality, will be described.

Stress management program

In the survey of the Faculty of Nursing population, stress was identified as the main health concern by students in all four undergraduate years. This is not surprising in view of the results of studies of stress experienced by university students (Gupta, McMahon & Sandhu, 1985) and the increasing suicide rates for young adults (Tousignant, 1985). Stressful situations are also frequently encountered by health professionals in their practice. Therefore, students should learn the skills that will eventually help them, their colleagues, and their clients to cope with these situations by using healthy behaviours.

Efforts were made to identify the specific stressors experienced by undergraduate nursing students in different years of the program and to help them to cope with these concerns regarding academic demands and clinical practice. Discussion sessions were organized for first year students to help

them develop strategies to facilitate their transition to life in a professional faculty. Regular meetings were arranged for groups of second year students to encourage them to use peer support in coping with their first concurrent clinical experience. The project students who developed this latter program were the most successful in incorporating the evaluation phase of health promotion programming. They adapted a stress assessment questionnaire and administered it to the experimental groups before and after the series of meetings and to control groups at the same times. For both of these stress programs University Counselling and Learning Skills Service staff members acted as consultants to the project students, meeting with them at the beginning and end of the term to help them plan and assess their programs.

Sexuality program

Birth control education was one of the health promotion programs already being offered by the University Health Service. On several occasions project students collaborated with a nurse from the Health Service in setting up birth control displays and information centres on campus. The students, however, went on to develop a sexuality program with broader goals, such as clarifying sexual values and examining the preparation of nursing students in the area of sexuality. Activities included setting up question-and-answer boards on campus, responding to invitations to speak to groups of students outside the faculty, arranging for speakers and films for nursing students and writing articles for campus newspapers. Project students also reviewed the nursing courses in the undergraduate program, made recommendations regarding the teaching of sexuality and set up a resource file for students and faculty. This program has been the most successful in achieving continuity in program development and the project objective of collaboration with university student services in promoting health on the campus.

The Festival of Health

To further its goals of offering health promotion services to the broader university community and demonstrating nursing's role in health promotion, the project has sponsored a Festival of Health in each of the past two years. Project students were able to achieve the objective of collaborating with students from other health science faculties, as well as with university student services, and selected community agencies in staging the fairs. Displays and activities were geared to increasing the health awareness of the university population and acquainting them with available health promotion services.

Of the 450 visitors to the second fair, 60 completed evaluation questionnaires, and 75% of these reported that the fair had made them more aware of their own health status and of the health services available. The Festival of Health, however, was a relatively expensive program and time-consuming to

organize; it may be that a less ambitious undertaking, geared to population subgroups such as a women's health fair, would meet the project's educational and service goals equally well.

Expansion of Programs

From its inception the project defined health promotion in terms of political, social and environmental, as well as life-style changes. But initially, activities tended to focus on helping individuals to change their health behaviours. Soon students became familiar with such current thinking as that found in Canadian and international statements on health promotion (Canadian Public Health Association, 1986; Epp, 1986; Kickbusch, 1986). Eventually the theme, "Promote health through healthy life-style, healthy environment and healthy public policy", was adopted by the project. The implementation of this broad theme in practice is illustrated in the anti-smoking and alcohol use programs.

Anti-smoking program

The project was approached by students who requested help in changing smoking practices in the Faculty of Nursing. The project participants assumed an advocacy role and worked with the Student Council to conduct a referendum regarding smoking practices. This referendum resulted in community action to establish some restrictions on smoking in the student lounge. The project now plans a campaign in the faculty to increase awareness of the effects of second-hand smoke. This is the next step in trying to obtain policy changes that will result in a smoke-free environment in the Nursing building. This experience of mobilizing the community to achieve a healthier environment through changes in policy helped the students to understand better some of the concepts presented in the literature on health promotion.

Alcohol Use program

Another program that focuses on the social environment developed out of one project student's concern about excessive alcohol use on the campus. Her survey of first year nursing students' knowledge and use of alcohol prompted a teaching session adapted to the specific learning needs identified. This student also investigated whether or not there were others on campus who were concerned with developing policies and making environmental changes to support students in the safer use of alcohol. In response to the lack of activities and resources identified, the project group collaborated with other concerned members of student services to establish a coffee house that provides a place where people from all sectors of the university community can socialize in a setting in which alcoholic beverages are not served.

Marketing

Critical to the project's success has been the marketing of its programs in the Faculty of Nursing and, in some cases, on the campus in general. This advertising campaign made use of posters, flyers, radio and newspapers. Within the faculty, advertising was directed at nursing students as both consumers and providers of health promotion services. It was soon discovered that activities were most successful in attracting participants in a busy professional faculty when they took place during class time or were part of a course requirement. This close association of the project with the curriculum requires the support of the faculty. One example of such cooperation was that of a teacher of a first-year nursing course who invited project students to share teaching with her in such areas as sexuality, life-style, alcohol use and stress management. A project participant who was interested in identifying life-style assessment tools that would be useful in the health fair examined some of the tools described in the literature and chose four to be tested and evaluated by first-year students in the class on life-style. Another means of fostering more involvement of students and faculty in project activities has been through the faculty-student advisory committee to the project. However, the most effective marketing device has been the success of project activities, especially those like the Festival of Health, which are highly visible and reach large numbers of people.

Evaluation of the Project

As a health service

At the beginning of the project, participants were confronted with the difficult problem that every health promotion practitioner faces, that of evaluating effectiveness of programs in relation to changes in the health status of the population concerned. To circumvent this problem, programs were assessed in terms of impact on health awareness, knowledge and behaviour rather than in terms of health outcomes. Faculty-wide evaluation of the impact of the project was carried out each year using a questionnaire. The greatest impact has been on awareness of project activities, but there has also been an impact on health awareness, less impact on health knowledge and least impact on health behaviours. Project students also evaluated the impact of individual programs using a variety of techniques that included comparison of experimental and control groups, soliciting reactions from participants, noting attendance at programs and monitoring changes in behaviour, policies and the environment.

Because the main goal of the project was educational, many of the service-related objectives (1-7) were stated in terms of process or professional practice. These are more readily evaluated than outcome objectives (Green,

Kreuter, Deeds & Partridge, 1980). Process evaluation carried out by the project students and faculty coordinator indicated that the project has achieved many of its service-related objectives. As the project became better known and its impact recognized, more students became involved in its activities. The health interests of the faculty population have been surveyed and some of the health risks and problems of groups within the student population have been identified. Health promotion programs have been developed to address some aspects of the health interests, risks and problems. Some of these programs were closely associated with the curriculum. In the course of developing programs, project students collaborated with other health promotion services on campus, with other health science students and with other health professionals. There have been efforts to offer limited health promotion services to members of the university community outside the Faculty of Nursing: some of the activities in the sexuality program, the health fairs and the coffee house.

As a learning experience

The project's main goal was educational, as such, its effectiveness and efficiency as a learning experience in community nursing were also evaluated at the end of the second year. No attempt was made to determine what influence the project experience had on the level of student performance in community nursing. Instead, effectiveness as a learning experience was determined by comparing the kinds and numbers of activities undertaken by students engaged in the project with those of other fourth year students. This comparison showed that, without neglecting other required experiences in community nursing, project students had more practice in health promotion than did the other students. The activities in which the greatest differences were noted were those related to developing and evaluating health promotion programs, setting up groups for health promotion and testing health promotion models and strategies. Students had ample opportunity to meet the learning-related objectives of the project (5-12) not only by developing programs but also by participating in regular project meetings in which programs were evaluated and health promotion theory and research were discussed. They reported that they appreciated practising in a setting that was strongly learning-oriented and one that gave them the freedom to be highly creative and independent.

The efficiency of the project was evaluated in terms of faculty time invested. As would be expected, additional time was needed for the coordinator to supervise students in the absence of the usual community agency personnel (almost three hours per week) and to administer a project that was not under the auspices of any service agency (two hours per week). Some of this time spent by faculty on the project can be viewed as valuable clinical practice for nurse educators. In addition, there are many research pos-

sibilities inherent in the project, which faculty might develop as part of their academic role.

As a demonstration of nursing's role in health promotion

To determine if the project had been successful in demonstrating nursing's role in health promotion within the faculty, a question to this effect was included in the impact questionnaire that was distributed faculty-wide at the end of the second year. Nursing students reported that a number of programs, especially the Festival of Health and the social and political activities, had broadened their perception of nursing's role in health promotion. No formal attempt was made to assess the impact of the project on students outside the Faculty of Nursing.

Problems and Possible Solutions

Some of the main problems encountered in developing the project were related to the fact that the sponsor is an educational institution, and not a service institution. Funding for health services is difficult to obtain in an educational setting. It is not easy to provide continuity in programming in a project that has to be reactivated each academic year. In addition, every term brings a new group of student participants with different interests that they wish to pursue. The main goal of the project is to provide practice in developing health promotion programs; therefore each group has to work through the very complex programming process, encountering many of the same problems found by earlier groups.

It is important that some continuity in programming be provided by the faculty coordinator as the dual responsibilities of facilitating learning and maintaining adequate programming are balanced. A second faculty member now shares the coordinator responsibilities and is assessing the project as a possible learning experience for students in the Master's of Nursing program. It might be feasible for the project to collaborate more closely with the university student or employee health services to provide a more permanent base for the development of health promotion programs. This arrangement would facilitate offering programs to other sectors of the university and, possibly, involve other health science students in their development.

Greater continuity and improved quality of programming would probably result from concentrating on fewer areas and recruiting fourth year students who are interested in developing those particular programs. To provide a sounder basis for determining which programs should be established, the two faculty coordinators are developing a research proposal to obtain funding to assess the health attitudes and behaviours of first-year university students.

Health promotion programs would have a greater impact within the Faculty if more students could be involved in program activities. Experience has shown that this occurs when activities are closely associated with or integrated into the curriculum. There is ample opportunity for inclusion of more health promotion strategies in a health science curriculum. Such course time use would seem to be justified when students are not only consumers, but future providers of health promotion services.

Attracting fourth year students to participate in the project as part of their community nursing experience can be a problem. The possibilities for practice in an unstructured project within their own university community do not, initially, seem as concrete or as exciting as the opportunities available with traditional community agencies. It has proven helpful to have current project participants meet with incoming fourth year students to share their enthusiasm and explain how they have been able to meet their community nursing objectives. The future assessment of health attitudes and behaviours will clearly identify program needs and will also help to define practice opportunities for fourth year students.

Review of the first three years of the health promotion project suggests that, in the course of providing valuable learning experiences to nursing students, such a project can offer needed health services on the campus, while demonstrating nursing's role in health promotion.

Similar projects might be developed by schools of nursing in universities and colleges both with and without well developed health promotion services. It is important that young adults learn to make healthy decisions in relation to life-style, environment and public policy. Students in universities and colleges can be helped to do so by nursing students who provide leadership in health promotion within their own campus community.

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RÉSUMÉ

Pratique en soins communautaires: projet de promotion de la santé de la faculté des sciences infirmières

Au cours des trois dernières années, la faculté des sciences infirmières de l'Université de Toronto a développé un projet de promotion de la santé: a) pour fournir à ses élèves de 4^e année une occasion unique d'expérience en milieu pratique, b) pour offrir des services de promotion de la santé à une plus vaste communauté, et c) pour démontrer le rôle du secteur infirmier dans la promotion de la santé. Pour commencer, les élèves ont développé des programmes s'adressant à leurs pairs qui visaient à un changement du style de vie dans les domaines identifiés parmi les plus intéressants d'après un sondage mené auprès du corps professoral; c'est-à-dire le stress, le bien-être, la nutrition et la sexualité. Les élèves eurent bientôt fait, toutefois, d'élargir leur approche pour inclure des considérations d'éléments d'ordre social, politique et environnemental affectant les comportements de la santé tels que l'usage de la cigarette et de l'alcool.

Certains programmes ont été offerts aux étudiants autres que les élèves de la faculté. Un festival de la santé a été organisé à travers le campus, en collaboration avec d'autres élèves des sciences de la santé ainsi que des services universitaires aux étudiants et plusieurs agences communautaires choisies, afin d'éveiller la conscience de la population universitaire et l'informer sur les services de promotion de la santé qui lui sont accessibles.

L'évaluation du projet comme expérience d'apprentissage démontre que les étudiants impliqués dans le projet ont eu plus de pratique dans la promotion de la santé que les autres élèves de 4^e année, surtout pour ce qui est de développer et évaluer les programmes de promotion de la santé, organiser des groupes de travail et tester les modèles.

PERTES ET MENACES PERÇUES PAR LES PERSONNES AGÉES A L'UNITÉ DE SOINS INTENSIFS CORONARIENS

Nicole Guinard-Lachance et Jacqueline Laurin

Le stress psychologique et les réactions émotives des personnes âgées hospitalisées en soins aigus sont peu connus. Pourtant ces états peuvent compromettre les traitements médicaux les plus au point ou compromettre la réadaptation de l'individu âgé vers son indépendance physique, psychologique ou sociale.

L'hospitalisation dans une unité de soins intensifs coronariens et l'infarctus du myocarde sont reconnus pour leur effet stressant. Plusieurs études, du point de vue médical et infirmier, ont démontré l'importance d'identifier et de pallier au plus tôt à cette situation stressante pour les malades de tout âge (Granger, 1974; Pancheri et al., 1978).

Un nombre toujours croissant de personnes âgées se retrouvent dans les unités de soins intensifs médicaux et coronariens à cause d'une maladie aiguë ou à cause de l'exacerbation d'une maladie chronique (Campion et al., 1981). Pourtant, Wolanin (1984) affirme que les soins intensifs aux personnes âgées sont présentement à la frontière des connaissances infirmières. L'infirmière (sous-entend le masculin) doit connaître ce que les personnes âgées identifient comme sources de stress, si elle veut offrir à cette population une suppléance professionnelle adéquate.

Selon Lazarus (1980), le stress psychologique, pour tout être humain, découle de la transaction entre une situation et la perception de cette situation par la personne concernée. Cette perception en est une de perte (harm/loss), de menace (threat) ou de défi (challenge).

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But de l'étude

Le but de cette étude descriptive est d'identifier les pertes et les menaces qui sont perçues par les personnes âgées hospitalisées à l'unité de soins intensifs coronariens, à la suite d'un infarctus du myocarde et d'en mesurer leur intensité.

Questions de recherche

Quelles sont les pertes perçues par les personnes âgées hospitalisées à l'unité de soins intensifs coronariens, en rapport avec leur vieillesse, leur hospitalisation dans une unité de soins intensifs coronariens et leur infarctus du myocarde?

Quelles sont les menaces perçues par les personnes âgées, en rapport avec leur vieillesse, leur hospitalisation dans une unité de soins intensifs coronariens et leur infarctus du myocarde?

Recension des écrits

Le cadre de référence retenu dans cette étude, est la théorie du stress psychologique de Lazarus (1980) et de Lazarus et Folkman (1984). Il a permis de classer les pertes et les menaces perçues par les personnes âgées, en relation avec leur vieillesse, leur hospitalisation dans une unité de soins intensifs coronariens et leur infarctus du myocarde.

Pertes et menaces liées à la vieillesse

Kane, Ouslander et Abrass (1984) disent que la vieillesse est caractérisée par une variété d'altérations dans la vie. C'est un temps de pertes: rôle social, revenu, époux, parents et amis (par décès ou invalidité). Burnside (1973) rapporte que, parmi les pertes physiques, la perte de mobilité, parce qu'elle signifie l'isolement physique et sociale, affecte au plus haut point l'indépendance de la personne. Les pertes sensorielles, surtout de la vision et de l'audition, entraînent aussi l'isolement et ont des répercussions psychologiques sur les personnes âgées (Burnside, 1981). Le changement de l'image corporelle précipite certaines personnes âgées dans une réaction de choc et d'incrédulité lorsque le reflet du miroir est celui d'un vieillard (Butler et Lewis, 1982).

Les pertes sociales sont en grande partie liées à la retraite: perte de revenu, du rôle social, du style de vie, de l'interaction avec les compagnons de travail, du statut social, du prestige et de l'estime de soi (Palmore et al., 1979; George et al., 1984).

Kane, Ouslander et Abrass (1984) disent que la vieillesse est aussi un temps de menaces: peur pour la sécurité personnelle, la sécurité financière et peur de la dépendance. Palmore (1979) dit qu'une accumulation de pertes et de menaces multiplie les effets psychologiques. Selon ces auteurs, la personne âgée "à risque" est celle ayant expérimenté plusieurs événements stressants dans un temps assez court, et la plus "fragile", celle qui a peu de ressources physiques, psychologiques et sociales pour composer avec ces pertes et ces menaces.

Pertes et menaces lors d'une hospitalisation dans une unité de soins intensifs coronariens

L'hospitalisation a un impact psychologique reconnu chez les malades. Kornfeld (1979) croit que la reconnaissance de cet impact n'est pas seulement humanitaire mais une nécessité médicale à cause des changements cliniques importants.

Certaines pertes et menaces entraînées par l'hospitalisation de la personne âgée sont identifiées: les préoccupations personnelles menaçantes pour des êtres chers (Davies et Peters, 1983), la peur de la dépendance (Jackson, 1984), l'environnement étranger de l'hôpital (Jeans, Mackenzie et Taylor, 1983). Par ailleurs, l'investigatrice n'a trouvé aucun résultat de recherche relatif aux pertes et aux menaces perçues spécifiquement par les personnes âgées hospitalisées à l'unité de soins intensifs coronariens.

Davis (1972) mentionne que les éléments stressants de l'hospitalisation sont communs à tous les patients en général mais qu'en plus, dans le contexte de l'unité de soins intensifs coronariens, ces éléments sont grandement amplifiés. Pour elle, quatre grandes catégories de stress influencent la sécurité émotive des patients hospitalisés à l'unité de soins intensifs coronariens: l'entrée et la sortie de l'unité, la nature de l'environnement, la nature de la maladie et l'interaction avec l'équipe soignante.

A l'unité de soins intensifs coronariens, l'admission peut signifier la perte d'un monde familier et la menace de l'inconnu (Roberts, 1980); le transfert lui, est une expérience de séparation avec quelquefois un sentiment de rejet (Roberts, 1976). L'environnement même de cette unité représente une privation sensorielle (Chodil et William, 1970) et une perte de contrôle (Roberts, 1976). Pour ce qui est de l'interaction avec un personnel plus jeune (Goebel, 1982), si la communication est inadéquate, elle peut entraîner la dépersonnalisation et la déshumanisation de la personne âgée.

Pertes et menaces lors d'un infarctus du myocarde

Les pertes et les menaces liées à la maladie ont suscité de nombreux écrits. La maladie grave dérange la stabilité d'une personne, disent Moos et Tsu

(1977). La séparation d'avec la famille et les amis, la perte des rôles dans sa vie, les changements permanents dans sa fonction corporelle ainsi qu'un avenir incertain et imprévisible en sont les éléments responsables. Les pertes sociologiques, spécialement le manque d'attaches et de ressources interpersonnelles, sont attribuées aux malades cardiaques de tout âge (Berkman, 1982). La menace par l'infarctus du myocarde même, est une menace de mort à laquelle l'individu doit faire face avec passivité (Moos, 1977). C'est aussi une menace de baisse de qualité de la vie (Roberts, 1976). D'autres menaces et pertes plus concrètes sont perçues par les victimes: douleur, symptômes physiologiques intenses, conséquences de leur survie ou de leur mort (Thomas et al., 1983).

La méthode

Définitions opérationnelles des principaux termes

Stress psychologique: Tel que défini par Lazarus (1980), le stress psychologique est un état mental référant à une évaluation cognitive, c'est-à-dire au jugement d'une demande, par la personne concernée, sur le potentiel d'atteinte à son bien-être. Cette demande externe ou interne peut être considérée comme A) une perte, B) une menace.

A. Perte: Dommage déjà encouru, telle que blessure ou maladie, perte de l'estime de soi, de l'estime sociale, perte d'une personne significative etc... (Lazarus, 1980), lié à la vieillesse, à l'hospitalisation dans une unité de soins intensifs coronariens ou à l'infarctus du myocarde. La perte peut être temporaire ou permanente. Chaque perte porte aussi en elle une menace pour le futur.

Dans cette étude, une perte est considérée comme perçue lorsque le sujet indique que le contenu d'une question, catégorisée perte, le préoccupe un peu ou beaucoup.

B. Menace: Dommage évitable ou inévitable mais qui n'est pas encore arrivé (Lazarus, 1980), lié à la vieillesse, à l'hospitalisation dans une unité de soins intensifs coronariens ou à l'infarctus du myocarde.

Dans cette étude, une menace est considérée comme perçue lorsque le sujet indique que le contenu d'une question, catégorisée menace, le préoccupe un peu ou beaucoup.

Intensité: Valeur de la force avec laquelle, par exemple, une situation est perçue. Dans cette étude, l'intensité est la valeur donnée à la force de perception d'une perte ou d'une menace par le sujet.

Instruments de collecte des données

Deux instruments servent à cette étude. Le premier est un instrument sur les préoccupations des personnes âgées à l'unité de soins intensifs coronariens et le deuxième est un questionnaire court sur le statut mental des personnes âgées (QCSMPA). Une liste de renseignements généraux complète cette section.

Instrument sur les préoccupations des personnes âgées à l'unité de soins intensifs coronariens. L'instrument sur les préoccupations des personnes âgées à l'unité de soins intensifs coronariens a été développé par Guinard (1987). Le questionnaire comprend un inventaire de 61 pertes ou menaces et est divisé en trois dimensions: 25 questions pour la dimension vieillesse, 23 questions pour la dimension hospitalisation dans une unité de soins intensifs coronariens et 11 questions pour la dimension infarctus du myocarde. Chaque dimension comprend aussi des éléments différents. Il s'agit pour la vieillesse et pour l'infarctus du myocarde de pertes et de menaces physiques et psychologiques. Pour la dimension hospitalisation dans une unité de soins intensifs coronariens, les pertes et les menaces sont liées aux préoccupations personnelles, à l'entrée et à la sortie de cette unité, à l'environnement de l'unité et finalement à l'interaction avec le personnel.

Le questionnaire a été administré entre quatre et 14 jours post-infarctus, c'est-à-dire le jour précédent ou suivant la sortie du malade de l'unité de soins intensifs coronariens. Chaque question fut présentée au sujet, imprimée en gros caractères afin d'en faciliter la lecture pour des personnes âgées et sur carte individuelle de couleur différente selon la dimension. Cette stratégie des cartes est suggérée par Gibson et Aitkenhead (1983), les personnes âgées seraient moins familières que les plus jeunes avec les formats de questions à choix multiples et auraient besoin de plus d'indices que ce qui est offert habituellement. Le temps requis pour répondre aux questions a varié entre 30 et 60 minutes.

Afin que les sujets comprennent bien les questions, le mot "préoccupation" est utilisé pour définir "perte" ou "menace". Chaque carte comprend donc une question touchant une préoccupation possible et le sujet a deux choix de réponse: "oui" ou "non". Si "oui", les sous-réponses peuvent être "un peu" ou "beaucoup"; si "non", les sous-réponses peuvent être "pas du tout" ou "sans objet". Pour fin d'analyse, certaines valeurs ont été attribuées à chacune des sous-réponses. Ainsi, la réponse "oui beaucoup" vaut 2; la réponse "oui un peu" vaut 1 et les réponses du côté "non" valent 0. A partir de ces valeurs, des moyennes d'intensité obtenues par le groupe pour chacun des éléments, furent calculées de la façon suivante: des échelles entre 0 et 1 pour chaque sujet ont été formées à partir de leurs réponses. Par exemple, si pour l'élément "pertes physiques liées à la vieillesse", un sujet répond "oui

beaucoup" à toutes les questions de cet élément, il obtient le score maximum de 1. Par contre, si un sujet répond "non" à toutes les questions de cet élément, il obtient le score minimum de 0. Tous les scores entre 0 et 1 sont donc possibles. Les données ont été traitées par le test bilatéral de Student pour données appariées, sur ordinateur à l'aide du logiciel S.P.S.S..

La validité nominale et la validité de contenu du questionnaire sur les préoccupations des personnes âgées à l'unité de soins intensifs coronariens ont été décrites dans le document original (Guinard, 1987). Aucun test de fidélité du questionnaire n'a encore été effectué. Une autre limite méthodologique consiste dans le fait que le questionnaire dépend exclusivement des réponses subjectives des sujets avec tous les problèmes associés possibles: falsification rétrospective, mémoire inadéquate, conformité sociale, ambiguïté du langage etc.

Questionnaire court sur le statut mental des personnes âgées (QCSMPA): L'évaluation de la capacité mentale des sujets a été déterminée par la traduction libre du "Short portable mental status questionnaire for the elderly" (SPMSQ), effectuée par l'investigatrice et soumise à trois personnes bilingues: une infirmière et deux personnes d'un autre milieu professionnel.

Cet instrument fut développé par Pfeiffer (1975). Deux raisons ont motivé l'investigatrice pour cette évaluation: premièrement, la capacité cognitive de l'individu est déterminante par rapport à la perception du stress et deuxièmement pour assurer une certaine homogénéité de l'échantillon.

Pfeiffer élaborait dix questions, dont sept testent l'orientation de la personne. Des autres trois items étudiés, l'un vérifie la mémoire fonctionnelle surtout par rapport à la capacité de s'occuper adéquatement de soi-même, l'autre est un test de la mémoire de faits anciens et le dernier item évalue la capacité de réussir des opérations mentales. Pfeiffer identifia quatre sous-groupes correspondant à quatre portées de résultats: intact (0-2 erreurs), légèrement atteint (3-4 erreurs), modérément atteint (5-7 erreurs) et sévèrement atteint (8-10 erreurs) dans la capacité intellectuelle.

Les sujets de l'étude ont tout d'abord répondu à ce questionnaire présenté par l'investigatrice. Seules les données fournies par ceux qui se sont qualifiés comme intact/légèrement atteints intellectuellement ont été considérées.

Liste de renseignements généraux: Une liste de renseignements généraux comprend vingt items divisés en caractéristiques socio-démographiques et en caractéristiques liées à l'histoire médicale des sujets. Ces renseignements sont nécessaires afin de décrire l'échantillon de l'étude et furent recueillis à partir du dossier médical et complétés par l'entrevue.

Milieu

L'étude s'est déroulée dans trois centres hospitaliers universitaires francophones de Montréal, après avoir obtenu la permission de la direction des soins infirmiers et l'approbation de comités d'éthique. Il a été nécessaire de recourir à ces différents centres à cause de la rareté des sujets au moment de la collecte des données.

La recherche a été présentée aux sujets comme une étude cherchant à améliorer les soins infirmiers à l'unité de soins intensifs coronariens en connaissant mieux notre clientèle. L'investigatrice s'est présentée aux sujets avec une lettre de demande de participation de la personne. Cette lettre précisait clairement le fait que la personne était entièrement libre de participer à la recherche ou non et sur le fait que si elle acceptait, elle était libre de se retirer en tout temps. Evidemment, la confidentialité des renseignements fournis lui a été assurée. Un formulaire de consentement à signer par les répondants accompagnait cette lettre.

L'infirmière soignante du malade a été contactée avant l'entrevue pour vérifier auprès d'elle si l'état de santé du sujet permettait l'investigation.

Description de l'échantillon

Sélectionné avec l'aide des infirmières-chefs des unités concernées, un échantillon de convenance de 30 personnes âgées entre 65 et 81 ans, vivant dans la communauté et ayant séjourné à l'unité de soins intensifs coronariens à cause d'un infarctus du myocarde, ont été questionnées. Il est à noter que le nombre restreint des sujets peut difficilement promouvoir la généralisation des résultats. De plus, au point de vue de la statistique, ce petit nombre de sujets combiné à un grand nombre de variables, limitent les possibilités de résultats significatifs.

Résultats

Pour mieux étudier l'intensité des pertes et des menaces perçues par les sujets, des moyennes ont été calculées et traitées à l'aide du test-t de Student. Nous remarquons au tableau 3, qu'il n'y a aucune différence significative d'intensité entre les pertes liées aux trois différentes dimensions. Par contre, ce même tableau démontre l'existence d'une différence statistiquement significative entre l'intensité des menaces liées à la vieillesse (0,1143) et celles liées à l'infarctus (0,1796) avec une valeur t de -3,02 et une probabilité de 0,005. De plus, il existe aussi une différence significative entre l'intensité des menaces liées à l'hospitalisation (0,1088) et celles liées à l'infarctus (0,1796) avec une valeur t de -2,99 et une probabilité de 0,006.

Tableau 1

Nombre et pourcentage de sujets selon les données socio-démographiques (N=30)

	N	%		N	%
<i>Groupe d'âge</i>			<i>Temps vécu adresse pre- cedente¹</i>		
65 à 69 ans	16	53.3			
70 à 74 ans	8	26.7			
75 à 81 ans	6	20.0	Moins d'un an	(1)	(3.3)
			1 an à moins de 6 ans	(7)	(23.4)
<i>Sexe</i>			6 ans et plus	(4)	(13.3)
Féminin	17	56.7			
Masculin	13	43.3	<i>Étage du domicile</i>		
<i>Niveau de scolarité</i>			1e étage	14	46.7
Primaire	12	40.0	2e étage ou plus avec ascenseur	5	16.6
Secondaire	13	43.3	2e étage ou plus sans ascenseur	11	36.7
Collégial	4	13.4			
Universitaire	1	3.3			
<i>État civil</i>			<i>Personnes demeurant avec les sujets</i>		
Marié(e)	11	36.7	Aucune	13	43.3
Veuf(ve)	13	43.3	Une	10	33.4
Divorcé(e) ou séparé(e)	4	13.3	2 ou plus	7	23.3
Célibataire	2	6.7			
<i>Retraite</i>			<i>Dependants</i>		
Oui	25	83.3	Aucun	26	86.7
Non	5	16.7	Un	3	10.0
			2 ou plus	1	3.3
<i>Occupation présente ou passée</i>			<i>Animaux</i>		
Col bleu	11	36.7	Aucun	23	76.7
Col blanc	7	23.3	Un	5	16.6
Profession nel(le)	3	10.0	2 ou plus	2	6.7
Ménagère	9	30.0			

Tableau 1 continué

	N	%		N	%
<i>Lieu de résidence</i>			<i>Parents avec qui ils ont des contacts réguliers</i>		
Montréal	22	73.3	Aucun	1	3.3
Banlieue de Montréal	7	23.4	5 ou -	15	50.0
Autre	1	3.3	6 ou +	14	46.7
<i>Temps vécu adresse actuelle</i>			<i>Amis avec qui ils ont des contacts réguliers</i>		
Moins d'un an	3	10.0	Aucun	10	33.3
1 an à moins de 6 ans	9	30.0	5 ou -	12	40.0
6 ans et plus	18	60.0	6 ou +	8	26.7

¹ Les données présentées pour le temps vécu à l'adresse précédente sont entre parenthèses car seuls les 12 sujets ayant vécu moins de six ans à l'adresse actuelle sont inclus dans ces données.

Afin de répondre plus spécifiquement aux questions de recherche, les pertes et les menaces rapportées par les sujets pour chacune des trois dimensions vieillesse, hospitalisation dans une unité de soins intensifs coronariens et infarctus du myocarde, sont présentées sous forme de tableaux accompagnées de la moyenne d'intensité obtenue par le groupe pour chacun des éléments. Il est à noter le nombre important de réponses négatives aux questions.

Pertes et menaces liées à la vieillesse

Les pertes et les menaces liées à la vieillesse, sont divisées en pertes physiques (0,1433) et psychologiques (1367) et en menaces physiques (0,1167) et psychologiques (0.1130).

Les données du tableau 4 démontrent que parmi les pertes physiques liées à la vieillesse, la baisse de capacités physiques et le changement dans les fonctions corporelles sont les plus citées. Les pertes psychologiques seraient surtout le manque de soutien et la solitude éprouvée.

Parmi les menaces physiques, celle qui ressort le plus est la baisse future des capacités physiques. Les menaces psychologiques sont surtout une baisse future des activités, la crainte d'un placement en institution et l'idée de la mort.

Tableau 2

Nombre et pourcentage des sujets selon les données associées à l'histoire médicale (N=30)

	N	%		N	%
<i>Nombre d'infarctus</i>			<i>Jours d'hospitalisation à l'unité de soins intensifs coronariens</i>		
Premier	21	70.0			
Deuxième	6	20.0			
Troisième	3	10.0	2	2	6.7
			4	5	16.6
<i>Jours post-infarctus</i>			5	4	13.3
			6	2	6.7
4	2	6.7	7	6	20.0
6	4	13.3	8	1	3.3
7	7	23.3	9	6	20.0
8	5	16.7	10	2	6.7
9	5	16.7	13	2	6.7
10	1	3.3			
13	4	13.3	<i>Autre maladie sérieuse actuelle</i>		
14	2	6.7			
<i>Nombre d'hospitalisations à l'unité de soins intensifs coronariens</i>			Aucune	12	40.0
			Une	10	33.3
			Deux ou plus	8	26.7
			<i>Centre hospitalier</i>		
Première	15	50.0			
Deuxième	9	30.0	Centre A	10	33.3
Troisième	5	16.7	Centre B	9	30.0
Quatrième	1	3.3	Centre C	11	36.7

Tableau 3

Moyenne, écart type et valeur t relatifs à l'intensité des pertes et des menaces dans les trois dimensions

<i>Pertes liées A</i>	Moyenne	Ecart type	t	p
La vieillesse	0,1400	0,139		
L'hospitalisation	0,1278	0,172	0,48	0,637
La vieillesse	0,1400	0,139		
L'infarctus	0,1667	0,231	-0,59	0,559
L'hospitalisation	0,1278	0,172		
L'infarctus	0,1667	0,231	-0,78	0,439
<i>Menaces liées A</i>				
La vieillesse	0,1143	0,102		
L'hospitalisation	0,1088	0,094	0,36	0,720
La vieillesse	0,1143	0,102		
L'infarctus	0,1796	0,137	-3,02	0,005*
L'hospitalisation	0,1088	0,094		
L'infarctus	0,1796	0,137	-2,99	0,006*

* significatif à 0,05.

Pertes et menaces liées à l'hospitalisation

La répartition des pertes et des menaces liées à l'hospitalisation, sont subdivisées en préoccupations personnelles (pertes: 0,1833; menaces: 0,1458), entrée et sortie de l'unité (menaces: 0,1000), environnement de l'unité (pertes: 0,1167; menaces: 0,1200) et interaction avec le personnel (pertes: 0,1167; menaces: 0,0778). (Aucune perte due à l'entrée et à la sortie de l'unité n'a été identifiée parmi les pertes et les menaces comprises dans l'instrument sur les préoccupations à l'unité de soins intensifs coronariens.)

Tableau 4

Nombre de sujets ayant rapporté des pertes et des menaces physiques et psychologiques liées à la vieillesse, réparties selon l'intensité (N=30)

Vieillesse	Intensité			S.O.	Moyenne
	Un peu	Beaucoup	Pas du tout		
<i>Pertes physiques</i>					0.1433
Problèmes habituels de santé:	4	1	16	9	
Baisse de capacités:	10	3	14	3	
Changement de l'apparence physique:	1	3	11	15	
Changement dans les fonctions corporelles:	5	3	9	13	
Difficulté à voir ou entendre:	1	1	8	20	
<i>Pertes psychologiques</i>					0.1367
Retraite ou baisse d'activités:	1	2	20	7	
Solitude éprouvée:	4	4	0	22	
Manque de soutien:	5	6	10	9	
Décisions prises dans le passé:	3	2	25	--	
Baisse des capacités mentales:	0	0	5	25	
<i>Menaces physiques</i>					0.1167
Problèmes possibles de santé:	4	2	24	--	
Baisse future des capacités physiques:	9	4	17	--	
Changement futur de l'apparence physique:	2	0	28	--	
Changement futur des fonctions corporelles:	5	0	25	--	
Possibilité de baisse de la vue, de l'ouïe:	1	1	28	--	

Tableau 4 continué

Vieillesse	Intensité			S.O.	M o y e n n e
	Un peu	Beaucoup	Pas du tout		
<i>Menaces psychologiques</i>					0.1130
Baisse future des activités:	5	5	20	--	
Solitude future:	3	1	26	--	
Déménagement récent ou prochain:	2	1	2	25	
Possibilité d'un déménagement futur:	4	1	25	--	
Possibilité de manquer de soutien:	2	2	26	--	
Probabilité d'un placement:	0	0	0	30	
Possibilité d'un placement: ¹	(6)	(1)	(23)	--	
Vie quand plus âgé(e):	3	0	27	--	
Idée de la mort:	1	5	24	--	
Baisse future des capacités mentales:	1	1	28	--	

¹Les réponses à cette question sont entre parenthèses car seuls les sujets ayant répondu "sans objet" à la question précédente, ont eu à répondre à cette question. Dans ce cas-ci, il s'agit des 30 sujets.

Les données du tableau 5 font ressortir que les pertes liées à l'hospitalisation seraient surtout la perte de la familiarité du domicile, le dérangement dans les habitudes personnelles et un sentiment de dépendance.

Ce tableau suggère que les principales menaces liées à l'hospitalisation seraient la date du congé de l'hôpital, les bruits étranges de l'unité, le manque d'informations sur leur état ou leur traitement, l'inquiétude par rapport à une personne ou un animal demeuré à la maison et les problèmes qui attendent les sujets à la sortie de l'hôpital.

Tableau 5

Nombre de sujets ayant rapporté des pertes et des menaces liées à l'hospitalisation, réparties selon l'intensité (N=30)

PERTES LIEES A L'HOSPITALISATION	Intensité			Moyenne
	Un peu	Beaucoup	Pas du Tout	
<i>Préoccupations personnelles</i>				0.1833
Perte de la fami- liarité du domicile:	7	2	21	--
<i>Environnement</i>				0.1167
Dérangement dans les habitudes:	3	5	22	--
Manque de sommeil:	3	2	7	18
Manque de visiteurs:	1	0	5	24
<i>Interaction avec le personnel</i>				0.1167
Sentiment de dépendance:	5	3	6	16
Manque de contrôle:	1	1	8	20
MENACES LIEES A L'HOSPITALISATION				
<i>Préoccupations personnelles</i>				0.1458
Personne ou animal à la maison:	5	2	11	12
Sécurité du domicile:	2	0	28	--
Date du congé:	6	4	20	--
Problèmes qui atten- dent à la sortie:	4	3	5	18
<i>Entrée et sortie de l'unité</i>				0.1000
Environnement non familier:	2	2	26	--
Transfert avec in- formation d'avance:	2	1	10	17
Transfert sans in- formation d'avance:*	(2)	(0)	(5)	--

Tableau 5 continué

MENACES LIEES A L'HOSPITALISATION	Intensité			S.O.	Moyenne
	Un peu	Beaucoup	Pas du Tout		
<i>Environnement</i>					0.1200
Routine de l'unité:	3	3	24	--	
Etat des autres malades:	3	2	25	--	
Possibilité de manquer de sommeil:	3	2	25	--	
Bruits étranges:	6	2	2	20	
Possibilité de man- quer de visiteurs:	3	0	27	--	
<i>Interaction avec le personnel</i>					0.0778
Manque d'informations:	7	1	2	20	
Possibilité qu'on ne dise pas tout:	3	2	25	--	
Manque de communi- cations:	2	1	2	25	
Réponses du personnel:	2	1	27	--	
Souci d'être accep- té(e):	3	0	1	26	
Jeune âge du person- nel:	1	0	19	10	

* Les réponses sont entre parenthèses car seuls les sujets ayant transféré et ayant répondu "sans objet" à la question précédente ont eu à répondre à cette question.

Pertes et menaces liées à l'infarctus

Les données relatives à l'infarctus sont divisées en pertes psychologiques (0,1667) et en menaces physiques (0,1667) et psychologiques (0,1900). (Aucune perte physique liée à l'infarctus n'a été identifiée parmi les pertes et les menaces comprises dans l'instrument sur les préoccupations à l'unité de soins intensifs coronariens).

Tableau 6

Nombre de sujets ayant rapporté des pertes psychologiques et des menaces physiques et psychologiques liées à l'infarctus, réparties selon l'intensité (N=30)

Infarctus	Intensité			S.O	Moyenne
	Un peu	Beaucoup	Pas du Tout		
<i>Pertes psychologiques</i>					0.1667
Style de vie:	3	6	21	--	
Recommandations médicales:	3	1	7	19	
<i>Menaces physiques</i>					0.1667
Retour possible de la douleur:	8	8	12	2	
Possibilité de douleur même si jamais ressentie:	(0)	(0)	(2)	--	
Retour possible d'autres symptômes:	2	5	10	13	
Possibilité d'au- tres symptômes non ressentis:	0	1	13	16	
Traitements spéciaux:	2	0	5	23	
<i>Menaces psychologiques</i>					0.1900
Attendre passivement:	5	4	9	12	
Santé future:	7	3	20	--	
Recommandations mé- dicales possibles:	8	0	22	--	
Conséquences possi- bles de la maladie:	5	5	20	--	
Conséquences possi- bles de la mort sur affaires personnelles:	4	2	24	--	

Les réponses sont entre parenthèses car seuls les sujets ayant répondu "sans objet" à la question précédente ont eu à répondre à cette question.

Tel que présenté au tableau 6, la perte psychologique liée à l'infarctus serait surtout celle liée au style de vie antérieur. Nous voyons aussi au tableau 6 que le retour possible de la douleur est la menace la plus citée liée à l'infarctus du myocarde et même de toutes les menaces possibles du questionnaire. L'item "les conséquences possibles de la maladie" est aussi

une menace fortement citée, suivie de l'inquiétude en rapport avec leur santé future, le fait d'avoir à attendre passivement leur rétablissement, le retour possible d'autres symptômes que la douleur et finalement les recommandations médicales anticipées.

Tableau 7

Ordre décroissant des moyennes de l'intensité des pertes et des menaces selon les éléments des trois dimensions

Elements des dimensions	Moyennes
Menaces psychologiques liées à l'infarctus	0.1900
Pertes liées à l'hospitalisation: préoccupations personnelles	0.1833
Pertes psychologiques liées à l'infarctus	0.1667
Menaces physiques liées à l'infarctus	0.1667
Menaces liées à l'hospitalisation: préoccupations personnelles	0.1458
Pertes physiques liées à la vieillesse	0.1433
Pertes psychologiques liées à la vieillesse	0.1367
Menaces liées à l'hospitalisation: environnement	0.1200
Menaces physiques liées à la vieillesse	0.1167
Pertes liées à l'hospitalisation: environnement	0.1167
Menaces psychologiques liées à la vieillesse	0.1130
Pertes liées à l'hospitalisation: interaction avec le personnel	0.1000
Menaces liées à l'hospitalisation: entrée-sortie de l'unité	0.1000
Menaces liées à l'hospitalisation: interaction avec le personnel	0.0778

Le tableau 7 démontre que les menaces psychologiques liées à l'infarctus ont la moyenne d'intensité la plus élevée, soit 0,1900. Les pertes liées à l'hospitalisation pour l'élément "préoccupations personnelles", suivent de près avec une moyenne de 0,1833. Par contre, les menaces liées à l'hospitalisation pour les éléments "entrée-sortie de l'unité" et "interaction avec le personnel", ont des moyennes d'intensité les moins élevées, soit respectivement 0,1000 et 0,0778.

Pour terminer l'analyse des données, certaines caractéristiques des sujets de l'étude et de leur environnement, ont été appariées et soumises au test-t de Student lorsque la distribution des sujets l'ont permis. Aucune différence significative entre les sujets avec différentes caractéristiques socio-démographiques ou liées à l'histoire médicale n'a été observée.

Interprétation des résultats

Réponses négatives

Les réponses négatives, quand au fait d'être préoccupé ou non par les pertes et les menaces suggérées par le questionnaire, sont nettement majoritaires. Cela, contrairement aux attentes face à un questionnaire basé sur une recension importante des écrits sur les pertes et les menaces liées aux trois dimensions: vieillesse, hospitalisation dans une unité de soins intensifs coronariens et infarctus du myocarde. Et cela aussi, malgré le fait que des juges ont étudié les énoncés du questionnaire et ont avancé que ces énoncés étaient pertinents pour une population âgée, hospitalisée et atteinte d'une maladie grave. Ces résultats démontrent peut-être un effet de Hawthorne ou encore de la désirabilité sociale de la part des sujets. Les résultats peuvent aussi s'expliquer par ce qu'avancent certains auteurs.

Lazarus (1980), suggère que la façon de composer avec une situation possède deux fonctions. Dans la première fonction, les efforts sont dirigés vers la résolution du problème alors que dans la deuxième fonction, les efforts sont dirigés vers la régulation des émotions générées par la perception de stress. Dans les situations évaluées comme n'ayant que peu de possibilités d'un changement bénéfique, l'individu utiliserait la deuxième fonction pour composer avec cette situation et ainsi, baisser le niveau de détresse et de dérangements somatiques. De même, Cay (1982) prétend que lors d'une hospitalisation à l'unité de soins intensifs coronariens à la suite d'un infarctus du myocarde, la personne atteinte tente de composer par des efforts dirigés vers la régulation des émotions.

Pour leur part, Hackett et al. (1968) concluent une recherche sur 50 personnes âgées entre 37 et 74 ans, victimes d'un infarctus du myocarde, en disant que la négation est peut-être la plus répandue des façons de composer avec le stress émotionnel aigu. Les résultats de l'étude de Hackett et al. démontrent qu'il n'y aurait aucune corrélation entre la façon de nier et le sexe ou l'âge des sujets. Andréoli et al. (1979) rapportent deux façons de nier: la négation de la maladie elle-même et la négation des sentiments associées à une maladie menaçante pour la vie.

Ces mêmes résultats sont cependant en désaccord avec d'autres auteurs. Par exemple, Thomas et al. (1983) considèrent que quel que soit le diagnostic ou

le degré de maladie des personnes hospitalisées à l'unité de soins intensifs coronariens, celles-ci sont disposées et même désirent discuter de leurs problèmes. Cependant, leur instrument consistait en questions ouvertes et réponses enregistrées contrairement aux questions fermées de la présente étude et celles de l'étude de Hackett et al. (1968).

Réponses aux questions de recherche

Les principales pertes perçues par les sujets de cette étude sont, en rapport avec la vieillesse: la baisse de leurs capacités physiques, un manque de soutien et la solitude. Burnside (1973, 1981) souligne aussi l'importance des pertes physiques encourues par les personnes âgées. George et al. (1984) pour leur part, suggèrent que le manque de soutien et la solitude expérimentées par les personnes âgées, sont souvent associées à la perte des personnes aimées. Le dérangement dans les habitudes personnelles, la perte de la familiarité du domicile et le sentiment de dépendance prédominent dans les préoccupations liées à l'hospitalisation elle-même. Finalement, pour la dimension infarctus, un style de vie antérieur ayant pu contribuer à la maladie, préoccupe le plus grand nombre de sujets.

Les menaces les plus citées sont, pour la vieillesse: une baisse future de leurs capacités physiques et de leurs activités, l'idée de la mort en plus de la possibilité d'un placement en institution. Parmi les menaces liées à l'hospitalisation, la date de la sortie de l'hôpital prédomine. Cette menace avait déjà été identifiée par Davies et Peters (1983). Pour leur part, les menaces liées à l'infarctus sont prédominées par le retour possible de la douleur. Thomas et al. (1983) ont aussi suggéré que la douleur est la première préoccupation des patients de leur échantillon, patients âgés entre 31 et 80 ans. Les écrits ne sont pas unanimes sur le sujet de la perception de la douleur par les personnes âgées. Cependant, l'idée prédominante est que celles-ci ressentent moins la douleur de l'infarctus que les sujets plus jeunes. Les résultats de la présente étude semblent en contradiction avec cette idée généralisée. Les conséquences de la maladie lors du retour à la maison, l'état de santé future et le fait d'avoir à attendre passivement leur rétablissement sont les autres menaces les plus citées liées à l'infarctus du myocarde. Il est à noter que parmi les 30 sujets, six d'entre eux en étaient à leur deuxième infarctus et trois autres à leur troisième infarctus. Ceci pourrait avoir influencer certaines des réponses.

Intensité des pertes et des menaces liées à la vieillesse, l'hospitalisation dans une unité de soins intensifs coronariens et l'infarctus du myocarde

L'ensemble des menaces psychologiques liées à l'infarctus a une moyenne d'intensité supérieure aux autres pertes et menaces du questionnaire. Les pertes psychologiques et les menaces physiques liées à l'infarctus ont aussi

des moyennes d'intensité élevées. Il est difficile de commenter sur ces résultats étant donné le peu d'appui ou d'objection retrouvé dans les écrits sur les pertes et les menaces perçues par les personnes âgées victimes d'un infarctus. Il demeure que, quel que soit l'âge de la victime, il est bien reconnu que l'infarctus du myocarde est une maladie redoutable et menaçante pour tous.

La perte et les menaces liées aux préoccupations personnelles, élément de l'hospitalisation, ont des moyennes d'intensité supérieures aux autres pertes et menaces de la dimension hospitalisation. Davies et Peters (1983) croient aussi que les préoccupations personnelles sont prédominantes pour les personnes âgées hospitalisées.

Pour leur part, les menaces liées à l'interaction avec le personnel ont la moyenne d'intensité la plus basse de tous les éléments du questionnaire. Ce résultat peut refléter la croyance de Mayberrey et Kent (1984) que les médecins et les infirmières réussissent à sécuriser les malades. Cependant, ces auteurs croient aussi que le personnel soignant peut à l'occasion angoisser davantage les malades. Ce qui ne semble pas être le cas pour les sujets de cette étude. Une autre possibilité consiste dans le fait que les sujets ont peut-être craint de discréditer le personnel, en répondant de façon critique, malgré la confidentialité des réponses.

Les pertes et les menaces liées à la vieillesse occupent une situation moyenne par rapport au reste des préoccupations des sujets de l'étude, avec une intensité moins élevée que certaines et plus élevée que d'autres. Selon Lazarus (1980), certains facteurs situationnels peuvent augmenter ou diminuer la perception de perte ou de menace d'un événement. Ces facteurs peuvent être l'imminence d'un danger, l'incertitude face à un événement, sa durée et sa situation par rapport à d'autres événements stressants. Ainsi, face à l'infarctus et à l'hospitalisation, les pertes et les menaces liées à la vieillesse ont peut-être un attribut plus chronique et passent probablement au deuxième plan.

En conclusion, la recension des écrits a permis d'élaborer le questionnaire et les réponses positives obtenues à chacune des questions ont pu nous éclairer sur les pertes et les menaces perçues le plus fréquemment ou le plus intensément par les sujets de cette étude.

Recommandations

Suite aux résultats obtenus, les recommandations suivantes sont faites pour la recherche et pour la pratique infirmière:

Recommandations pour la recherche infirmière

1. Procéder à une étude méthodologique de l'instrument pour identifier les préoccupations des personnes âgées à l'unité de soins intensifs coronariens.

2. Reproduire l'étude avec un plus grand nombre de répondants, ce qui pourrait confirmer ou infirmer les résultats obtenus par la présente étude et permettre d'établir des mesures d'association entre les différentes caractéristiques socio-démographiques et médicales des sujets.

3. Vérifier si la négation des sujets est superficielle et dépend du questionnaire, ou si elle est une réaction de défense nécessaire afin de mieux composer avec leur situation difficile.

4. Reprendre cette recherche par une approche phénoménologique avec des questions ouvertes.

Recommandations pour la pratique infirmière

1. Rassurer les patients âgés sur les moyens de contrôle de la douleur dans l'éventualité d'une réapparition de cette douleur.

2. Renseigner les patients âgés sur l'évolution normale du rétablissement.

3. Mettre l'accent sur ce que les patients âgés peuvent faire pour s'aider et ne pas avoir à attendre passivement leur rétablissement.

4. Être sensibilisé au fait que les malades âgés, hospitalisés, ont beaucoup de préoccupations personnelles et que ces préoccupations ont une place prépondérante dans leur esprit, surtout ce qui a trait à une baisse présente et future de leurs capacités physiques, une diminution possible de leurs activités, un manque de soutien, la date de leur sortie de l'hôpital, une personne ou un animal demeuré à la maison et la possibilité d'un placement en institution.

5. Structurer un programme qui s'adresserait au malade et à sa famille afin de les aider à satisfaire les besoins identifiés par les préoccupations des personnes âgées de cette étude. D'autre part, ce programme se devrait d'inclure les ressources offertes par l'équipe multidisciplinaire.

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ABSTRACT

The number of elderly patients requiring care in intensive care units continues to grow. Little is known of how this particular group perceives their losses or infirmities and what members of this group consider to be threats to their physical, psychological or social well-being.

Recognised high-stress situations, such as ICU treatment following a myocardial infarction, may be more stressful because of patient age. In an attempt to identify these perceived losses and threats, the researcher designed a questionnaire based on the Lazarus (1980) theory of psychological stress.

The results of the study show that a high proportion of the questions not areas of concern for the elderly patient. The positive responses given were listed by degree of importance, spanning an range from actual fear of pain to personal preoccupations and fear of diminished capacity.

Recommendations for nursing research and practice accompany this descriptive study.

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ACTOR-OBSERVER ATTRIBUTIONS FOR FAILURE TO CONTROL PHYSICAL CONDITIONS

Evelyn Perloff and Patricia Bohachick

In the actor-observer attribution paradigm Jones and Nisbett (1972) proposed that the causal explanation or attribution made by individuals (actors) for their own behaviour differs from the explanation that others (observers) make of that behaviour. That is, it has been theorized that actors tend to attribute their behaviour to situational demands or events (job pressures, legal problems, social relations, etc.), whereas observers attribute the same behaviour to elements in the actor's disposition (personality, attitudes, physical make up, etc.). It seemed to us that the Jones and Nisbett position had reached a kind of adolescence in terms not only of its age but also its unsettled nature of research findings. Certainly, a number of studies have confirmed actor-observer differences (Arkin & Duval, 1975; Eisen, 1979; Miller, 1975; Nisbett, Caputo, Legant & Marecek, 1973). On the other hand, a comparable number has either disconfirmed (Calder, Ross & Insko, 1973; Miller & Norman, 1975; Storms, 1973) or only partially supported the Jones and Nisbett hypothesis (Avis, 1979; Feather & Simon, 1971; Herzberger & Clore, 1979; Fichten, 1980; Harvey, Harris & Barnes, 1975; Ross, Bierbrauer & Polly, 1974).

In spite of the fairly extensive research comparing actors' and observers' attributions, these studies have for the most part, concentrated on laboratory effects (Eisen, 1979; Feather & Simon, 1971; Herzberger & Clore, 1979; Nisbett, Caputo, Legant & Marecek, 1973; Storms, 1973). Application of the Jones and Nisbett hypothesis to events outside the laboratory are few (Avis, 1983; Fichten, 1980).

In the Avis (1983) study, causal attributions of students' academic performance were provided by teachers (observers) and students (actors). Consonant

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with the Jones and Nisbett hypothesis, teachers attributed less importance to situational factors versus dispositional factors than did students (Avis, 1983). Other findings did not support actor-observer predictions. Fichten (1980) compared "happy and distressed couples' self and spouse perceptions and their attributions about the causes of their own and their spouse's behavior" (p.1). Results indicated that distressed couples made causal dispositional attributions for their spouse's negative behaviour but causal situational attributions for their own negative acts. Additional results again only offered partial support for hypothesized actor-observer differences.

It seemed clear, at least, to us that there was a general dearth of applied research, with particular absence of studies related to health behaviour, designed to test the Jones and Nisbett hypothesis. And yet back in 1974, Rosenstock and Kirscht noted: "Every health program that involves obtaining the cooperation of clientele . . . makes some assumption about how people behave, and why they behave as they do and how that behavior might be modified" (p. 470). If patients (actors) and health-care professionals (observers) do differ in their causal attributions of health and illness behaviour, it surely follows that recognition and understanding of these differences are essential for successful patient care.

The purpose of the present research was to assess differences in actors' (patients') and observers' (health care professionals') attributions for failure to control unhealthy physical conditions. Actors would be represented by patient groups with two diagnoses. Observers would include four groups of health care professionals (master's prepared nurse clinicians, undergraduate senior nursing students, junior medical students and freshman medical students).

Following directly from the Jones and Nisbett (1972) actor-observer paradigm, we then hypothesized that patients (actors) would be more situationally oriented and less dispositionally oriented concerning lack of control of their unhealthy physical condition than health care professionals (observers). We also contended that, of the four health care professional observer groups, master's prepared clinicians would identify most with patients in attributions of their behaviour, because nursing stresses psychosocial aspects of patient care. Conversely, we anticipated that junior medical students would be most dispositional in their attribution of patients' failure to control their unhealthy physical conditions, because medicine has an educational emphasis on the pathophysiological aspects of illness. (See Figure 1).

Two conditions were selected for study - hypertension and obesity - because they represented physically unhealthy conditions and permitted comparison on two additional dimensions. A first dimension suggested a physical-psychological continuum, with hypertension physically based and

ACTORS		OBSERVERS		
Patients	Master's Prepared Nurse Clinicians	Senior Nursing Students	Freshman Medical Students	Junior Medical Students
Most Situational			Most Dispositional	

Figure 1
Anticipated causal attributions for sample actors and obsesvers

obesity psychologically oriented. The second dimension, probably not uncorrelated with the first, reflected a continuum of controllability-uncontrollability, where hypertension suggests more external control and obesity implies more internal control.

Method

Prior to design of this study, a questionnaire had been developed to measure common attributions offered by patients for their failure to improve a physically unhealthy condition. Construction of the questionnaire not only followed appropriate measurement procedures, but also derived from common attribution theory. More specifically, items were prepared to assess dimensions of control, stability and locus. The format selected resembled that of questionnaires used in other attribution studies. A structured scale approach was used because Elig and Frieze (1979) have shown that this method not only has better internal validity and reliability, but that a structured scale approach was preferred to open-ended questions.

The questionnaire required respondents to rate the extent to which each of 28 factors was involved when patients' high blood pressure or overweight problem did not improve. Ratings were made on a seven-point scale where 1 and 7 represented lowest and highest degrees of attribution, respectively.

The questionnnaire was initially reviewed by 12 psychology and nursing faculty members to ensure that items were relevant and clearly stated. Following further editing, the scale was pre-tested with 138 graduate nursing students in various areas of specialization. The final questionnaire administered contained 28 items. A copy of the questionnaire is available from the authors.

The questionnaire was factor analyzed and revealed the existence of two scales. Reliability (Cronbach's alpha) for the dispositional scale (internal items) was .80, with fairly high intercorrelations among the items. Reliability for the situational scale (external items) of the questionnaire was .64. Additionally, items did not correlate highly. It seemed that judges could place items into internal or external categories, but subjects appeared to understand the relationship between causality and failure to control unhealthy conditions for dispositional factors only. This problem could probably be solved by items that explain situational causes more fully. Therefore, it seemed that we would be wisest to adopt the dispositional scale by itself to test our hypotheses.

Two studies were conducted. They involved health care professionals' (observers') and patients' (actors') attributions for failure to control (1) high blood pressure or (2) an overweight problem.

Procedures for conducting both studies were straight forward, with participation voluntary and anonymous. Written consent to participate in the study was obtained from all participants. Both groups of patients (hypertensive and overweight) completed questionnaires during routine clinic registration procedures. Health care professionals, recruited at the University of Pittsburgh School of Medicine and School of Nursing, completed their questionnaires during the first ten minutes of a regularly scheduled class.

Study 1

Subjects

This first study recruited 76 patients with hypertension from a hypertension clinic in a large teaching hospital. The health care professionals included 24 master's prepared nurse clinicians, 30 undergraduate senior nursing students, 19 junior medical students and 24 freshman medical students.

Of the 76 patients with hypertension, 55 percent were female. Patients' ages ranged from 15 to 84 years, with 48% between 45 and 64. Just over half the patients (54%) were married, with the remaining 46% single, widowed or divorced. Of the 76 patients, 21% were college graduates, 35% had completed high school and the remaining 44% had some high school or less. Employment information indicated that 46 percent were employed and 54% were not employed.

Not surprisingly, health care professionals differed from patients. Thus, of the 43 medical students, almost two-thirds were male (65%) and 70% were 23 years of age or younger. Just over two-thirds (69%), were single or separated and 31% were married. Among the 54 nurses, however, most were

female (83%) and less than half (41%) were 23 years of age or younger. Again, twothirds (67%) were single or separated and 33% were married.

Results

Table 1 presents attribution means and standard deviations for lack of control of hypertension. Means for the five groups surveyed were: senior nursing students, MS=45.40; master's prepared nurses, MM=45.33; freshman medical students, MF=44.88; junior medical students, MJ=44.26; and patients, MP=38.53.

Table 1

Attribution of Means and Standard for Lack of Control of Hypertension

Group		M	SD	N
Nurses				
	Senior	45.40	6.28	30
	Master's	45.33	6.46	24
Medical Students				
	Freshman	44.88	6.51	24
	Junior	44.26	4.64	19
Patients		35.53	11.76	76

Table 2 presents a one-way analysis of variance for patient's and health care professional's attributions for patients' lack of control of their hypertension. The resulting $F_{4,168} = 5.53$ was statistically significant at $p = .0003$ and indicated that health-care professionals (four nursing and medical student groups) were more dispositional for patients' failure to control their hypertension than patients themselves. In contrast, our hypothesis that nurses would be less dispositional than medical students was rejected. That is, there were no significant differences among the four groups of health professionals.

Table 2***One-Way Analysis of Variance for Patient's and Health Care Professional's Attributions for Patients' Lack of Control of their Hypertension***

Source	df	SS	MS	F	P
Between groups	4	1821.01	455.25	5.53	.0003
Within groups	168	13831.79	82.33		
Total	172	15652.80			

Study 2***Subjects***

A total of 37 clients with obesity were recruited from a weight loss clinic in the same Northeastern metropolitan area. Of the health professionals who completed the questionnaire, there were 27 master's prepared nurse clinicians, 19 undergraduate senior nursing students, 15 junior medical students and 22 freshman medical students.

Demographic characteristics of the 37 overweight clients included the following. Of the group, 84 percent were female and in the age range between 35 and 64 years. Over two-thirds of clients (68%) were married, with the remaining 37% single, widowed or divorced. By education, 62% had completed high school and 38% were college graduates. Seventy-three percent were employed and 27% were not employed.

Among the 37 medical students three-quarters were male (76%), 70% were 23 years of age or less, 59% were single or separated, and 41% were married. Of the 46 nurses almost all were female (96%), 39% were 23 years of age or less, over half (57%) were single or separated and 43% were married.

Results

Table 3 presents attribution means and standard deviations for patients' unsuccessful weight control. Means for the five groups surveyed were: senior nursing students, MS=49.89; master's prepared nurses, MM=43.45; freshman medical students, MF=48.21; junior medical students, MJ=46.60; and patients, MP=39.43.

Table 3***Attribution of Means and Standard Deviations by Group (Obesity)***

Group	M	SD	N
Nurses			
Senior	49.89	5.53	19
Master's	43.45	6.28	27
Medical Students			
Freshman	48.21	6.55	22
Junior	46.60	5.73	15
Patients	39.43	7.70	37

Table 4 presents a one-way analysis of variance for patient's and health care professional's attributions for unsuccessful weight control. The resulting $F_{4,115}=11.94$ was statistically significant at $p<.001$. These results indicated that health-care professionals (the four nursing and medical student groups) were again more dispositional in their attributions for clients' failure to control their weight.

Table 4***One-Way Analysis of Variance for Patient's and Health Care Professional's Attributions for Patients' Unsuccessful Weight Control***

Source	df	SS	MS	F	P
Between groups	4	2074.63	518.66	11.94	.0000
Within groups	115	4993.96	43.43		
Total	119	7068.59			

Discussion

Although these two studies provided evidence of an actor-observer effect in health settings, we were unable to separate perceptual, motivational or information explanations to account for dispositional differences. That is, patients, like actors in other actor-observer studies, described themselves as less blameworthy than did the health care professionals who served as observers. Certainly, patients and health care professionals differed in how much they knew (information), with health care professionals far more knowledgeable about the physical conditions of hypertension and obesity. Patients, on the other hand, are far more aware of a variety of specifics that may have affected their health-related behaviour. As an example, Rodin (1978) pointed out health-care professionals may view patients not adhering to their medication regimens as "recalcitrant and uncooperative," but patients "would know that they stopped the medicine because it made them feel nauseous" (p. 531).

We suspect, however, that motivational factors may be most responsible for the significant actor-observer differences we noted. That is, attribution literature has acknowledged actors' hesitancy to accept responsibility for unsuccessful behaviour, seeking instead to blame either others or the situation (environment). The present studies, which involved actor-observer attributions for a highly undesirable outcome (failure to control unhealthy conditions), were probably more extreme examples of a negative outcome than has heretofore been reported. Not surprisingly, then, the patients should have been significantly less dispositional than the health care professionals, and review of the findings unequivocally found this to be so, $p < .0005$.

In contrast, lack of control of patient's unhealthy conditions may be viewed by health care professionals as a treatment failure, resulting in greater stress on patients' dispositionality. What we are suggesting here is that health-care professionals, in order to maintain their positive self-image for quality of patient care, blamed patients more intensely than observers would have in situations that were neither so personally nor professionally threatening.

Although we suspect that Jones and Nisbett may be pleased with our findings, we believe a more salient factor is the direct application of these results to health practice, especially because statistical significance held across two conditions (hypertension and obesity). Our conclusions that health care practitioners will be more likely to hold patients responsible for failure to improve than will the patients themselves should not be surprising to behavioural or health professionals; however, empirical data to this effect have been difficult to obtain. Such findings in health care settings are important because "the differences between the actor's biases and the observer's biases in attribution could sow seeds for misunderstanding between patients

and staff" (Rodin, 1978, p.533). What follows now, however, is recognition and acceptance of these findings and implementation of programs of behaviour change for patients and health-care professionals.

Focus of such programs should undoubtedly be cognitive and affective. That is, we should recognize that misattributions by both patients and health care professionals do exist and even get reinforced. Misattributions can be reversed if the observer's attention is directed specifically to situational demands on the actor (Jones, 1979). Therefore, it is important that health professionals become sensitive to their patients' attributions for failure to control unhealthy physical conditions. At the same time, we know that the feeling dimension can be influenced by employing a variety of role-playing techniques. Through role playing the health professional can gain a patient perspective on situational variables surrounding unhealthy physical conditions. By attending to situational variables such as financial and time cost of treatment, availability of resources, and quality of social support the health professional may develop a greater understanding of patients' behaviours with regard to health matters. This approach may be particularly appropriate because demographic characteristics of patients and health care practitioners often differ. We are unaware of any empirical data that suggest that attributions are either age related or education related. We recognized, of course, that the patient and health care professional samples were not comparable, especially with regard to age and education, but we also know that this is reality in health practice - patients are generally older, not as highly educated and probably of lower socioeconomic status than health care professionals.

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RÉSUMÉ

Attributions acteur-observateur pour le manque de contrôle des conditions physiques malsaines

L'objectif de cette recherche était d'évaluer les différences entre les attributions des patients (les acteurs) et les professionnels de la santé (les observateurs) pour le manque de contrôle des conditions physiques malsaines. Deux études ont été menées. L'échantillon de la première étude consistait de 76 patients souffrant d'hypertension et 94 professionnels de la santé. Tous les participants ont rempli un questionnaire où on leur demandait de marquer le degré auquel chacun de 28 éléments choisis était impliqué lorsque le niveau d'hypertension des patients ne s'améliorait pas. Une analyse des variantes a indiqué que les professionnels de la santé étaient beaucoup plus portés que les patients eux-mêmes ($p = .003$) à attribuer à leur disposition le fait que les patients étaient incapables de contrôler leur hypertension.

Dans la seconde étude, 37 clients d'un programme de contrôle de poids et 83 professionnels de la santé ont rempli un questionnaire où ils devaient indiquer leur perception d'éléments reliés au défaut de contrôler son poids. Une analyse des variantes a indiqué que les professionnels de la santé attribuaient le manque de succès des clients à contrôler leur poids bien plus ($p < .001$) à des éléments de disposition que ne le faisaient les clients obèses. La reconnaissance et l'appréciation des professionnels de la santé du fait que les patients et les professionnels diffèrent dans leur perception des éléments associés au défaut de contrôler les conditions physiques malsaines pourraient former la base d'une plus grande compréhension et acceptation des comportements des patients face aux questions de santé.

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DILEMMAS OF ETHICS AND VALIDITY IN QUALITATIVE NURSING RESEARCH

Carole A. Robinson and Sally E. Thorne

Nurses engaged in qualitative research are faced with role and relationship dilemmas that have a significant bearing on the ethics of their encounters with patients in the research context and on the validity of the research findings. The dilemmas to be addressed, those of informed consent, influence, immersion into the data and intervention within the research context, are not new. However, experience has taught the authors that additional consideration is required in order to manage the research process in ways compatible with the dual considerations of responsibility to participants and responsibility for systematic, scientific inquiry.

Qualitative and quantitative paradigms of nursing research reflect orientations to research problems and research processes that are philosophically distinct. Quantitative approaches originate from empirical principles concerning the necessity for explaining behaviour through rigorous and objective measurement of that which is amenable to reliable and valid quantification. In contrast, qualitative approaches seek to explain behaviour not through measurement, but through systematically entering into the context that would explain the beliefs, thoughts, and intentions underlying the behaviour (Bernheimer, 1986).

While research guided by either paradigm may involve data collection by the interview method, the role of the researcher in conducting the interview is specifically determined by the philosophical perspective inherent in the research paradigm. Distinctions within this role appear in the selection of data sources, the structure of the interview, the relationship that is formed between researcher and informant and the conduct of the research throughout the research process. Because of the expectation that the roles of nurse and researcher can and should be both distinct and separate, the nature of the role

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required of a qualitative researcher presents some peculiar dilemmas for the nurse who is using such an approach to explore clinical questions.

The professional orientation of nursing plays a role in shaping the nature and process of the qualitative inquiry. In several important ways, the act of gathering relevant, individualized data and subjecting it to an established set of analytic processes for the purpose of formulating defensible conclusions is indistinguishable from the essence of nursing action. It has been said, in fact, that the nurse behaves as an implicit social scientist in order to account for competent nursing action.

Just like scientists constructing theories, nurses observe patient behaviour (signs and symptoms), impose structure on their observations through conceptualization and categorization, formulate and test implicit theories about health and illness and the nature of patients and use hypotheses generated from these personal theories to guide observation and action (Kasch, 1986, p.228).

The cognitive processes of qualitative analysis, and the interactional context of qualitative data gathering are similar to those of nursing practice. As such, distinctions between the roles of nurse and researcher are easily blurred. Further, as Styles (1982) explains, the obligation to attend to clinical concerns is something of a "moral imperative" for nurses. Thus it is unlikely that qualitative nurse researchers can completely shed the trappings of their clinical role. While early efforts to explain the difficulties qualitative researchers experience with divesting themselves of the role of nurse attributed the problem to neophyte nurse researchers who were insufficiently comfortable adopting a research role (Byerly, 1969; Davis, 1968), it seems more fruitful to recognize that the problem reflects an inherent dilemma for all nurse researchers involved in qualitative studies of clinical nursing phenomena (Field & Morse, 1985). It is our belief that, by virtue of being a nurse, the qualitative researcher faces unique issues associated with informed consent, influence, immersion into the data and intervention within the research context. These four aspects of the research process illustrate the dilemmas we confront when we attempt to combine the ideologically distinct roles of nurse and researcher.

Informed Consent

Informed consent has long been recognized as a problematic issue in qualitative research (Archbold, 1986; Byerly, 1969; Wax, 1977). Of concern is the reality that the nature of qualitative inquiry precludes prior knowledge of precisely what will occur in the context of the research encounter (Cassell, 1980). Further, because detailed explanations of what the researcher expects to find would contravene the underlying assumptions and shape the data con-

struction, they are not expected in qualitative research designs. Traditionally, the expectation has been that consent is a product of on-going negotiation throughout the period of data gathering (Wax, 1977). Because data collection and analysis occur simultaneously, consent implied at one stage of the fieldwork cannot be assumed once the original intent of the researcher has been revised or refined (Byerly, 1969).

Qualitative nurse researchers share this concern with other researchers; however, their status as nurses further complicates the inherent problem. While the social status of nursing affords nurse researchers some advantages in terms of access to and credibility in certain types of fieldwork situations (Olesen & Whittaker, 1967), it also poses some disadvantages in terms of the social role that participants expect of a nurse in the research context (Wilson, 1985b). The social image of nursing is that of dedication and altruism, an image that is cherished and cultivated within the profession. While other professional groups may share comparably powerful social images, ours is distinguished by the fact that the attributes are interpreted as belonging in the context of personal qualities rather than skills. As Kim (1983) states,

... most of what nurses do is not significantly different from what ordinary people do in their everyday lives. What is different is not the acts themselves, but when, how and why they are carried out. In nursing, the same acts take on special meanings in their enactment (p.12).

While nurses may be able to isolate and enumerate some of the fine distinctions between the actions required in clinical and research roles, it behooves us to recognize that the lay public is much less aware of these subtle differences, and therefore likely to confuse the roles. Thus, informed consent may be further compromised by participants' assumptions about the research encounter based on expectations of the researcher as nurse.

Some authorities suggest that the dilemma be addressed by emphasizing at every opportunity the research aspect of the role (May, 1979). While this may be of some benefit in assuring on-going consent, it raises the likelihood that data are influenced by the researcher's focus upon role. How informants might respond to repeated assertions about one's professional role is unknown. Further, if informants are to be expected to consider the researcher as a non-nurse, it is doubtful that such assertions would prove successful.

Another approach to the dilemma addresses the specificity of consent as the central issue. From this perspective, when informants' responses to an interviewer are incongruent with the research context, the interviewer must recognize that consent to participate in research has been theoretically withdrawn (Field & Morse, 1985). If this perspective were taken seriously, the qualitative nurse researcher would have to distinguish between responses

that implied informant role and those that implied patient role. However, such distinctions would be impossible in most instances, because it is only in the extreme cases that we can be certain informants perceive us in the role we try to portray.

The authors perceive that informed consent is problematic at best and perhaps even impossible in the context of qualitative nursing research; therefore it is our opinion that the obligation of the nurse researcher is to account for and acknowledge the expectations inherent in the roles of both nurse and researcher. The assumption of informed consent must be treated with caution, and, as such, the ethical obligations of the professional nurse must be recognized as operating within the clinical research situation.

Influence

The issue of influence requires close examination in every qualitative research project. In contrast to quantitative designs which aim to control for all possible avenues of influence upon the data, qualitative researchers accept the premise that there is "no way to study a thing without changing it" (Sandelowski, 1986, p.34). As Knaack (1984) points out, by merely attending to selected aspects of an experience or seeking clarification of a perception, the researcher often triggers shifts in the meaning an informant assigns to the phenomenon under study. In recognition of this issue, qualitative researchers have addressed the role of researcher bias in both construction and interpretation of data. Concern about researcher bias in relation to data construction will be addressed here in terms of influence, while bias in relation to data interpretation will be addressed in terms of the issue of immersion. Bias occurring through researcher influence on the construction of data is viewed not as a limitation, but as an inherent component of the data, that must be accounted for in the process of data analysis and in the reporting of findings (Byerly, 1969). The researcher is viewed as the instrument of inquiry, thus the qualities of that instrument must be known. This knowledge is perceived as an asset to the research process in that it explains the findings in the context of the relationship that was the basis for data gathering.

Beyond individual assumptions and biases, the nurse involved in qualitative research brings to the endeavor the assumptions and biases of the profession. Styles (1982) believes that socialization and enculturation into the profession of nursing are sufficiently powerful to make "the sense of self and sense of vocation ... inseparable, inextricably bound together" (p.107). She maintains that the sense of mission, awareness of the social sanction for that mission and certainty about the nature and importance of the work are characteristic of nurses' socialization. Kim (1983) contends that, because of this professional enculturation, nurse researchers bring a unique perspective to the study of any research problem, and that this perspective can be differentiated

from the perspective of any other discipline using similar methods to study a similar issue.

Nurses who do qualitative research, therefore, have an obligation to account for the influence of their professional perspective upon the process and outcome of their research. It has been recognized, for example, that nurses have an advantage in obtaining certain species of data that might not be available to non-nurses (Chenitz, 1986). The nurse researcher expects to have access to private or personal information, and rightly assumes that informants will offer it more readily than they would to non-nurses. Informants appreciate that the business of nursing requires involvement in the most intimate of bodily functions and human experiences, thus are disinclined to protect the nurse researcher from the detail and specificity they expect nursing knowledge to require (Byerly, 1969).

Influence upon data occurs not only in relation to the species of data that are available to the nurse researcher, but also in relation to the process of obtaining that data. Fieldworkers and qualitative researchers of all disciplines recognize the necessity for developing trusting relationships with informants in order to generate data that are accurate and true. The context of all nursing practice is the development of just such trusting relationships; as a result, nurses have well developed skills in this aspect of the research relationship. Moreover, nurses have developed the capacity to manipulate those very skills toward the goals of their professional practice. They use their relationships with patients not only to facilitate data gathering, but also as tools for interpersonal influence (Kasch, 1986). Because of this, accepted practice as to appropriate roles for social scientists engaged in fieldwork cannot be adopted without condition. While supportive responses might be essential to encourage the sharing of private information (Swanson, 1986) and interdependency might be productive in equalizing the balance of power (Wax, 1977), nurses are trained to use these skills toward more goal-directed functions such as comforting, teaching, or reassuring (Kasch, 1986). By virtue of training received in the constructively manipulative aspects of these interactional behaviours, the nurse is at special risk for influencing the data source during the data gathering process.

It is essential to recognize that our efforts to build rapport, foster trust and engage the informant in introspection are made easier by our knowledge of and expertise in the nurse-patient relationship. We can no more abandon these special skills than we can deny our nursing perspective. However, in acknowledging that our communications skills are powerful tools, we are required to take responsibility for the ethical implications of the relationships we develop. Data are being influenced, but, even more importantly, people are being influenced. Therefore, rather than claiming that there is no known risk to the informant because talking is a neutral activity, we must acknowl-

edge that even the process of reflecting upon an experience under the guidance of a skilled interviewer can have a powerful impact on the informant's view of the event (Archbold, 1986). Thus, the already thorny issue of informed consent takes on added significance as a dilemma in qualitative nursing research.

Immersion

Quantitative and qualitative research are often distinguished by their variant concerns with objectivity and subjectivity. While qualitative research implies a preference for subjectivity, its techniques of disciplined inquiry are as thorough and objective as those of quantitative research (Bernheimer, 1986). The tension between subjectivity, which is essential for data collection, and objectivity, which is essential for data analysis, is apparent in the concern qualitative researchers have for the issue of immersion.

The literature on fieldwork contains abundant advice on how to immerse oneself in the data in order to gain access to the processes or perspectives being studied. It further provides caution as to the problems inherent in over-immersion, or "going native" (Evaneshko, 1985). A measure of objectivity is essential for the analysis of data, which occurs concurrently with data collection; with this in mind, some researchers advocate periods of immersion interspersed with periods of withdrawal from the data (Byerly, 1969; Glaser & Strauss, 1966). The assumptions underlying the concern for immersion are that objectivity is the foundation for valid data, while bias related to data interpretation is a product of subjectivity.

All qualitative methods require direct, subjective involvement with the subject of inquiry as an essential part of the research process (Wilson, 1985a). Clearly, the intimacy that occurs in the relationship between researcher and informant promotes both the telling and the judging of truth (Leininger, 1985; van Binsbergen, 1979). However, total immersion can cause the informants' way of thinking to be adopted by the researcher, producing confusion and the loss of critical faculties necessary for analysis (Hutchinson, 1985; Sanday, 1979). Without critical analysis, the researcher is at risk of misinterpreting data, special pleading, premature analysis or inability to make sense of the data (Duffy, 1985; Glaser & Strauss, 1966; Sandelowski, 1986).

When the qualitative researcher is a nurse and the focus of study is a clinical one, there is an added dimension to the more general subjectivity-objectivity dilemma. As Kim (1983) states, nursing scientists do not enjoy the same privilege of objective distance that other scientists rely upon. She maintains that while nurses may strive for detachment in their scientific inquiries, they must continually balance this attitude with one of advocacy

for client well-being. The focus of nursing is the experience of the human person, and clinical research serves as an indepth exploration into that experience; thus the nurse researcher is at once the observer and the recipient of the knowledge gained through observation. It does no more good to insist that a researcher ignore her nursing imperative than it would to tell a nurse to cease systematic inquiry. Inherent in the qualitative nurse researcher role is the fact that neither stance can be shed and neither perspective can be even temporarily abandoned. Thus nurses engaged in qualitative research have an investment in confronting the dilemma of tension between opposing perspectives, and finding strategies to strive toward a sort of equilibrium. Rather than trying to protect ourselves against the dangers of over- or under-immersion, our sights should be set on ways to judge and account for the quality of our immersion in the dual roles of qualitative researcher and nurse. At very least, the practice of accounting for our efforts toward balancing the tensions associated with immersion should be reflected in our research reports and in our guidance for beginning nurse researchers.

Intervention

Perhaps the most problematic repercussion to result from the contamination of nurse and researcher roles is the reality that our research relationships foster expectations that we will intervene no matter how vehemently we try to protest that we are not acting in a clinical role. Chenitz (1986) argues that as long as we claim the identity of "nurse" researchers we imply a promise to intervene. The frequency with which the issue of intervention is addressed in the qualitative nursing research literature supports her claim that this is a particularly pressing problem for nurses in research.

In the traditional participant-observer fieldwork role, it was recognized that intimacy between informants and investigators increased the richness and validity of the data obtained (Gold, 1958; Pearsall, 1965). Toward this end, various tactics were sanctioned to foster intimacy, including such acts as doing favors for potential informants (Douglas, 1976). Nurse investigators have correctly identified the reality that such acts on their part toward potential or actual informants would heighten role confusion and reduce the likelihood of effective informed consent.

While it is true that all social scientists conducting qualitative research can encounter situations in which intervention seems imperative, it must be recognised that the nurse faces unique challenges to both ethics and validity that are distinct from those of other researchers. Unlike the quantitative research situation, in which the rules governing interference are explicit and precise, the qualitative researcher must consider the implications of each instance of influence upon the data that are generated. Thus when the qualitative investigator encounters a situation in which intervention is

needed, the guiding principle is the ethic of respect for the personal autonomy of the individual (Cassell, 1980). Social scientists view this ethic as being of particular import when the investigation of a group of people is undertaken for the express purpose of improving their lot or improving their quality of life (Schensul & Schensul, 1978).

What distinguishes this general societal obligation from the specific obligation of the nurse in clinical research is the entirely different relationship nursing has to the knowledge and skills necessary to effect an intervention (Davis, 1968). As Styles (1982) has argued, there is a form of moral obligation on the part of one who has acquired nursing knowledge and skills. The essential humanism that is part of the social role of "nurse" cannot be disregarded merely to expedite the research process. As Byerly (1969) explains, nurse researchers feel obliged at times to make "nursing judgements," and recognize that if not for the self-imposed restrictions arising from their research, they would intervene and bring about change.

Current theorists addressing the problem faced by qualitative nurse researchers tackle the dilemma in two ways. The first reflects strategies to avoid intervening and therefore contaminating data. Some of the suggestions offered include conscientiously remaining on the margin of the group under study (Davis, 1968), withholding intervention until the end of data collection (Archbold, 1986; Field & Morse, 1985; Swanson, 1986) or deliberately communicating the transition between roles when intervention is inevitable (Swanson, 1986). Included in the discussion of strategy by all of these theorists, though, is the recognition that no guidelines will serve all eventualities. Field and Morse (1985), for example, make the argument that intervention may be essential. They maintain that refusing to become involved in order to maintain access to informants or preserve the validity of the data is indefensible. They further note that failure to intervene in certain circumstances would reflect valuing of research above the quality of life.

The second way of tackling the dilemma reflects awareness that intervention is in fact an obligation for the nurse researcher at times. Archbold (1986) and Davis (1986) believe that the issue should be addressed from the stance that nurse researchers can and will intervene from time to time because ethical obligations to the informants take precedence over the interests of the researcher. Because of this, they suggest that attention be directed to the methods by which this phenomenon can be addressed in the process of conducting research. Davis (1986) believes that it is essential to account for any intervention in the course of data analysis. She argues that the researcher must be alert to instances when intervention has occurred, the reasons for its occurrence and the implications of its occurrence for the informants and the data constructed. Archbold (1986) raises the further issue of obligation for clinical follow-up that might be necessary because of intervention. Clearly

her perspective is that the moral obligation of a professional nurse goes beyond what is essential for the immediate well-being of the informant. She acknowledges, however, that there exists little guidance as to how "contaminated" data should be properly treated in order to improve validity of the findings. It is our contention that the expectation for intervention is a natural occurrence when nurse researchers investigate clinical concerns with informants who have the potential to be the client of nursing. Thus, obligation for the qualitative nurse researcher is again one of accounting for the particular influence of intervention on data construction and the research relationship.

Implications for Nursing Research

The issues we have raised are those that have provoked much thought and consideration in our own research. We have come to believe that concern about adhering to the rigors of scientific methodology has led to an artificial separation of the roles of nurse and researcher, which has exacerbated existing conflicts in the qualitative research endeavor. As an alternative approach, we argue that each role stimulates the other and that, in fact, these roles are so closely intertwined as to be inextricably linked. We believe that efforts to clarify the distinctions between the roles will only serve to complicate the dilemmas faced by nurses in qualitative research. From our perspective, the task should properly be one not of differentiation but rather of deliberate fusion. While clinical nursing can be defined as including an inherent aspect of systematic inquiry, so can clinical nursing research be understood to include some components of professional nursing practice.

One such component, the commitment to on-going assessment, is a useful means by which to address the dilemmas of informed consent and intervention in qualitative clinical nursing studies. We have argued that informed consent may be impossible in the truest sense. However, if the ethical principles underlying the intent of informed consent are of value, then efforts to produce the closest approximation to informed consent are required. Given that involvement in the research process itself will alter the nature of informed consent, our obligation must be to on-going assessment of commitment to continue in the informant role. The circumstance in which informed consent may be most severely jeopardized is the event of intervention on the part of the researcher. Whether such intervention constitutes a major or minor shift to the role of "clinician," it nevertheless upsets the critical balance sufficiently to oblige the researcher to reassess the existence of consent, and, if it exists, the foundation for that consent.

One general strategy that has served us well in our efforts to address dilemmas of ethics and validity is the formalized and systematic use of colleagues in the context of a research team or in the capacity of project

advisors. Teams of peers can address the issues of ethics and validity in a number of ways. First, freedom to immerse in subjective data can be greater if a trusted team member can be relied upon to carry the banner of objectivity. Designated perspectives within the research team allow the team to capitalize upon the subjectivity-objectivity tension in order to attain new depth of meaning without sacrificing validity. Ethical considerations related to informed consent, influence and intervention can be addressed as part of the on-going data gathering process if team members monitor each other's field notes and transcriptions. Correspondingly, project advisors or consultants could be most effectively employed if actually involved in monitoring the process of research in a similar manner. In this way, a broader perspective of the data becomes possible and analysis gains depth and credibility.

The net result of these strategies is to clarify the interaction between the process and product of the research endeavor. In order to account for this interaction in such a way that informs other researchers and assists interpretation of the data, it would seem essential to give a detailed description of the research process, including critical examination of issues associated with informed consent, influence, immersion and intervention, in the written research report.

The issues we have discussed are sufficiently critical to demand the serious consideration of all qualitative nursing research theorists. We believe that a body of theory addressing qualitative nursing research issues must evolve, and must continue to reflect the peculiarities that our profession brings to our interpretation of these methods of inquiry. Careful reflection, meticulous reporting and vigorous debate must be hallmarks of the process we use and are seen to use as qualitative nursing research evolves into a distinct and potent form of knowledge development.

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RÉSUMÉ

La relation dans le contexte de la recherche qualitative des soins infirmiers: Dilemme de morale et de validité

Ce papier adresse le dilemme qui se pose lors d'une recherche qualitative axée sur l'expérience de clients de soins infirmiers. La discussion porte sur quatre secteurs d'intérêt identifiés comme suit: le consentement avisé, l'influence, l'immersion et l'intervention. Les auteurs soutiennent que lorsque le processus de recherche dépend d'une relation intime entre le chercheur, qui est également infirmier/ère, et l'informateur, qui est également passible de recevoir des soins infirmiers, certaines des suppositions inhérentes à la méthodologie de recherche qualitative sont mises en question. L'interaction unique entre les soins infirmiers et les rôles de la recherche qualitative est perçue comme exigeant une considération sérieuse de la part de tous les chercheurs du secteur de la recherche qualitative des soins infirmiers.

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